

# BCN Provider News



- Cover Story**
- Network Operations**
- BCN Advantage**
- Patient Care**
- Behavioral Health**
- Quality Counts**
- Pharmacy News**
- Billing Bulletin**
- Referral Roundup**
- Index**

## Blue Cross and BCN changing professional provider consultant model

Blue Cross Blue Shield of Michigan and Blue Care Network will be changing the way we assign our professional provider consultants in the next few months. Our new professional consultant model will have fewer office visits. However, it will maintain our commitment to serving the provider community with continued education, provider forums, online tools and telephone support. Watch for more information in upcoming issues of *BCN Provider News* and *The Record*.

As a reminder, we told you back in July **you can obtain claims information 24 hours per day** through our automated telephone system. In our November-December issue we gave you **tips for navigating PARS**.

Please see [Consultant model](#), continued on Page 3

## Physician organizations receiving additional information to help providers address opioid epidemic

As part of Blue Cross Blue Shield of Michigan's continuing efforts to address the opioid epidemic, Value Partnerships, in cooperation with Pharmacy Services, is accelerating efforts on multiple fronts to further reduce fraud and the abuse of controlled substances.



Our current Fraud, Waste and Abuse Program already identifies the following:

- Health care providers who are writing opioid prescriptions for patients who may be doctor-shopping, which is the practice of visiting multiple physicians to obtain multiple prescriptions
- Patients who have been prescribed part of or all of a dangerous drug combination known as the triple threat — concurrent use of opioids, benzodiazepines and muscle relaxants. Triple threat combinations are often linked to recreational patient use and frequently lead to overdose and even death.

Please see [Physician organizations](#), continued on Page 2

### Inside this issue...

**04** Blue Cross Blue Shield of Michigan releases statement on opioid bill package

**14** Get ready for annual visits for your Medicare Advantage patients

**17** From the medical director: Making the case for medication-assisted treatment

**29** Best Practices: Controlling high blood pressure

### Feedback | [Subscribe](#)

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

# Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

**Physician organizations**, *continued from Page 1*

Blue Cross has a long-standing practice of alerting prescribing physicians when one of these situations occurs. Since April of 2016, Blue Cross Pharmacy Services has seen a 33 percent drop in members identified in the doctor-shopping analysis, and a 54 percent drop in members receiving the dangerous triple threat drug combination.

Since December, our Physician Group Incentive Program’s participating physician organizations have been receiving monthly reports about physicians who could unknowingly be involved in these potentially dangerous scenarios.

This process change provides us with an additional venue for educating providers about the importance of using the Michigan Automated Prescription System, or MAPS. The tool helps prescribers identify patients who may be improperly seeking Schedule 2 to 5 drugs. It’s used to identify and prevent drug abuse and diversion at the prescriber, pharmacy and patient level.

For more information, go to [michigan.gov/mimapsinfo](http://michigan.gov/mimapsinfo) or reach out to your physician organization.

**New flyer on opioid epidemic**

To learn more about what Blue Cross and Blue Care Network are doing to battle the opioid epidemic, see our recent **flyer**. It provides statistics about the opioid epidemic, outlines our comprehensive strategy and shows results from our various initiatives.



*Blue Cross opioid flyer*



**Editor**  
Cindy Palese  
[bcnprovidernews@bcbsm.com](mailto:bcnprovidernews@bcbsm.com)

**Provider Communications**  
Catherine Vera-Burgos, Manager  
Elizabeth Donoghue Colvin  
Jennifer Fry  
Tracy Petipren

**Market Communications Publications**  
Cathy Rauckis

**Contributors**  
William Beecroft, M.D.; Belinda Bolton; Terri Brady; Richard Cook, Pharm. D; Laura Cornish, Pharm. D; Duane DiFranco, M.D.; Kelly Redmond-Anderson; Mary Ellison; Teresa Javarjian

BCBSM and BCN maintain [BCBSM.com](http://BCBSM.com), [ahealthiermichigan.org](http://ahealthiermichigan.org), [mibluesperspective.com](http://mibluesperspective.com), [valuepartnerships.com](http://valuepartnerships.com) and [theunadvertisedbrand.com](http://theunadvertisedbrand.com). The Blues do not control any other websites referenced in this publication or endorse their general content.

References to "Blue Care Network" and "BCN" in this publication refer to all Blue Care Network of Michigan, Blue Care of Michigan, Inc., BCN Services Company and Blue Cross Complete of Michigan products, except where noted otherwise. Clinical information in this issue is consistent with *BCN Clinical Practice Guidelines* and applies to the care of BCN and BCN subsidiary/affiliate corporation members regardless of product. More information is available in the *BCN Provider Manual* on web-DENIS. Specific benefit information is available on web-DENIS, PARS or by calling Provider Inquiry.

*No portion of this publication may be copied without the express written permission of Blue Care Network of Michigan, except that BCN-participating health care providers may make copies for their personal use. In no event may any portion of this publication be copied or reprinted and used for commercial purposes by any party other than BCN.*

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

# Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Consultant model, continued from Page 1

Here are the key phone numbers to call:

For patients with this coverage:

Call this number:

- Blue Cross Medicare Plus Blue PPO (Medicare Advantage PPO).....1-866-309-1719
- Federal Employee Program .....1-800-840-4505
- All other coverage (commercial Blue Cross, BCN and BCN AdvantageSM) for professional providers.....1-800-344-8525
- All other coverage (commercial Blue Cross, BCN and BCN Advantage) for facility providers .....1-800-249-5103
- All coverage for vision and hearing providers.....1-800-482-4047

## Provider forums coming to a town near you

As you read this article, we’re planning and scheduling the next set of Blue Cross Blue Shield of Michigan and Blue Care Network provider forums. As we work through the details, be sure to check next month’s issue of *The Record* for dates, times, registration information and topics.

This year, the morning sessions will have content specifically geared toward physician office staff who are responsible for closing quality measures and coding gaps. These sessions will also look at the overall patient experience.

Topics will include:

- Patient experience
- Coding and documentation
- HEDIS® measures

Afternoon sessions will be suited toward all office personnel and will cover topics like:

- New provider service model
- eviCore and prior authorizations
- eReferral
- The opioid epidemic
- Behavioral Health
- Updates for Provider Enrollment and Data Management and PARS (provider automated response system)

These forums are well received and provide valuable information to keep your staff up to date on the latest information. If you haven’t been to one yet... be sure to check your April issue of *The Record* and future issues of *BCN Provider News*. We look forward to seeing you.

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





# Michigan opioid legislation takes effect in March

## Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index

In December, Lt. Governor Brian Calley signed into law a bill package that will tighten requirements around opioid prescriptions in the state of Michigan. The bills become Public Acts 246-255 of 2017.

The new law states the following:

- Prescribers cannot prescribe a Schedule 2-5 drug unless the prescriber has a bona-fide prescriber-patient relationship with the patient (beginning March 31, 2018).
- Prescribers cannot prescribe or dispense a controlled substance that exceeds a three-day supply without obtaining and reviewing a report from the Michigan Automated Prescription System (MAPS). All prescribers also would have to register with MAPS by June 1, 2018.
- Opioid prescriptions for acute pain would be limited to a seven-day supply, effective July 1, 2018.
- Providers will be required to discuss with a minor and their parent the risks of addiction and overdose, before prescribing an opioid to a minor. Information on the dangers of opioid addiction would also have to be provided to adult patients. Both minors, their parents, and adult patients would have to sign a form provided by the state to confirm they received the information (effective June 1, 2018).

- A prescriber must obtain and review a patient’s data from MAPS before dispensing or prescribing buprenorphine, or a drug containing buprenorphine and methadone, to a patient in a substance use disorder program.
- A health professional who has treated a patient for an opioid-related overdose, is required to provide information to the patient on substance use disorder services.
- An eligible individual may receive medically necessary acute medical detoxification for opioid use disorder, medically necessary inpatient care at an approved facility, or care in an appropriately licensed substance use disorder residential treatment facility through Medicaid.
- By the 2019-2020 school year, the state model for health education is required to include instruction on prescription opioid drug abuse. By July 1, 2019, the state department of education is to provide to school districts a grade and age-appropriate model program of instruction on prescription opioid drug abuse based on the recommendations of the state’s Prescription Drug and Opioid Abuse Commission.

## Blue Cross Blue Shield of Michigan releases statement on opioid bill package

Blue Cross Blue Shield of Michigan is committed to reducing addiction and the toll it is taking on families across the state. We’re actively engaging with physicians, public health advocates and officials on initiatives to combat the opioid epidemic by enhancing awareness. The following is a statement about the new legislation from Blue Cross Blue Shield of Michigan CEO Dan Loepp:

*“We are pleased with this bipartisan approach to address the opioid epidemic. It is a strong step forward that strengthens Michigan’s efforts to reduce addiction and abuse. We applaud leaders across government for their work to protect families from this crisis.*

*As Michigan’s largest health insurer with a strong social mission, Blue Cross Blue Shield of Michigan shares the concern over the crisis and we are also expanding our efforts to prevent addiction and overdose deaths in Michigan. We have significant efforts underway to combat the opioid epidemic by enhancing awareness, and through partnerships with physicians and public health advocates and officials.”*

Please see [Opioid bill](#), continued on Page 5



# Network Operations

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



## Blue Cross, Partners announce \$570,000 to communities across state

Nine community coalitions throughout Michigan will receive a total of \$570,400 in funding through the *Taking Action on Opioid and Prescription Drug Abuse in Michigan by Supporting Community Responses* initiative, courtesy of Blue Cross Blue Shield of Michigan, **The Blue Cross Blue Shield of Michigan Foundation, The Michigan Health Endowment Fund, The Community Foundation for Southeast Michigan** and **The Superior Health Foundation**. The partnership provides one-time grants to begin new projects, or to enhance or expand existing projects aimed at reducing opioid and prescription drug abuse and harm.

"This joint effort is a major initiative designed to help community coalitions address the growing opioid epidemic impacting Michigan residents in every corner of our state," said Daniel J. Loepp, president and chief executive officer of Blue Cross Blue Shield of Michigan. "It's imperative we turn our attention to the needs of the individuals and families being affected by this crisis. This funding will promote a larger network of resources throughout the state with an emphasis on prevention, treatment and support services."



### Opioid bill, *continued from Page 4*

We are working on several strategic initiatives to prevent overdose deaths, including:

- Limiting the quantity and day supply of addictive substances. An initial fill of a prescription for one of these medications will be limited to a five-day supply. Additional fills will be limited to no more than a 30-day supply, but will not apply to members with a cancer diagnosis or who are terminally ill.
- Working directly with doctors to coordinate care to reduce opioid abuse and overdose from prescriptions for controlled substances from multiple doctors without their shared knowledge of prescriptions from others.
- Creation of the Opioids Provider Toolkit, which provides physician organizations links to best practices and resources, tips to safely manage pain and information on available data and resources on opioid use.
- Development of awareness programs about deadly drug interactions from certain regimens with no legitimate medical rationale.
- Coordination of drug usage reviews and research to alert physicians before patients take a combination of opioids and other medications that can lead to fatal overdose. After six months of working with doctors, we've seen a nearly 51 percent reduction in Blue Cross members taking both opioid and benzodiazepine drugs.

# Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## New work group addresses health and health care disparities

Blue Cross Blue Shield of Michigan has formed a Health Disparities Action Team led by Diversity and Inclusion to support its social mission to increase access to affordable health care, enhance the quality of care patients receive and improve the health of Michigan’s citizens and communities.

“Helping to address health and health care disparities is a key objective of the Diversity and Inclusion Corporate Strategic Plan,” said Bridget Hurd, senior director, Diversity and Inclusion. “Promoting health equity and cultural competency in the delivery of health care is essential to achieving positive health outcomes for our members. The Health Disparities Action Team evaluates how we can impact health outcomes through our policy and programs.”

The cross-functional action team focuses on:

- Detecting and monitoring known health and health care disparities, and distinguishing what can be effectively addressed

- Implementing policies and programs that address the health and health care disparities among African-American members, other minority ethnicities and members of the LGBTQ community
- Influencing members to make healthy lifestyle choices and engage in regular preventive screenings
- Partnering with stakeholders to provide education and information to members

“Understanding the health and health care disparities of our diverse members is very important. Not only is it the right thing to do but it is also important from a business point of view,” said Dr. Marc Keshishian, senior vice president, chief medical officer, Blue Care Network and Blue Cross Blue Shield of Michigan vice president, Health and Clinical Affairs. “Understanding and responding to the health and health care needs of diverse cultures and communities makes people feel welcomed in the health care system and opens the door for obtaining care at the right time, in the right place and in the right way. As a result, we are able to improve everyone’s health and health outcomes, which leads to lower costs for all of us.”

The work team has a shared vision that includes building upon and leveraging existing Blue Cross and BCN policies and programs to effectively address health disparities.

Measures of success for the work of the Health Disparities Action Team include annual data collection; identification of disparities and focus areas; implementation, measurement, review, and evaluation of existing programs to ensure clear goals and measures; coalition-building of internal and external stakeholders and internal awareness of programs; and a comprehensive approach to addressing health and health care disparities.

Data collection and analysis conducted during the past year show disparities in preventive screenings, emergency department visits and hospital readmission within 30 days. Throughout 2018, the action team will initiate action items to address these disparities.





# Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## 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](http://bcbsm.com/providers). Complete these steps:

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

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](http://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.

### Network guidelines for member access

All Blue Care Network members should have appropriate and timely access to their practitioners. The following established guidelines for member access to care serve as BCN quality indicators:

<b>Access to primary care</b>	<ul style="list-style-type: none"> <li>• Regular and routine care – 30 days</li> <li>• Urgent care – 48 hours</li> <li>• After-hours care – 24 hours a day, 7 days a week</li> </ul>
<b>Access to behavioral health care</b>	<ul style="list-style-type: none"> <li>• Non-life-threatening emergency – 6 hours</li> <li>• Urgent care – 48 hours</li> <li>• Initial visit for routine care – 10 business days</li> <li>• Follow-up routine care – within 30 days of request</li> </ul>
<b>Access to specialty care</b>	<ul style="list-style-type: none"> <li>• High-volume specialist:                             <ul style="list-style-type: none"> <li>Ob-GYN - Regular and routine care – 30 business days</li> <li>- Urgent care – 48 hours</li> </ul> </li> <li>• High-impact specialist:                             <ul style="list-style-type: none"> <li>Oncology - Regular and routine care – 30 business days</li> <li>- Urgent care – 48 hours</li> </ul> </li> </ul>

For more detailed information, see the Access to Care chapter in the *BCN Provider Manual*, located on web-DENIS.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

# Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Clinical review decisions are based solely on appropriateness of care

Utilization decisions regarding care and service are based solely on the appropriateness of care prescribed in relation to each member’s medical or behavioral health condition.

Blue Care Network’s clinical review staff doesn’t have financial arrangements that encourage denial of coverage or service that would result in underutilization. BCN-employed clinical staff and physicians don’t receive bonuses or incentives based on their review decisions. Review decisions are based strictly on medical necessity within the limits of a member’s plan coverage.



## Staff available to our members for UM issues

Did you know that we’re available for our members (your patients) to discuss utilization management issues during and after normal business hours? Our staff members identify themselves by name, title and organization when receiving or returning calls. We also provide language assistance free of charge to discuss utilization management issues to our members. We offer TTY/TDD assistance for the hearing impaired. Please instruct your patients to call the number on the back of their member ID card for information about our communication services.

See also “Behavioral health providers may discuss decisions with BCN physician reviewers,” **Page 28.**



# Network Operations

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



BCN Provider News

[Feedback](#)

## Your patients may be surveyed about their experiences and satisfaction

We recognize that providing quality care is a collaborative effort between our plan and our health care providers — and we're committed to partnering with our providers to create a seamless care experience.

One measure of our members' care experience is the Consumer Assessment of Healthcare Providers and Systems, or CAHPS®, survey. This standardized survey of the patient experience of care, will be sent to a random sampling of our members — your patients — soon.

This survey is administered by the Centers for Medicare & Medicaid Services and used to help assess quality of care from a health plan member's perspective. The survey measures patient experiences over the past six months in areas including:

- Getting needed care
- Getting care quickly
- How well doctors communicate
- Health plan customer service
- How people rate their health plan

Research has shown that practices with a high level of patient satisfaction benefit in many ways:

- Patients who are highly satisfied are more loyal.
- Patients who are highly satisfied are more likely to adhere to treatment plans.
- Practices with high patient satisfaction have higher levels of employee satisfaction and less employee turnover.

We'll provide more details in future web-DENIS messages and newsletter articles.

## Clarification: We've made changes to the Ambulance Provider Participation Agreement

As noted in the June 2017 *Record*, Blue Cross Blue Shield of Michigan has a new ground and air Ambulance Provider Participation Agreement, which includes Blue Care Network. At this time, Blue Cross ambulance providers that did not sign the new agreement will not be affected by this change. These providers may continue to participate under the Blue Cross-only agreement. However, eventually, Blue Cross may phase out the Blue Cross-only agreement and solely have the joint Blue Cross and BCN agreement for those providers that wish to participate.



# Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Complete your attestation through CAQH

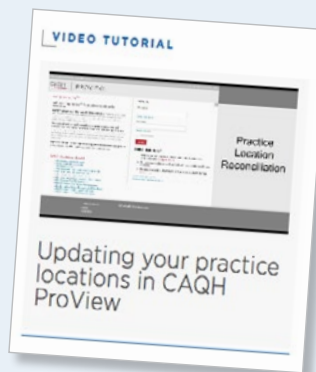
As communicated in the last issue, Blue Cross Blue Shield of Michigan and Blue Care Network have transitioned from the PRIME Hub website to CAQH ProView for the quarterly attestation process.

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.

A video is now available explaining the new CAQH ProView Practice Location Reconciliation tool. Go to the **CAQH page** and look for the video on "Updating your practice locations in CAQH ProView."



The tool will be available on March 16.

Welcome to the CAQH ProView application



PROVIEW™

### CAQH ProView™

Welcome to CAQH ProView™, formerly the Universal Provider Datasource®.

**CAQH ProView is more than a credentialing database.** Available at no cost to you, CAQH ProView eliminates duplicative paperwork with organizations that require your professional and practice information for claims administration, credentialing, directory services, and more.

**Through an intuitive, profile-based design, you can easily enter and maintain your information for submission to your selected organizations.** Help reduce inquiries for your administrative information and save even more time by keeping your CAQH ProView profile complete and up-to-date. Ensure that the healthcare organizations you authorize have instant access to accurate, timely information.

**Sign in on the right to update your existing profile information or, if you are a new provider to CAQH ProView, register to create a profile.**

#### CAQH ProView Reference Material

- [Provider Quick Reference Guide](#)
- [Dentist Quick Reference Guide](#)
- [Provider User Guide](#)
- [Video: Single Sign-on for Dentists](#)
- [Video: Practice Location Reconciliation](#)
- [Video: Providers – Get Started with CAQH ProView](#)
- [Video: How to Log In for the First Time](#)
- [Video: I forgot my username/password](#)
- [Video: How to Upload Documents in CAQH ProView](#)
- [Video: Required Field Changes Part 1](#)
- [Video: PLI Changes and Address Standardization](#)
- [Video: Specialties Section Changes and NPI Validation](#)
- [Video: Changes to Practice Locations Section](#)
- [Video: Changes to Hospital Affiliations Section](#)

[TERMS OF SERVICE](#)

[PRIVACY](#)

[CAQH.ORG](#)

© 2018

# How to submit inpatient authorization requests to BCN during upcoming holiday closures

Blue Cross Blue Shield of Michigan and Blue Care Network corporate offices are closed on Friday, March 30 for Good Friday.

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



During holiday closures, BCN's inpatient utilization management area remains available to accept inpatient authorization requests for BCN HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members.

Here's what you need to know about submitting inpatient authorization requests when our corporate offices are closed.

### Acute initial inpatient admissions

Submit these authorization requests through the e-referral system, which is available 24 hours a day, seven days a week.

### Post-acute initial and concurrent admission reviews

Follow the current process you use to submit these requests by fax at 1-866-534-9994.

### Other authorization requests

The types of requests listed below must be submitted by fax:

- Acute inpatient concurrent reviews and discharge dates, but only for facilities reimbursed on the basis of DRGs
- Authorization requests for sick or ill newborns
- Requests for enteral and total parenteral nutrition

For these requests, we accept faxes from midnight on Sunday through 4 p.m. on Friday. We don't accept faxes on weekends. Fax BCN HMO (commercial) requests to 1-866-313-8433. Fax BCN Advantage requests to 1-866-526-1326.

### Additional information

You can also call the BCN After-Hours Care Manager hotline at 1-800-851-3904 and listen to the prompts for help with the following:

- 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
- Handling emergency discharge planning coordination and authorization
- Handling expedited appeals of utilization management decisions

Note: Do not use the after-hours care manager phone number to request authorization for routine inpatient admissions.

Refer to the document **Submitting acute inpatient admission requests to BCN** for additional information.

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



# Network Operations

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



# BCN medical directors are a resource for physicians

Plan medical directors work with affiliated practitioners and providers to ensure appropriate care and service for BCN members. Plan medical directors are available throughout the state. Our medical directors:

- Provide clinical support for utilization management activities, including investigation and adjudication of individual cases
- Assist in the design, development, implementation and assessment of clinical protocols, practice guidelines and criteria that support the appropriate use of clinical resources
- Adjudicate provider appeals
- Work with physicians and other health care providers to improve clinical outcomes, appropriate use of clinical resources, access to services, effectiveness of care and costs
- Serve as a liaison with the physician community

## Clinical review decisions are based solely on appropriateness of care

Utilization decisions regarding care and service are based solely on the appropriateness of care prescribed in relation to each member's medical or behavioral health condition. BCN's clinical review staff doesn't have financial arrangements that encourage denial of coverage or service that would result in underutilization. BCN-employed clinical staff and physicians don't receive bonuses or incentives based on their review decisions. Review decisions are based strictly on medical necessity within the limits of a member's plan coverage.

## Providers may discuss decisions with BCN physician reviewers

Blue Care Network demonstrates its commitment to a fair and thorough process of determining utilization by working collaboratively with its participating physicians.

BCN's plan medical directors may attempt to contact the treating health care practitioner for additional information about any review deemed necessary. When BCN

doesn't approve a request, we send written notification to the appropriate practitioners and providers, and the member. The notification includes the reason the service wasn't approved as well as the phone number to contact BCN's plan medical directors to discuss the decision.

If you're a practitioner and would like to discuss your patient's condition or treatment with one of our plan medical directors, call 248-799-6312 from 8:30 a.m. to 5 p.m. Monday through Friday. To discuss an urgent case with one of our plan medical directors after normal business hours, call 1-800-851-3904.

## How to obtain a copy of utilization management criteria

Upon request, Blue Care Network provides the criteria used in the decision-making process. Call Care Management at 248-799-6312, from 8:30 a.m. to 5 p.m. Monday through Friday.

Due to licensing restrictions, BCN can't distribute complete copies of the InterQual® criteria to all practitioners and providers. However, all contracted hospitals have the electronic version of the criteria as part of BCN's licensing agreement.

## Staff available to our members for utilization management issues

Did you know that we're available for our members (your patients) to discuss utilization management issues during normal business hours and after hours? Our staff identifies themselves by name, title and organization when receiving or returning calls. We also provide language assistance free of charge to discuss utilization management issues to our members. We offer TTY/TDD assistance for the hearing impaired. Please instruct your patients to call the number on the back of their ID card for information about our communication services.

# Network Operations

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



## Tell us what you think about our provider manuals – you could win a prize!

Blue Cross Blue Shield of Michigan and Blue Care Network have several provider manuals. Here's how to find them:

1. Go to **bcbsm.com** and log in to Provider Secured Services.
2. Click on *Provider Manuals* (lower right side of page).

You can also click on *Provider Manuals* within web-DENIS.

We want our provider manuals to be easy for you to use, so you can find the information you need quickly. As part of our continuing effort to improve service to you, we would like your opinion on our provider manuals. Can you spare five minutes to take an online survey? Your input will give us insight into which manuals you use and how we can improve them.

Please complete the **online survey** by **April 30**. You could win a **\$25 gift certificate**.

Participation in the survey is not necessary to win. The drawing is open to all active Blue Cross or BCN providers. Enter by completing the survey no later than April 30, 2018, or by sending an e-mail with your name, phone number and "Survey drawing" in the subject line to [ProviderOutreach@bcbsm.com](mailto:ProviderOutreach@bcbsm.com) by April 30, 2018.

All entries must be received by April 30, 2018. One winner will be selected in a random drawing from among all eligible entries. The winner will receive a \$25 gift card. The drawing will take place by May 4, 2018. The winner will be notified by telephone or email following the drawing.



# BCN Advantage

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Get ready for annual visits for your Medicare Advantage patients

Now that we're embarking on a new year, you'll start seeing new and existing BCN Advantage patients for their "Welcome to Medicare" visits, annual wellness visits or routine physical exams. To help you prepare, we want to share this important information about these different visits:

- New BCN Advantage members should be scheduling their "Welcome to Medicare" preventive visit, also known as the initial preventive examination, and their routine physical exams.
- Existing BCN Advantage members should begin scheduling their annual wellness visit and their routine physical exams.

### Welcome to Medicare visit

The "Welcome to Medicare" preventive visit is sometimes referred to as the initial preventive examination. This is a one-time appointment for new Medicare patients to be scheduled within their first 12 months of enrollment. Medicare pays for one visit per member, per lifetime.

This visit is a great way to get up-to-date information on health screenings, shot records, family medical history and other preventive care services for your patients. These visits can be scheduled at the same time or coordinated with the patient's routine physical exam to get the best picture of your patient's health.

The "Welcome to Medicare" visit will include a health risk assessment and self-reported information from your patient to be completed before or during the visit. For more information about health risk assessments, visit **Framework for Patient-Centered Health Risk Assessments** on the Centers for Disease Control and Prevention website.

During the "Welcome to Medicare" visit, you should:

- Perform a health risk assessment
- Record your patient's medical and social history (like alcohol or tobacco use, diet and activity level)
- Check height, weight and blood pressure
- Calculate body mass index
- Perform a simple vision test

- Review potential risk for depression and patient level of safety
- Offer to talk about creating advance directives
- Educate the patient on preventive services needed and prescribe appropriate services
- Create a screening schedule (checklist) for appropriate preventive services

**Billing code for "Welcome to Medicare" visit, also called initial preventive physical examination**

G0402

### Annual wellness visit

The annual wellness visit is a chance for you to develop or update your patient's personalized prevention plan based on his or her current health situation and risk factors. Health risk assessments are also part of the annual wellness visit. The assessment includes self-reported information from your patient to be completed before or during the visit.

Medicare will cover an annual wellness visit every 12 months for patients who've been enrolled in Medicare for longer than 12 months. Patients can schedule their annual wellness visit on the same day or coordinate it with their routine physical exam (next page) to help give you a complete view of their health.

Services at the annual wellness visit include:

- Health risk assessment
- Review of medical and family history
- Develop or update a list of current providers and prescriptions
- Height, weight, blood pressure and other routine measurements
- Detection of any cognitive impairment
- Personalized health advice
- A list of risk factors and treatment options
- Education on preventive services needed and prescribe appropriate services

Please see [MA annual visits](#), continued on Page 15

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42





**MA annual visits**, *continued from Page 14*

- A review and update of the screening schedule (checklist) for appropriate preventive services

**Billing codes for annual wellness visits, which include a personalized prevention plan of service**

G0438 — First visit AWW, can only be billed one time, 12 months after a G0402 (IPPE)

G0439 — Annual wellness visit (subsequent)

Note: G0438 or G0439 must not be billed within 12 months or previous billing of a G0402 (IPPE)

**Routine physical exam**

The routine physical exam is typically covered annually by the patient’s Medicare Advantage health care plan. These exams are part of preventive services that aren’t part of the “Welcome to Medicare” visit or annual wellness visit.

Routine physical exams are used to get information about the patient’s medical history, family history and perform a head-to-toe assessment with a hands-on examination to assess your patient’s health, address any abnormalities or signs of disease. Routine physical exams should include the following:

- A visual inspection
- Palpitation
- Auscultation
- Manual examination

**Billing codes for annual exams or physicals**

**New patient**

\*99386 (40-64 years old)

\*99387 (65 years and older)

**Established patient**

\*99396 (40-64 years old)

\*99397 (65 years and older)

**Care plans**

These preventive visits are an excellent opportunity for you and your patients to plan their care for the year. Care plans should include a schedule for preventive services and health screenings, many of which are required annual services to meet Healthcare Effectiveness Data and Information Set, commonly known as HEDIS® specifications.

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

\*CPT codes, descriptions and two-digit modifiers only are copyright 2017 American Medical Association. All rights reserved.

You’ll need to recommend and prescribe — or refer your patient — needed preventive services that apply to his or her care plan. Some examples of preventive services include:

- Colon cancer screening
  - FOBT yearly
  - Sigmoidoscopy every five years
  - Colonoscopy every 10 years
  - Cologuard® every three years
- Breast cancer screening
  - Mammography every two years
- Osteoporosis testing in older women
  - Bone mineral density testing in women ages 65-85 every two years
- Comprehensive diabetes care
  - A1c blood sugar screening — two to four times per year
  - Urine microalbumin screening — yearly
  - Retinal eye exam — every other year if negative or every year if positive

These visits also provide a great opportunity to review or create a risk assessment for your patients, including a full list of their long-term chronic conditions. This will help your patients take advantage of disease and care management programs, as well as prevention initiatives.

This visit benefits both you and your patient by:

- Uncovering care management opportunities
- Identifying practice patterns
- Managing patient medications better
- Reducing avoidable hospital admissions

For more information on risk adjustment and HEDIS best practices, refer to our online provider manuals.

Note: BCN Advantage only reimburses one evaluation and management code on a date of service.



## Reminder: CMS transitioning to new fraud-protected Medicare card

As you read in the **September Record** and the September-October **BCN Provider News**, the Centers for Medicare & Medicaid Services is taking steps to remove Social Security numbers from Medicare cards. This initiative will help prevent fraud, fight identity theft and protect essential program funding, as well as the private health care and financial information of Medicare beneficiaries.

CMS will issue new Medicare cards with a new unique, randomly-assigned number called a Medicare Beneficiary Identifier to replace the existing Social Security-based Health Insurance Claim Number — both on the cards and in various CMS systems. **Keep in mind that your systems must be able to accept the new MBI format by April 2018.**

CMS will start mailing cards to Medicare recipients in April 2018. All Medicare cards will be replaced by April 2019.

### Provider ombudsman announced

CMS recently named Dr. Eugene Freund as the provider ombudsman for the new Medicare card. He will:

- Serve as a CMS resource for the provider community
- Ensure that CMS hears and understands any implementation problems experienced by clinicians, hospitals, suppliers and other providers
- Communicate about the new Medicare card to providers
- Help develop solutions to any implementation problems that may arise

To reach the ombudsman, contact: [NMCProviderQuestions@cms.hhs.gov](mailto:NMCProviderQuestions@cms.hhs.gov).

For more information, visit the **CMS** website.

## Amerigroup is not affiliated with Blue Cross Blue Shield of Michigan or Blue Care Network

If you recently received an invitation from Amerigroup Michigan, Inc., an Anthem, Inc. company, to participate in Amerigroup's Medicare Advantage provider network, please note the following:

- While Amerigroup is a subsidiary of Anthem, Inc., it does not offer Blue Cross or Blue Shield branded products or services.
- Amerigroup's Medicare Advantage offering and provider network is not affiliated in any way with Blue Cross Blue Shield of Michigan or Blue Care Network and is not part of the Blue Cross and Blue Shield Association's BlueCard Program.
- Claims, provider inquiries, and member servicing for Amerigroup will not be handled by Blue Cross or BCN.

If you have additional questions, the invitation document contains Amerigroup's contact information.

# Patient Care

## Making the case for medication-assisted treatment

By Dr. Kristyn Gregory



Addiction is a chronic disease, one characterized by compulsive use despite harmful consequences and relapse. However, relapse doesn't mean that the treatment did not work. As with other chronic health conditions, treatment generally isn't a cure. Those in recovery will be at relapse risk for years, possibly for life. Successful treatment and management may include medications, much like other chronic health conditions, such

as diabetes or hypertension, in addition to lifestyle changes and improved health habits.

In the battle against opioid abuse and addiction, there are evidence-based prevention and treatment strategies designed to help people recover and regain control of their lives. Tragically, these are highly underutilized throughout the United States, which prompted an initiative by the Secretary of Health and Human Services in 2015 to address the problem of opioid use.

This initiative emphasizes **preventive measures** like health care provider education in appropriate opioid-prescribing, increasing availability and access to naloxone, and wider implementation of evidence-based treatment strategies. Combined, these strategies all have a role in combatting the **opioid epidemic** affecting Michigan and the rest of the country.

### A unique approach

**Medication-assisted treatment**, or MAT, combines behavioral therapy and medications to treat substance use disorders. Methadone, buprenorphine and naltrexone are effective medications used to treat opioid use disorders. While these medications could assist many in recovery and have been shown to reduce mortality, they remain underutilized. Overcoming barriers, such as limited number of trained prescribers, and common misperceptions regarding these medications, is an essential part of fighting the opioid epidemic.

While relapse is a normal part of the recovery process, it can also be a time of increased risk for fatal overdose. The period following detoxification is one of elevated risk if the person returns to drug use. Maintaining abstinence using medications that reduce withdrawal and cravings, without producing the euphoria, can reduce the risk of a potentially fatal relapse in this period.

Because methadone and buprenorphine are themselves opioids, many assume that utilizing them in recovery is just replacing one addiction for another. Unfortunately, this belief has contributed to low access and utilization of medication-assisted treatment. However, when prescribed and monitored properly, these treatments have proven effective in helping patients recover. They have been shown to be safe and cost effective and reduce the risk of overdose. Aside from their clinical effectiveness, medication-assisted treatments also allow for patients to regain a sense of normalcy and functionality in their lives, often by decreasing criminal activity associated with substance abuse disorders, increasing patients' ability to secure and maintain employment and even improving birth outcomes for pregnant women who have substance use disorders.

Please see [From the medical director](#), continued on Page 18

- Cover Story
- Network Operations
- BCN Advantage
- Patient Care
- Behavioral Health
- Quality Counts
- Pharmacy News
- Billing Bulletin
- Referral Roundup
- Index





Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

From the medical director, continued from Page 17

## Buprenorphine and methadone

Methadone is a synthetic full mu-opioid agonist that can reduce or eliminate cravings, control physiological withdrawal and prevent the euphoria from the use of other mu agonists. It has a long half-life and is dosed daily when used for opiate maintenance treatment. It is *dispensed*, not prescribed, from an opioid treatment program, or OTP. OTPs are subject to both federal and state regulations and initially require patients to have daily observed dosing. When certain criteria are met, the patient may have gradual increase in abilities to have “take-home doses” and self-administer them at home. When used for opioid maintenance, methadone must be dispensed from an OT; program physicians are required to be either board-certified in addiction medicine or a psychiatrist.

Buprenorphine is an opioid partial agonist that is effective for the treatment of opioid use disorder. Like methadone, it can reduce or eliminate cravings and control withdrawal. Unlike methadone, it can be prescribed outside of an opioid treatment program. Under the **Drug Addiction Treatment Act of 2000**, or DATA, any physician can apply for a waiver to treat 30 to 100 patients in the office. Physicians are required to complete an eight-hour course, which is free through multiple avenues and can be completed on line. There’s a shortage of providers, and increasing the number of providers is a key element in increasing access to medication-assisted treatment.

Buprenorphine comes in an oral tablet or sublingual formulation; buprenorphine/naloxone preparations reduce the risk of misuse by injection. Generally, the oral formulations are taken one to two times a day for maintenance. In addition, there have been recent U.S. Food and Drug Administration approvals of longer acting formulations — a six-month subdermal implant (Probuphine®) which was FDA-approved in 2016 and a monthly subcutaneous formulation, Sublocade™, approved in November 2017. Any of these formulations may be prescribed by a DATA- waived physician. The longer acting formulations have the potential to reduce the risk of diversion and provide lengthier periods of recovery.

## Naltrexone

Naltrexone is an opioid antagonist that works by blocking the activation of opioid receptors. Instead of controlling withdrawal and cravings, it treats addiction by preventing any opioid drug from producing rewarding effects. It can be prescribed without a DATA waiver, and does not require dispensing in an OTP. Naltrexone is also used to reduce cravings for alcohol. Naltrexone comes in an oral tablet formulation, as well as an injectable monthly long acting formulation, Vivitrol. Because it is not an opiate agonist, it does not carry the risk of diversion associated with the agonist medication-assisted treatment. However, it requires a more extensive period off any opiate medication, generally seven to 10 days, to avoid a precipitated withdrawal. Like the agonist medications, it has been shown to reduce the risk of relapse and increase time in recovery.

## A holistic approach

The success of medication-assisted treatment is partly due to its integrated approach to recovery. It is a single component of a more complex treatment plan that involves regular counseling, behavioral therapies and collaboration of patient and provider. We can join the fight in this epidemic by increasing access, reducing barriers and challenging negative stigma of addiction.

### References

Drug Overdose Data Deaths <https://www.cdc.gov/drugoverdose/data/statedeaths.html>

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths. ASPE. <https://aspe.hhs.gov/basic-report/opioid-abuse-us-and-hhs-actions-address-opioid-drug-related-overdoses-and-deaths> Published November 23, 2015

The American Society of Addiction Medicine. *Advancing Access to Addiction Medications*. [http://www.asam.org/docs/default-source/advocacy/aaam\\_implications-for-opioid-addiction-treatment\\_final](http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final)



# Checklists for opioid prescribing

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

## Patient Care

### Cover Story

### Network Operations

### BCN Advantage

### Patient Care

### Behavioral Health

### Quality Counts

### Pharmacy News

### Billing Bulletin

### Referral Roundup

### Index



BCN Provider News

[Feedback](#)

By Manveen Saluja, M.D.FACP

*Dr. Manveen Saluja is a clinical associate professor at Wayne State University, assistant professor of medicine at Oakland University William Beaumont School of Medicine and a board-certified rheumatologist.*

Initial evaluations and follow-up are important when prescribing an opioid to a patient. Following specific office protocols and using a checklist can help avoid overdose and prevent drug diversion.

### Initial evaluation before starting opioids

- Consider opioid therapy only if the expected benefits for both pain and function are anticipated to outweigh risks to the patient. Confirm non-drug therapy and non-opioid medications have been tried and optimized.
- Assess risk of dependence and potential harm. Consider the following:
  - Screen for risk of dependence using an instrument such as SOAPP-R or ORT.
  - Obtain a Prescription Drug Monitoring Program report, for example, MAPS.
  - Obtain a urine drug screen to determine concurrent substance use.
  - Conduct a mental status examination as these medications can cause drowsiness and impair cognitive function.
- Conduct standard elements of pain assessment on all new and established patients including the PEG scale. Tracking the PEG scale throughout therapy can help avoid inappropriate dose escalation and lead to conversations about dose tapering.
- Avoid prescribing opioids with benzodiazepines, muscle relaxants or hypnotics due to high risk of death. Counsel patients on current alcohol use.
- Prescribe the lowest effective dose of immediate-release opioids and no greater quantity than needed for the

expected duration; if acute pain, three days or fewer is sufficient for most cases.

- There is no safe lower limit of dose or duration for opioid use. After seven days of use, the risk of chronic use rises three to four-fold.

- Consider using a controlled substance agreement with the patient to outline concurrent drug use, periodic monitoring (MAPS, urine screens) including the office refill policy.

### When considering long-term opioid therapy (Adults with chronic pain $\geq$ three months, excludes cancer and palliative care)

- Set realistic goals for pain and function based on diagnosis (for example, ability to perform daily functions).
  - Assess pain and function (for example, **PEG scale**) at baseline and throughout therapy.
- Use opioids as part of a pain management plan that includes non-drug and non-opioid therapies, as appropriate.
- Discuss benefits, risk factors and potential harm (addiction, overdose) with your patient.
- Evaluate misuse; consider re-checking MAPS and a urine drug screen.
- Set criteria for stopping or continuing opioids.
- Schedule initial reassessment within one to four weeks.

Please see [Opioid checklist](#), continued on Page 20

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

Feedback

## Opioid checklist, continued from Page 19

## Assessment at return visit

- Continue to re-assess pain and function (for example, PEG scale) and compare results to baseline.
  - Improvement in pain and function of at least 30 percent as compared with the start of treatment or in response to a dose change. (*A decrease in pain intensity in the absence of improved function is not considered meaningful improvement except in very limited circumstances such as catastrophic injuries, including multiple trauma or spinal cord injury.*)
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk. Taper as necessary.
  - Check MAPS.
  - Check for opioid use disorder if indicated (difficulty controlling use). Refer for treatment if needed.
- Determine whether to continue, adjust, taper or stop opioids.
  - Calculate opioid dosage morphine milligram equivalent (MME).
  - If  $\geq 50$  morphine milligram equivalents /day total, increase frequency of follow-up; consider offering naloxone with overdose prevention education to your patient and caregivers. Consider specialist referral when factors that increase risk for harm are present, such as:
    - History of overdose
    - History of substance use disorder
    - Higher dosages of opioids ( $\geq 50$  MME/day)
    - Concurrent use of benzodiazepines with opioids
    - Avoid  $\geq 90$  MME /day total, or carefully justify; consider specialist referral.
  - Schedule reassessment at regular intervals ( $\leq$  three months).
    - If renewing without a patient visit, make sure you schedule a return visit less than or equal to three months from the last visit.

50 MME/day = Total daily dose:

- 50 mg/day of hydrocodone
- 33 mg/day of oxycodone

90 MME/day = Total daily dose:

- 90 mg/day hydrocodone
- 60 mg/day oxycodone

## Additional tips to consider:

- Avoid providing early refills for lost or stolen prescriptions.
- Require face-to-face visits based on the patient's level of risk.
- Prescribe opioids electronically, if possible.

Sources:

Parchman ML, Von Korff M, Baldwin LM, et al. Primary care clinic re-design for prescription opioid management. J Am Board Fam Med 2017;30:44-51

<https://www.cdc.gov/drugoverdose/prescribing/guideline.html><http://www.mqic.org/guidelines.htm>



# Patient Care

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Choosing Wisely – Imaging tests often unnecessary for low back pain

Low back pain is a common problem for many adults. In fact, as many as 80 percent of all adults will have low back pain at some point in their lifetime, according to the National Institute of Neurological Disorders and Stroke. It is the most common cause of job-related disability and a leading contributor to missed work days.

### Causes of low back pain

The most common causes of low back pain are muscle strains and sprains. These injuries often happen from improper lifting, twisting or overstretching.

In many cases, low back pain will get better on its own after a few days or weeks without the need for any imaging tests, such as an X-ray, MRI or CT scan, unless they've had:

- Back pain for longer than six weeks
- Weight loss
- Fever
- Loss of bladder or bowel control
- Loss of feeling or strength in your legs
- Problems with reflexes
- History of cancer

### Treatments for low back pain

In most cases, self-care and medicines are all that's required to treat low back pain. If these treatments don't relieve your patient's pain, he or she may need another type of treatment.

- **Heat or ice.** Hot or cold packs can help reduce swelling and relieve pain.
- **Rest.** A day or two of rest may be good for back pain, but more than this may cause more harm than good. Instruct your patients to try lying on their back with pillows propped up under their knees to relieve pressure on the back.



- **Exercises, physical therapy or massages.** Prescribing specific exercises to help stretch and strengthen the back muscles may also be helpful as well as a physical therapy program or massages.
- **Pain relievers.** You may want to suggest starting with over-the-counter medicines to help relieve the pain and inflammation of low back pain. These include nonsteroidal anti-inflammatory drugs like ibuprofen, naproxen sodium and ketoprofen. If NSAIDs don't help, stronger pain relievers may be necessary.
- **Surgery.** This may be an option if other treatments don't work. In most cases, surgery is only used to repair serious injuries or relieve a compressed nerve.

As we've discussed in previous issues of the *BCN Provider News*, *Choosing Wisely* is a great place to look for information on health topics. The organization has valuable information on treating low back pain and imaging tests for low back pain. Please visit [choosingwisely.org](http://choosingwisely.org) for more information.

*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, can cause harm.*

*To assist in these conversations, several specialty societies have created lists of "Things Physicians and Patients Should Question" — evidence-based recommendations that should be discussed to help make wise decisions about the most appropriate care based on your individual situation.*

References:  
National Institute of Neurological Disorders and Stroke  
[Choosing Wisely](http://choosingwisely.org)

# Patient Care

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

Feedback

## Online health assessment helps your patients identify their health risks

Looking for a tool that can help your patients pinpoint their health risks? Then the Blue Cross Blue Shield of Michigan and Blue Care Network online health assessment on the Blue Cross® Health & Wellness website can help. It gives our members an easy way to see how their lifestyle choices affect their health and helps them learn about their modifiable health risks.

When your patients with BCN coverage take the health assessment, they receive immediate feedback. A report explains their risk levels and makes recommendations so they can take action. The assessment also gives them a health risk score to encourage positive changes. Members can print this information to share with you so you can work with them to lower those risks.

The health risk score your patients receive is derived from an analysis of their modifiable health risks. These include:

- Alcohol use
- Blood pressure
- Blood sugar
- Cholesterol
- Emotional health
- Exercise
- Nutrition
- Sleep
- Stress
- Tobacco use
- Weight

The Blue Cross health assessment uses engaging graphics and easy-to-read questions that guide members through a series of modules that assess various aspects of their lifestyle, health conditions and well-being. It also asks questions that assess a member’s readiness to make changes. Members are asked to input various biometric screening results; For BCN members who use the qualification form, their test results automatically upload into the health assessment.

### Fast and easy to use

The health assessment only takes a few minutes to complete, and it’s intuitive and user-friendly. Your patients with BCN coverage can take the health assessment on their computers or mobile devices through their member account at [bcbsm.com](http://bcbsm.com) or they can take it using the Blue Cross mobile app. The Blue Cross health assessment is powered by WebMD® and NCQA-accredited.

WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing health and wellness services.



# Patient Care

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## March is Kidney Month

To raise awareness and promote kidney health, the National Kidney Foundation has designated March as National Kidney Month.

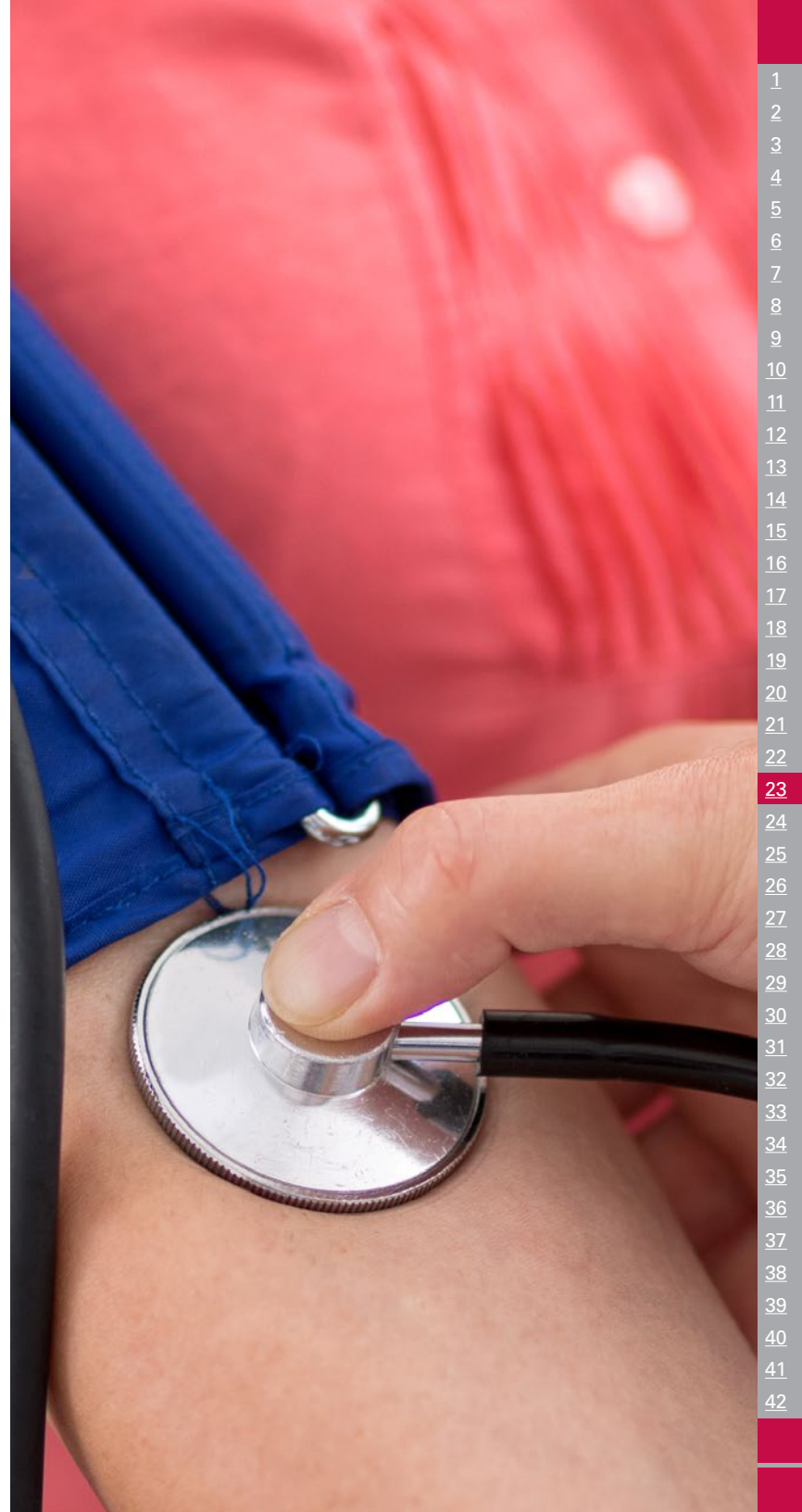
People with diabetes, high blood pressure and family history of kidney disease are at risk of developing chronic kidney disease. African Americans, Hispanics and senior citizens have a much higher risk of developing CKD.

You can do your part by monitoring the blood pressure of diabetic and hypertensive members and evaluating their kidney function annually by performing tests such as urine albumin and glomerular filtration rate. You can also encourage healthy lifestyle changes pertaining to diet, exercise and symptom management, such as a stable hemoglobin A1C and cholesterol level.

For more information regarding kidney disease, check the **National Kidney Foundation** website.

We want to stress the importance of educating your at-risk patients about CKD. Through early detection and member education, you can help slow progression of the disease as well as minimize the severity of other associated medical conditions, such as heart disease and stroke.

For additional information regarding **CKD guidelines** refer to the Michigan Quality Improvement Consortium guidelines.



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42



Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Criteria corner

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

### Interpreting symbols: Greater than or equal to

*In all subsets, when a greater than or equal to sign is associated with the frequency of an intervention, what is the correct interpretation or application of the criteria?*

This frequency indicator covers services provided greater than or equal to every x hours, depending upon the time specified. For example, greater than or equal to 6x/24h should be interpreted as the service is provided at least six times in 24 hours or more than six times in 24 hours. This would be inclusive of more frequent services, such as those occurring every five hours or more frequently, every four hours or more frequently. Confusion sometimes arises when a physician orders a treatment frequency of q.i.d. (four times a day). In this instance, it is acceptable for the reviewer to convert the frequency to every six hours.

### Interpreting symbols: Slash marks (/)

*How are slash marks (/) interpreted in the InterQual® Level of Care Criteria?*

When interpreting InterQual criteria, the slash mark is read as either "or" or "per" depending on how it appears in the criteria. The slash mark means "per" when there are no spaces before or after the slash mark. For example, "3x/24h" should be interpreted as "3x per 24h". The slash mark means "or" when there is a space before and after the slash mark. For example, "Antireflux surgery / Hiatal Hernia Repair" should be interpreted as "Antireflux surgery" or "Hiatal Hernia Repair."

When criteria points are more complex, the case type (upper- vs. lower-case letters) assists the reviewer in interpreting the criteria, as indicated in the following example:

Example: "Craniotomy: Biopsy of brain tumor / metastases." Because the first letters after the slash are in lower case, the correct interpretation of this criterion is "Craniotomy: Biopsy of brain tumor" or "Craniotomy: Biopsy of brain metastases."

### Interpreting symbols: Asterisk (\*) in the Guidelines for Surgery and Procedures in the Inpatient Setting

BCN has a local rule that states:

BCN criteria classify procedures on the InterQual Inpatient surgery list that are followed by a single asterisk (\*) as outpatient procedures except when the procedure is on the CMS inpatient only list and the member is a BCN Advantage member.

- BCN criteria classify all other procedures on the InterQual inpatient list as inpatient procedures.
- BCN criteria classify procedures deemed by CMS as inpatient procedures to be inpatient procedures for BCN Advantage members only.

#### Example — Appendectomy\*:

- Appendiceal abscess
- Appendiceal phlegmon
- Perforated appendix

### Procedures known by other names in the Guidelines for Surgery and Procedures in the Inpatient Setting

When a procedure is also known by another name, or if a different procedure will produce the same result, the additional procedure name is italicized and indented beneath the original. For example: "Total Joint Replacement (TJR), Hip" is also known as "*Arthroplasty, Total, Hip.*"

#### Another example — Antireflux Surgery / Hiatal Hernia Repair:

- *Belsey's Wrap*
- *Collis Gastroplasty*
- *Dor Fundoplication*
- *Hill's Gastropexy*
- *Laparoscopic Fundoplication*
- *Nissen Fundoplication*
- *Open Fundoplication*
- *Rossetti Fundoplication*
- *Thal-Nissen Repair*
- *Toupet Fundoplication*

## Twice-yearly Drug Take Back Day events help battle opioid crisis



Americans nationwide did their part to reduce the opioid crisis as part of the 14th Prescription Drug Take Back Day on Oct. 28. The Drug Enforcement Administration announced that a record-setting 912,305 pounds — 456 tons — of potentially dangerous expired, unused, and

unwanted prescription drugs were turned in for disposal at more than 5,300 collection sites.

That's almost six tons more than was collected at last spring's event. This brings the total amount of prescription drugs collected by the DEA since the fall of 2010 to 9,015,668 pounds, or 4,508 tons.

As the state's largest health insurers, Blue Cross Blue Shield of Michigan and Blue Care Network have supported the DEA's Drug Take Back Day since 2011.



National Prescription Drug Take Back Day events continue to remove ever-higher amounts of opioids and other medicines from the country's homes, where they could be stolen and abused by family members and visitors, including children and teens.

"More people start down the path of addiction through the misuse of opioid prescription drugs than any other substance," said DEA Acting Administrator Robert W. Patterson. "The abuse of these prescription drugs has fueled the nation's opioid epidemic, which has led to the highest rate of overdose deaths this country has ever seen."

The DEA's next Drug Take Back Day is April 28, 2018, so mark your calendar.

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## 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

- Intensive cardiac rehabilitation
- Intravenous anesthesia for chronic pain, depression and other mood disorders
- Patient-specific cutting guides and custom knee implants
- Transmyocardial (periventricular) closure of ventricular septal defects

### Covered services

- Genetic testing-chromosomal microarray testing for the evaluation of early pregnancy loss and intrauterine fetal demise
- Magnetic resonance imaging for detection and diagnosis of breast cancer
- Prostatic urethral lift procedure for the treatment of BPH



*Medical Policy  
Updates*

# CDC offers opioid training for providers



The Centers for Disease Control and Prevention offers web-based **training** to help providers gain a deeper understanding of the CDC’s opioid prescribing guideline. Continuing education credits are available.

The web-based training features self-paced learning and case-based content.

The CDC also offers a webinar series that applies the CDC Guideline in a primary care practice setting from CDC and University of Washington experts. Archived webinars include slides, real case examples and question-and-answer sessions.

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



# University of Michigan offers online course about the opioid crisis

The University of Michigan is offering an online course, “Solving the Opioid Crisis,” through its Teach-Out program. Registration starts March 5 and will be available for three weeks.

Teach-Outs are short learning experiences, each focused on a specific current issue. In this Teach-Out, experts from the fields of Medicine, Pharmacy, Public Health, and Dentistry will examine the impacts of this national epidemic and answer key questions: What are opioids? How did we get to the current crisis? How can we recognize opioid abuse and what can we do about it? What makes the crisis so complex?

Providers and office staff can **enroll**.



# Behavioral Health

**Cover Story**

**Network Operations**

**BCN Advantage**

**Patient Care**

**Behavioral Health**

**Quality Counts**

**Pharmacy News**

**Billing Bulletin**

**Referral Roundup**

**Index**



BCN Provider News

[Feedback](#)

## Blue Care Network offers adult intensive services for members with acute behavioral health needs

Blue Care Network has contracted with select mental health providers to offer intensive services for adult members with more complex behavioral health treatment needs. We've developed referral and payment arrangements with these providers to offer this comprehensive service to our members.

Adult intensive services providers offer comprehensive services to members who may be having difficulty succeeding in routine outpatient care in the community or when stepping down from an inpatient or residential level of care with ongoing intensive needs.

Services may include psychiatric evaluation, psychological testing, partial hospitalization services, respite care (in home or crisis residential), patient support coordinator interventions, psychotherapy treatment, medical evaluation, possible hospitalization, medication administration and other specific interventions based on member needs. Providers may also offer injectable medications when appropriate. Research studies have shown improved clinical outcomes and increased quality of life scores as a result of using injectable medications<sup>1</sup>.

Members who might benefit from these services could include those who are diagnosed with chronic-complex depression, bipolar illness, schizoaffective/schizophrenic disorders or other psychotic disorders which have led to repetitive emergency room use or inpatient hospitalizations. The use of intensive outpatient services is an alternative to those repetitive inpatient hospitalizations. Outpatient services and short-term respite care may help even those with severe illness function better.

When a member is identified for these services, Blue Care Network arranges a clinical evaluation, coordinated with the family and caregiver and with the knowledge of the current treating provider. Depending on the outcome of the evaluation, the provider would develop an initial treatment plan and request BCN to authorize services.

Members can be referred to BCN behavioral health for these services from emergency rooms, therapists, facilities, clinics and primary care physicians. Please contact us at 1-800-482-5982. Our behavioral health clinicians are on call 24 hours a day, every day of the year.

### References:

1. The Use of Long-Acting Injectable Antipsychotics in Schizophrenia: Evaluating the Evidence  
Christoph U. Correll, MD (Chair); Leslie Citrome, MD, MPH; Peter M. Haddad, MD; John Lauriello, MD; Mark Olfson, MD, MPH; Stephen M. Calloway; and John M. Kane, MD  
<http://www.psychiatrist.com/JCP/article/Pages/2016/v77s03/v77s0301.aspx>

# Behavioral Health

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



BCN Provider News

[Feedback](#)

## Blue Care Network 2018 Behavioral Health Incentive Program

Blue Care Network is phasing out manual submissions for the Behavioral Health Incentive Program. Manual submissions for both the therapeutic alliance measure and the primary care physician 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 aren't yet submitting self-reported forms electronically to review instructions for electronic submission on web-DENIS. We're committed to helping providers with this transition.

The 2018 booklet, forms, and instruction guides are available on web-DENIS. To find the documents:

- Log into Provider Secured Services and click on *BCN Provider Publications and Resources*.
- Click on *Behavioral Health* under Other Resources.
- Scroll down to Behavioral Health Incentive Program.

## Behavioral health providers may discuss decisions with BCN physician reviewers

Blue Care Network is committed to a fair and thorough process of determining utilization by working collaboratively with its participating behavioral health practitioners.

BCN's behavioral health physician reviewers may contact practitioners for additional information about their patients during their review of all levels of care, patient admissions, additional hospital days and requests for services that require medical policy and benefit interpretations.

When BCN doesn't approve a service request, we send written notification to the requesting practitioner. The notification includes the reason the service wasn't approved as well as the phone number to call BCN's behavioral health physician reviewers to discuss the decision.

Practitioners may discuss any decision with a BCN behavioral health physician reviewer. Call Behavioral Health at 1-877-293-2788 Monday through Friday, 8 a.m. to 5 p.m. To discuss an urgent case after normal business hours with one of our behavioral health physician reviewers, call 1-800-482-5982.

### How to obtain a copy of Behavioral Health criteria

Upon practitioner request, Blue Care Network will provide you with the behavioral health criteria used in our decision-making process. Call 1-877-293-2788 to request a copy of the criteria.

# Quality Counts

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Best Practices

### Controlling high blood pressure

An interview with Dr. Tackabury

*Blue Care Network conducted an interview with Dr. Daniel Tackabury, in North Branch, about how he helps patients with high blood pressure stay healthy.*

#### What do you do to help your patients control their blood pressure?

I provide patient education and have patients come for blood pressure checks. Patients like the idea that they can come in and get a blood pressure check without a copay. It lets them know we do care.

#### How frequently do you schedule follow-up appointments for patients with high blood pressure?

It depends on how high a patient's blood pressure is. Sometimes, we check it every couple of days until we get it down. For others, it may be one to two weeks. If it's borderline high and we're starting a patient on medication, we might check monthly.

#### How have you responded to the new blood pressure guidelines from the American Heart Association?

We are following the older guidelines from the American Academy of Family Physicians until we have a consensus. With the American Heart Association guidelines, a lot more people have borderline high or high blood pressure. I do discuss it with patients if they're in that range and we start working on dietary and lifestyle mediations – increasing exercise and quitting smoking for example.



Dr. Daniel Tackabury

#### How do you make sure patients are compliant with taking medications or other treatments you recommend for high blood pressure?

I always educate the patient about medications and significant side effects. I advise them that if anything feels different (if they're lightheaded or dizzy or blood pressure is too low) definitely call us. We always want to know how the patient is feeling. If a patient has to discontinue a certain medication, there are other options. It doesn't necessarily mean another office visit.

#### What do you encourage patients to do in between follow-up visits?

We try to get patients to get a home blood pressure cuff and do self-monitoring. If they're getting a discrepancy, we have them bring in their blood pressure cuff and compare their blood pressure with one we take. If there's anything questionable or high when staff takes a patient's blood pressure, I repeat it myself in the office.

#### How else do you help patients stay on track?

I'm honest with patients about consequences. If blood pressure stays out of control, whether taking medications or not, these are the long-term consequences: kidney disease, heart attack, stroke. I think people respond to that.



# Quality Counts

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Appropriate treatment for upper respiratory infections in children and adults

At least two million people a year in the United States are infected with bacteria where antibiotic treatment is ineffective, according to the Centers for Disease Control and Prevention. At least 23,000 of them die each year as a result of these antibiotic-resistant infections.

Healthcare Effectiveness Data and Information Set® has three measures which focus on reducing antibiotic use.

- Appropriate testing for children with pharyngitis
  - The percentage of children ages 3 to 18 who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode
- Appropriate treatment for children with upper respiratory infection
  - The percentage of children ages 3 months to 18 years who were given a diagnosis of upper respiratory infection and weren't dispensed an antibiotic prescription
- Avoidance of antibiotic treatment in adults with acute bronchitis
  - The percentage of adults 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription

Blue Care Network participates in HEDIS annually. To support success in these three measures, we have two clinical practice guidelines for antibiotic utilization that are available at [Michigan Quality Improvement Consortium](#) website.

The guidelines address the following:

- Acute pharyngitis in children 2 to 18 years old
- Management of uncomplicated acute bronchitis in adults

These guidelines are printed on one-page templates for convenient reference.

It's challenging to work with a patient who is requesting an antibiotic when it isn't appropriate for them or their child. Both the [CDC](#) and [Michigan Antibiotic Resistance Reduction](#) websites offer resources to help providers with this discussion.

Go to the [CDC](#) website for a list of the top 18 **drug-resistant threats** to the United States as well as activities to combat antimicrobial resistance.



# Pharmacy News

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



## It's important for pharmacies to report patients' vaccinations to MCIR

Pharmacies play an important role in immunizations because they're easily accessible and offer convenient locations and hours. Vaccines protect children, adolescents and adults from potentially serious vaccine-preventable diseases, including measles, pertussis, meningitis, pneumonia and influenza.

Michigan's statewide immunization registry, the Michigan Care Improvement Registry, tracks all vaccines administered in Michigan. By law, providers are required to report all immunizations administered to every person younger than age 20 within 72 hours of administration. MCIR was expanded to a lifespan registry in 2006; reporting adult vaccinations is strongly encouraged.

Reporting data to MCIR is a good public health practice because:

- It reduces over-immunization by maintaining the patient's immunization history.
- It helps decrease missed opportunities for vaccination.
- It allows for sharing immunization records between vaccine provider offices.

Under Schedule B of the *Blue Cross and BCN Restated & Amended Preferred Rx Participation Agreement*, we require providers who administer vaccine products to do all of the following:

- Complete the required immunization training.
- Use reasonable commercial efforts to maintain and make available the provider inventory of covered vaccine products at the location the provider anticipates the eligible members may schedule their vaccine administration.
- Provide a secured area for physical storage of drugs. This doesn't mean that the provider will have inventory or security measures outside of the normal business setting.
- Register all administered vaccines with the Michigan Care Improvement Registry or another organization as identified by Blue Cross Blue Shield of Michigan and Blue Care Network.
- Require a written prescription from a licensed prescriber for all vaccine products.\*\*

Help your pharmacy, your patients and your patients' other providers know which vaccines the patients have received by documenting them in the Michigan Care Improvement Registry.

For more information on participating in MCIR, visit [mcir.org/providers/pharmacies](http://mcir.org/providers/pharmacies).

\*\*Blue Cross and BCN will accept standing orders from physicians.



## Chorionic gonadotropin and Novarel undergo tier changes, starting March 1

Blue Care Network and Blue Cross Blue Shield of Michigan have moved chorionic gonadotropin and Novarel® from Tier 2 to Tier 3 (nonformulary) for all HMO and PPO formularies, effective March 1, 2018.

Patients who are prescribed these drugs will have to pay a higher copayment if they don't switch to a lower-cost alternative drug. Tier 3 drugs may not be covered for members with a closed benefit.

On March 1, the following will become nonpreferred (Tier 3) drugs:

- Chorionic gonadotropin
- Novarel

Instead of the products listed, members can save money by switching to the lower cost alternative:

Higher cost drug	Tier	Copayment level
Chorionic gonadotropin	3	Nonpreferred brand
Novarel	3	Nonpreferred brand
Lower cost alternative	Tier	Copayment level
Pregnyl®	2	Preferred brand

This change doesn't apply to BCN Advantage<sup>SM</sup> members.

We've sent letters to affected members notifying them of these changes. Members are encouraged to contact their physicians and discuss switching to the preferred option listed.

You can also view all drug lists online at [bcbsm.com](http://bcbsm.com).

## Blue Care Network will no longer cover Alvesco

To address the high cost of drugs and provide the best value for our members, Blue Care Network commercial will no longer cover Alvesco®, starting March 1, 2018. If members continue to use Alvesco on or after this date, they will be responsible for the full cost.

Alvesco is used to treat asthma. There are lower-cost prescription alternatives available. The covered alternatives are listed below.

Drug not covered beginning March 1, 2018
Alvesco® (member pays full cost)
Covered preferred alternatives
Arnuity® Ellipta®
Asmanex®, Asmanex® HFA
Flovent® HFA, Flovent® Diskus®
Pulmicort solution, Pulmicort® Flexhaler®
Qvar®



# Pharmacy News

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



## Effective March 1, 2018, prescriptions for all growth hormone products will have mandatory prior authorization requirements

At Blue Care Network and Blue Cross Blue Shield of Michigan, we regularly review drug therapies to ensure we cover the right medication for the right situation.

Beginning March 1, 2018, all growth hormone products will require approval from us before they'll be covered under the Blue Cross and BCN prescription drug plan. Drug approval requirements for coverage and all drug lists can be found online at [bcbsm.com/pharmacy](http://bcbsm.com/pharmacy).

- Pediatric members and adult members have different coverage requirements.
- We cover nonpreferred growth hormone products after the member tries all preferred products and finds them not effective.

Here's some information about growth hormone products and copayment levels.

Higher cost (nonpreferred) drugs	Copayment level		
	3-tier benefit	4-tier benefit	5-tier and 6-tier benefits
Humatrope®	Nonpreferred brand (tier 3)	Specialty (tier 4)	Nonpreferred specialty (tier 5)
Omnitrope®			
Saizen®, Saizenprep®			
Serostim®			
Zomacton™			
Lower cost (preferred) alternatives	3-tier benefit	4-tier benefit	5-tier and 6-tier benefits
Genotropin®	Preferred brand (tier 2)	Specialty (tier 4)	Preferred specialty (tier 4)
Norditropin® FlexPro® (will be preferred effective 3/1/18)			
Nutropin AQ® Nuspin™			

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## BCN and Blue Cross fight Hepatitis A outbreak with access to vaccines at Michigan pharmacies

Eligible Blue Care Network and Blue Cross Blue Shield of Michigan commercial members are now covered for both the Hepatitis A vaccine and the combination Hepatitis A and B vaccine (Twinrix®) under their pharmacy benefits plan.

“In light of the Hepatitis A outbreak in Michigan, we wanted to make it as easy as possible for members to receive the Hepatitis A vaccine if they need it,” said Timothy Antonelli, R.Ph., manager, Pharmacy Services. “The vaccine is the best way to prevent this disease and it can even prevent the disease in those individuals who have been exposed to the Hepatitis A virus recently, so long as they get it within two weeks of exposure.”

Some of the vaccines that are currently billed under the medical benefit can also be billed through the pharmacy claims processing system.

In addition to influenza, pneumonia, shingles, HPV, meningitis and Tdap vaccines, the new policy allows participating pharmacies to bill Hepatitis A vaccines.

Hepatitis A is a highly contagious liver infection caused by the Hepatitis A virus, which often spreads when an infected person doesn’t wash his or her hands after going to the bathroom, then touches objects or food. Symptoms can range in severity from a mild illness of a few weeks to a severe illness lasting several months.

More than 20 Southeast Michigan residents have died since the outbreak began in August 2016. Transmission appears to occur through direct person-to-person contact and illicit drug use. Most Blue Cross and BCN commercial (non-Medicare) members with prescription drug coverage are eligible. The vaccine has no cost share to members if their benefits meet the coverage criteria.

Members who are outside of Michigan can get vaccines through the Express Scripts Pharmacy network.

Share this **fact sheet** from the Centers for Disease Control and Prevention with your patients.

You can find out more about the Southeast Michigan outbreak from the **Michigan Department of Health & Human Services**.



# Pharmacy News

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



## Two medical benefit drugs require authorization, beginning April 1

Blue Care Network will require prior authorization for two medical benefit drugs for dates of service starting April 1, 2018.

Drug name	Procedure code	Additional information
Makena™	J1726	Applies only to BCN HMO (commercial) members who start this drug on or after April 1, 2018
Tysabri®	J2323	Applies to BCN HMO (commercial) members who start this drug on or after April 1, 2018, and those who currently take the drug

Providers must submit an authorization request through the NovoLogix electronic system to demonstrate medical necessity. Authorization requests for these drugs should be submitted prior to the start of services.

Medical necessity criteria for these drugs include but are not limited to diagnosis, lab results, dose and frequency of administration. Documentation may also be required that shows the medications previously used to treat the member's condition, including the dose, regimens, dates of therapy and response. Additional pertinent clinical information may also be required.

These new authorization requirements do not apply to BCN Advantage<sup>SM</sup> members.

For a full list of drugs that require authorization and for information on how to request authorization, visit [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Click *BCN* and then click **Medical Benefit Drugs – Pharmacy**.

## Blue Cross and BCN will no longer cover topical lidocaine and benzocaine, effective May 1, 2018

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 do not cover select high-cost drugs for which more cost-effective therapeutic alternatives are available.

We will no longer cover topical lidocaine and benzocaine products, effective May 1, 2018. Affected members can continue to fill topical lidocaine and benzocaine prescriptions through April 30, 2018, but will be responsible for the full cost after this date.

The following table includes lower-cost prescription drugs and over-the-counter alternatives:

Prescription drug not covered beginning May 1, 2018
Benzocaine 10% ointment (Anacaine®)
Lidocaine jelly 2%
Lidocaine ointment 5%
Lidocaine/prilocaine cream (Emla®)
Over-the-counter alternatives
Benzocaine ointment 2%, 5%, 20%
Lidocaine gel 2%, 4%
Lidocaine ointment 2%, 4%, 5%

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.



- Cover Story
- Network Operations
- BCN Advantage
- Patient Care
- Behavioral Health
- Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



## Prevent unnecessary delays: Include key information for oncology medications

Blue Care Network and Blue Cross Blue Shield of Michigan are working with the medical community to ensure appropriate oncology care through pharmacy utilization management. To help us deliver effective therapy to your patients, while ensuring safe and appropriate use, we're asking providers to include key information for oncology medications.

To prevent delays in processing claims for oncology medications, submit all oncology pharmacy requests with the following information:

- Recent chart notes
- Diagnosis
- Documentation of trial and failure of alternatives

Chart notes are useful to verify dosing regimens and patient usage. If a patient continues therapy that was initiated in a hospital setting, hospital chart notes are required. This is especially important for cancer patients on chemotherapy. Claims will be denied if chart notes aren't included.

Documentation of trial and failure of alternatives and diagnosis ensure that the most up-to-date oncology prescribing guidelines are followed.

For more information on the Blue Cross utilization management criteria for oncology medications, visit the **Prior Authorization and Step Therapy Guidelines** page at [bcbsm.com](http://bcbsm.com).

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42

# Billing Bulletin

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



Selecting the diagnosis code that best captures a patient's condition at the time of his or her visit can be a challenge, but keeping some basic guidelines in mind helps. And to ensure best coding practices, providers can always refer to ICD-10-CM guidelines.

### Here's what you need to know about coding for cancer.

The documentation should always clearly indicate **one** of the following:

- The cancer is active and still being treated.
- The cancer is no longer active or is in remission **and** there's no recurrence; i.e., no further treatment is necessary.

When coding for active malignancy versus coding for a person with a history of malignancy, ICD-10-CM coding guidelines are specific.

Section I.C.2.m. states:

"When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

"When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85, personal history of malignant neoplasm, should be used to indicate the former site of the malignancy."

### Forms of active treatment include:

- Current hormonal therapy for the cancer or neoplasm (not for prophylactic purposes)
  - Watchful waiting or active surveillance, meaning the malignant neoplasm has not been treated but is being closely monitored for progression
  - A patient has a condition but isn't being treated because he or she refuses treatment or is too frail

An exception to these rules occurs when coding multiple myeloma and leukemia. For these diagnoses, there are "in remission" codes that providers should use once treatment is completed and the patient achieves remission.

Please see [Cancer coding](#), continued on Page 38

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)**Cancer coding**, continued from Page 37

The following scenarios help differentiate between situations where providers should use “history of malignancy” codes and those in which the malignancy should be coded as active.

**Scenario one:**

A patient with a history of breast cancer who had chemotherapy, radiation and a mastectomy — and who currently has no evidence of recurrence — comes in for an office visit. The provider documents that the patient isn’t receiving active therapy for breast cancer. The code for personal history of malignant neoplasm of the breast (Z85.3) should be used.

**Scenario two:**

A female patient who was diagnosed with cancer of the central portion of the right breast returns to the office for a visit after a mastectomy and is currently receiving radiation therapy. Doctors should document current active treatment (radiation), and use a code for active breast cancer; e.g., C50.111 malignant neoplasm of central portion of right female breast.

**Scenario three:**

A patient who was diagnosed with cancer of the axillary tail of the left breast three years ago — and who had a mastectomy followed by radiation and chemotherapy — comes in for an office visit. She is currently taking Arimidex® and undergoing adjuvant therapy, which is considered active treatment. Therefore, it’s inappropriate to use a “history of breast cancer” code. Providers should use active cancer codes for as long as the patient is still undergoing adjuvant therapy.

**Scenario four:**

A patient who was diagnosed with acute myeloblastic leukemia was treated with chemotherapy and successfully achieved remission. He returns to the office for a visit and has no evidence of recurrence. The code for acute myeloblastic leukemia in remission (C92.01) should be used.

**In summary**

- Clinical evidence needs to be documented to support an active cancer code. The documentation must clearly indicate that the cancer was either not treated or is being actively treated, including with adjuvant therapy.
- If the cancer has been eradicated and there’s no evidence of recurrence and no further treatment is needed, then it’s appropriate to use a “personal history of cancer” code.
- Multiple myeloma and leukemia have “in remission” codes that providers should use when a patient achieves remission following treatment.

*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.*

*Also, keep in mind that 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.*





# Billing Bulletin

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Question:

Our physician is providing conscious sedation services in the outpatient setting. We are reporting codes \*99152 and \*99153, but only being paid for the \*99152. The procedures are longer than 15 minutes. What do I need to report to have our physician paid for the services beyond 15 minutes?

## Answer:

CPT code \*99153 is considered a technical-only code when reported in the inpatient or outpatient locations. This determination is based on Centers for Medicare & Medicaid Services policy.

The rationale for this determination is that the physician work is typically performed in the initial part of the procedure, which would be the first 15 minutes, and be covered by either CPT code \*99151 or \*99152. Additional work performed after this time in a facility location is usually handled by a nurse or other trained person employed by the hospital.

## Question:

I sent in a clinical editing appeal for a code that was denied. That code was paid on the appeal, but another code was then denied. I did not appeal or question anything on that code. Why was payment taken back on a code that was not appealed?

## Answer:

When a claim line is appealed, our analysts are asked to review the documentation you submit, as well as all codes submitted on the claim. The goal of our review is to ensure that documentation supports the services and procedures reported on the claim and to make sure they're reported in line with correct coding and billing guidelines.

In the rare event where coding and documentation are not in alignment, you may see an adjustment to the claim. This can occur, even on a code or service that was not appealed. When this occurs, as it is a new edit or denial, you have a right to appeal the new determination.

## Question:

I do billing for a specialist who performs tilt table testing. I understand there are diagnosis restrictions and you expect the patient to have a cardiac work-up prior to a tilt table test. Can you explain why we received a denial for the testing when the patient had the cardiac workup including the required EKG within five months of the tilt table testing?

## Answer:

As you note, there are diagnostic restrictions for tilt table testing, which is reported under CPT code \*93660. We review claims to confirm other conditions have been ruled out, including cardiac related ones, and that the testing has been done within a reasonable period of time.

Our guidelines are based on the American Heart Association and the National Institute for Health and Care Excellence. In accordance with these guidelines and our health plan policy, we expect that the cardiac work-up, for which we would accept a 12-lead EKG, be completed within 90 days prior to performance of the tilt table testing.

\*CPT codes, descriptions and two-digit modifiers only are copyright 2017 American Medical Association. All rights reserved.

## 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 will answer your question in an upcoming column, or have the appropriate person contact you directly. Call Provider Inquiry if your question is urgent or time sensitive. Do not include any personal health information, such as patient names or contract numbers.



# Air ambulance billing instructions are now available

Instructions for billing emergency and non-emergency air ambulance services for dates of service on or after Jan. 1, 2017, are now available. Click on the PDF below to see them.

These instructions apply to both Blue Cross PPO (commercial) and BCN HMO (commercial) air ambulance claims. The Blue Cross PPO (commercial) and BCN provider manuals are being updated with links to this document.

To obtain the instructions on our website, complete the following steps:

1. Visit [bcbsm.com/providers](http://bcbsm.com/providers).
2. Click *Login*.
3. Log in to Provider Secured Services.
4. Click *BCN Provider Publications and Resources*.
5. Click *Billing / Claims*.
6. Click *Air ambulance services*.



The instructions document is also available on the BCBSM Provider Publications and Resources page titled "Clinical criteria and other resources." Look under the "Clinical criteria" heading.

In line with standard Blue Cross and BCN claims auditing policies, all air ambulance claims are subject to post-payment audit to ensure the appropriateness of claims payment.



## 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:

- Clinical editing appeals
- Documenting assistant surgeon services



# Referral Roundup

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



## Non-emergency air ambulance services require authorization starting April 2, 2018, for commercial members

Effective for dates of service on or after April 2, 2018, all non-emergency air ambulance transports for Blue Cross PPO (commercial) and Blue Care Network HMO<sup>SM</sup> (commercial) members require authorization. Requests for authorization must be submitted to and approved by Alacura Medical Transportation Management, LLC, prior to the flight. This requirement applies to both in-state and out-of-state air ambulance transports.

Alacura, an independent company working with Blue Cross and BCN, will use the Blue Cross and BCN medical policy titled **Air Ambulance Services** to determine the appropriateness of non-emergency flights.

There are no changes to member benefits related to air ambulance services. Non-emergency air ambulance services are eligible for reimbursement if the member has the benefit and if Alacura authorizes the flight.

### How to request an authorization

To contact Alacura about a non-emergency flight request, call 1-844-608-3676. If you're required to submit documentation, fax it to Alacura at 1-844-608-3572.

We're making this change because air ambulance transports that are not medically necessary or that are flown by noncontracted providers expose Blue Cross and BCN members to significantly greater out-of-pocket costs and are much costlier for the plan. The requirement for authorization prior to non-emergency flights is expected to lower costs for Blue Cross and BCN members and customers.

## Reminder: 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](http://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.

## Coming soon: One e-referral tool for BCN and Blue Cross

We're working to make our e-referral tool easier for you. We'll be combining the BCN and Blue Cross e-referral applications into one. This means you have one place to go to request authorizations and referrals for all your Blue Cross and BCN patients. Watch for announcements on [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com).



# INDEX: March–April 2018

## Index

### Cover Story

### Network Operations

### BCN Advantage

### Patient Care

### Behavioral Health

### Quality Counts

### Pharmacy News

### Billing Bulletin

### Referral Roundup

### Index



BCN Provider News

[Feedback](#)

### BCN Advantage

Get ready for annual visits for your Medicare Advantage patients . . . . . **Page 14**

Reminder: CMS transitioning to new fraud-protected Medicare card . . . . . **Page 16**

Amerigroup is not affiliated with Blue Cross Blue Shield of Michigan or Blue Care Network . . . . . **Page 16**

### Behavioral Health

Blue Care Network offers adult intensive services for members with acute behavioral health needs . . . . . **Page 27**

Behavioral health providers may discuss decisions with BCN physician reviewers . . . . . **Page 28**

How to obtain a copy of Behavioral Health criteria . . . . . **Page 28**

Blue Care Network 2018 Behavioral Health Incentive Program . **Page 28**

### Billing Bulletin

Coding Corner: Using a ‘history of cancer’ code vs. ‘active cancer’ code . . . . . **Page 37**

Billing Q&A . . . . . **Page 39**

Have a billing question? . . . . . **Page 39**

Air ambulance billing instructions are now available . . . . . **Page 40**

Clinical editing billing tips . . . . . **Page 40**

### Network Operations

Blue Cross and BCN changing professional provider consultant model . . . . . **Page 1**

Physician organizations receiving additional information to help providers address opioid epidemic . . . . . **Page 1**

Provider forums coming to a town near you . . . . . **Page 3**

Michigan opioid legislation takes effect in March . . . . . **Page 4**

Blue Cross Blue Shield of Michigan releases statement on opioid bill package . . . . . **Page 4**

Blue Cross, Partners announce \$570,000 to communities across state . . . . . **Page 5**

New work group addresses health and health care disparities . . **Page 6**

Direct reimbursement available to limited licensed psychologists and licensed marriage and family therapists beginning June 1, 2018 . . . . . **Page 7**

Network guidelines for member access . . . . . **Page 7**

Clinical review decisions are based solely on appropriateness of care . . . . . **Page 8**

Staff available to our members for UM issues . . . . . **Page 8**

Your patients may be surveyed about their experiences and satisfaction . . . . . **Page 9**

Clarification: We’ve made changes to the Ambulance Provider Participation Agreement . . . . . **Page 9**

Complete your attestation through CAQH . . . . . **Page 10**

How to submit inpatient authorization requests to BCN during upcoming holiday closures . . . . . **Page 11**

BCN medical directors are a resource for physicians . . . . . **Page 12**

Tell us what you think about our provider manuals – you could win a prize! . . . . . **Page 13**

### Patient Care

Making the case for medication-assisted treatment . . . . . **Page 17**

Checklists for opioid prescribing . . . . . **Page 19**

Additional tips to consider: . . . . . **Page 20**

Choosing Wisely – Imaging tests often unnecessary for low back pain . . . . . **Page 21**

Online health assessment helps your patients identify their health risks . . . . . **Page 22**

March is Kidney Month . . . . . **Page 23**

Criteria corner . . . . . **Page 24**

Twice-yearly Drug Take Back Day events help battle opioid crisis . . . . . **Page 25**

Medical policy updates . . . . . **Page 25**

CDC offers opioid training for providers . . . . . **Page 26**

University of Michigan offers online course about the opioid crisis . . . . . **Page 26**

### Pharmacy News

It’s important for pharmacies to report patients’ vaccinations to MCIR . . . . . **Page 31**

Chorionic gonadotropin and Novarel undergo tier changes, starting March 1 . . . . . **Page 32**

Blue Care Network will no longer cover Alvesco . . . . . **Page 32**

Effective March 1, 2018, prescriptions for all growth hormone products will have mandatory prior authorization requirements . . . . . **Page 33**

BCN and Blue Cross fight Hepatitis A outbreak with access to vaccines at Michigan pharmacies . . . . . **Page 34**

Two medical benefit drugs require authorization, beginning April 1 . . . . . **Page 35**

Blue Cross and BCN will no longer cover topical lidocaine and benzocaine, effective May 1, 2018 . . . . . **Page 35**

Prevent unnecessary delays: Include key information for oncology medications . . . . . **Page 36**

### Quality Counts

*Bet Practices:* Controlling high blood pressure . . . . . **Page 29**

Appropriate treatment for upper respiratory infections in children and adults . . . . . **Page 30**

### Referral Roundup

Non-emergency air ambulance services require authorization starting April 2, 2018, for commercial members . . . . . **Page 41**

Coming soon: One e-referral tool for BCN and Blue Cross . . . **Page 41**

*Reminder:* We’re changing the way we describe care management . . . . . **Page 41**

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42