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## New RationalMed program to identify medication-related safety issues

Beginning July 1, 2013, Blue Care Network is partnering with its pharmacy claims processor, Express Scripts, to launch RationalMed® for its commercial and Medicare populations. This new clinical program helps ensure safe and appropriate medication therapy is prescribed for our members. By combining medical and pharmacy claims, we are able to identify gaps in care and potential medication-related issues.

After providing member diagnosis data to the claims processor, the RationalMed® program identifies safety issues related to inappropriate pharmacy claims, based on the member's history. Prescribers will be notified with member prescription claim information and suggested interventions for a variety of safety-related issues, including risk of adverse drug events (such as drug-disease interaction), coordination of care (such as duplicate therapy, overuse of narcotics) and omission of care (such as missing laboratory testing needed when certain drugs are prescribed). This program is expected to enhance member safety and decrease overall drug and medical expense.

We estimate that between 2.5 and 10 percent of our member population will see improvement in their prescribed therapy. This figure is based on BCN's estimate that around half of all suggested interventions will be accepted, and that potential interventions will be identified for 5 to 20 percent of our members. Past experience suggests that a success rate of 50 percent or higher is expected in Michigan.



Nicole Lee

### Pharmacy presentation available on web-DENIS

Nicole Lee, a BCN pharmacist, explained the RationalMed program and other pharmacy news at the May Provider Partnership Open House.

For the complete pharmacy presentation, go to *BCN Provider Publications and Resources* in web-DENIS. Click on *Learning Opportunities* and go to *Provider Partnership Open House for Southeast Regional Primary Care Physicians – May 16, 2013*.



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# Blue Care Network hosts provider partnership open house

The Blue Care Network Southeast Provider Servicing team welcomed approximately 150 primary care physicians and their office staffs to Southfield for a special open house event to support provider partnership. Several BCN speakers were on hand to share information on proper coding and documentation, pharmacy updates and electronic data interchange.

Some of the presentations are covered in this issue and are identified with a Provider Partnership Open House banner. See:

- Introducing change in your practice, **Page 24**
- Complete documentation and appropriate coding, **Page 36**
- Training is available on documentation and professional coding, **Page 38**
- Helpful information about submitting electronic claims, **Page 39**

The presentations are available on web-DENIS in *BCN Provider Publications and Resources*. Click on *Learning Opportunities* and go to *Provider Partnership Open House for Southeast Regional Primary Care Physicians – May 16, 2013*.



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## The Blues Health Care Reform information designed with you in mind

Health care is changing quickly and everyone is feeling the effects. Whether you're a health care provider, a payer, an employer or a patient, it's hard to keep up with all of the new information that seems to be available every day. The biggest changes in the next few years for all of us are related to health care reform.

In the upcoming months, we'll publish many articles about health care reform in our newsletters. Some of the topics that we'll cover will be:

- Mandates that are part of the Patient Protection and Affordable Care Act
- Information on the new plans in Health Insurance Marketplace
- Notification of upcoming informational sessions related to reform
- How and where to get the most up-to-date information

At Blue Cross Blue Shield of Michigan and Blue Care Network, we understand that these changes will impact your practices and facilities and we're working to get you the information you need to do business with us.

For more information about health care reform, visit the **Blue Cross health care reform website**.

The BCN Health Care Reform page is available on web-DENIS. Go to *BCN Provider Publications and Resources* and click on *Health Reform* under *Resources*. This page contains information about preventive services and immunizations that are covered with no member cost sharing.



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## Blue Cross Blue Shield of Michigan and Blue Care Network recognized as leaders in adopting breast cancer genomics policies

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Breast cancer is one of the most commonly diagnosed cancers and the second leading cause of cancer death in women, both in Michigan and nationally. Breast and ovarian cancer can run in families and be caused by an underlying genetic change passed from parent to child.

The Michigan Department of Community Health is aiming to increase public awareness of hereditary cancers and encourages Michigan health plans to have written policies consistent with national guidelines. For instance, the U.S. Preventive Services Task Force recommends that women whose family history is associated with an increased risk for a change in the BRCA1 or BRCA2 gene should be referred for genetic counseling and evaluation for testing. By working with Michigan health plans as well as the Michigan Association of Health Plans, the MDCH Cancer Genomics Program is striving to ensure that BRCA-positive women have access to the life-saving screenings and interventions they need.

Blue Cross Blue Shield of Michigan and Blue Care Network received MDCH's award in 2010 for Cancer Genomics Best Practices and again in 2013 for their policies on clinical services related to the care of BRCA-positive women. Such services include mammography screening, breast MRI and the option of surgery to remove breast or ovarian tissue before cancer occurs. According to the National Comprehensive Cancer Network clinical guidelines, these services should be considered standard of care for women with a known BRCA mutation and increased risk for breast and ovarian cancer.

"Working with Michigan health plans as well as the Michigan Association of Health Plans to increase breast cancer screening, genetic counseling and testing in order to identify women with an inherited cancer risk is incredibly beneficial," said James K. Haveman, director of the MDCH. "Michigan health plans can make a tremendous difference in terms of patient access to genetic testing and services, and BCBSM and BCN have exemplary policies that can serve as a model for other health plans."

Additional Michigan health plans have been receptive to learning more about family history and cancer risk. MDCH is now focusing on access to care and available services for women who test positive for a BRCA mutation. These women have a lifetime risk of breast cancer that increases to 60 to 85 percent more than the general population risk of 12 percent, and the lifetime risk of ovarian cancer rises dramatically as well.

MDCH encourages Michigan residents to collect their cancer family history, record it and share it with their healthcare providers. There are many screening tests for inherited cancers, and with proper screening and management, providers and patients can gain some control over future cancer risks. But it's critical that patients learn their family medical histories and talk to their health care providers.

For additional information on the MDCH Cancer Genomics Program and their work with Michigan health plans visit the [MDCH Web page](#).

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## New Member Care Alert coming to web-DENIS eligibility screens

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In an ongoing effort to provide resources to physicians and other Blues health care providers to help you care for Blues patients, web-DENIS users will notice new Member Care Alert buttons on the web-DENIS eligibility screens in July.

The new alert buttons will be color coded to help you identify patient needs quickly. Here are the three colors you may see and what they will mean:

**MemberCareAlert** This member has an open diagnosis gap or treatment opportunity that requires action.

**MemberCareAlert** This member has a pending or closed diagnosis gap or treatment opportunity. No action is required.

**MemberCareAlert** This member doesn't have a diagnosis gap or treatment opportunity at this time. No action is required.

A diagnosis gap is a suspected or historical condition that has not been documented and coded in the current calendar year or has not been confirmed that the diagnosis is not applicable to the member.

A treatment opportunity is a preventive service or treatment needed by the member measured according to Healthcare Effectiveness Data and Information Set quality indicators.

The new Member Care Alert button will appear on the initial contract eligibility screen in a new right column.

It will also appear on the individual member's eligibility screen.

If you are a Blue Care Network primary care physician or a BCBSM Medicare Advantage PPO provider with access to Health e-Blue<sup>SM</sup>, clicking on one of these alert buttons will take you to Health e-Blue where you may search for patient diagnosis gaps and treatment opportunities by clicking on the Diagnosis Evaluation Panel or the Treatment Opportunities Panel.

The new Member Care Alert button will be available for BCN commercial and Medicare patients and BCBSM Medicare Advantage patients. Over the coming months, watch for more enhancements to these screens that will bring even more functionality for efficiently closing diagnosis gaps and treatment opportunities.

If you are a primary care office and need access to Health e-Blue, **register online today**. Please contact your BCN provider representative if you need assistance.



New Member Care Alert

## New documents, instructions, fax number available for facility form submissions

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In April, a new, easier-to-use facility record update was made available on the upgraded Facility Provider Enrollment website. These non-hospital facilities forms include:

- Facility record update — a combined form for both Blue Cross Blue Shield of Michigan and Blue Care Network providers
- Network agreement and signature documents for BCBSM — required for facilities wishing to participate in additional networks or for new facilities doing business with BCBSM. BCN sends most facility contracts under separate cover and BCN network approvals are made after credentialing is complete.

To download these forms, go to [bcbsm.com/providers](http://bcbsm.com/providers).

- Under Join the Blues Network, click on *Enrollment*.
- Click on *Provider Enrollment*.
- Complete the sections indicated to access the forms for your facility.

Starting July 1, please follow these new instructions to submit enrollment forms:

- The fax cover sheet must be the first page of your submission.
- Fax the enrollment form and attachments (for example, contract signature documents) to 1-866-900-0250. Be sure to fax the registration information separately for each facility. (For example, if you register two or more facilities, you must complete and send a separate form and fax for each facility. They can't be bundled into one fax transmission.)

- You can also mail the completed forms and documentation to:

Provider Enrollment and Data Management  
Blue Cross Blue Shield of Michigan  
Mail Code C-334  
P.O. Box 217, Southfield, MI 48034

If you have any questions, call Provider Enrollment and Data Management at 1-800-822-2761.



## BCN Advantage applies 2 percent cuts for certain Medicare services

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### Background

Sequestration is a government mechanism that involves a series of spending cuts required by the Budget Control Act of 2011, which was aimed at reducing the federal deficit. Sequestration was designed to take effect automatically in March 2013 unless Congress enacted legislation with an alternate deficit reduction plan. The required cuts are intended to decrease spending by \$1.2 trillion from fiscal year 2013 through fiscal year 2021.

Sequestration includes a 2 percent cut to payments under the Medicare program. The cuts will be applied to provider payments for services administered under Medicare Hospital Insurance (Part A) and Medicare Medical Insurance (Part B) and contractual payments to Medicare Advantage Plans (Part C) and Medicare Prescription Drug Plans (Part D).

For original Medicare, the Centers for Medicare & Medicaid Services has notified Medicare providers that:

- In general, Medicare FFS claims with dates of service or dates of discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment, prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.
- The claims payment adjustment shall be applied to all claims *after* determining coinsurance, any applicable deductible and any applicable Medicare Secondary Payment adjustments.

- Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. CMS encourages Medicare physicians, practitioners and suppliers who bill claims on an unassigned basis to discuss with beneficiaries the impact of sequestration on Medicare's reimbursement.

In response to the sequestration impacts to the Medicare program, BCN has issued notice to all Medicare Advantage providers that if they are reimbursed based on the Medicare reimbursement methodology or the Medicare-allowable rate, including providers who are reimbursed using a Medicare fee schedule, they will be subject to the same sequestration reduction applied by CMS for the same items and services.

BCN has implemented these Medicare Advantage provider sequestration reductions for most providers effective with claims having dates of service April 1, 2013 and after.

## Evaluate and close diagnosis gaps

As announced in the last issue, a new *Diagnosis Evaluation* report is available on Health e-Blue<sup>SM</sup>. Primary care physicians are urged to review this report for their Blues Medicare Advantage patients and take action to close any diagnosis gaps. More information is available in the Resources section of Health e-Blue by clicking on *2013 Diagnosis Closure Incentive Program and FAQ*.

A Medicare Advantage Diagnosis Closure Incentive Program frequently asked questions document is available on web-DENIS. To find it, click on *BCN Provider Publications and Resources* and then click on *BCN Advantage*.

If you have any questions about the new incentive program or the new Health e-Blue report, please contact your BCN provider representative.

### Coding corner

## Follow these coding tips to improve medical record documentation for fractures, osteoporosis

Coding for fractures can be a challenge, considering the different types of fractures and certain bone diseases that can impact a fracture. These conditions can vary from serious (requiring immediate treatment) to chronic conditions that may call for treatment other than just a cast or strapping procedure. Please see full article on **Page 47**.

## Training is available on documentation and professional coding

Sharon Bonner, a registered nurse and certified coder who is a senior auditor in the Utilization Review department at Blue Cross Blue Shield of Michigan, provided valuable tips on documentation and professional coding at the May 16 BCN Provider Partnership Open House. If you weren't able to attend, you can access Bonner's expertise one of three ways:

- By watching a computer-based training program on web-DENIS
- By downloading a series of reference cards on web-DENIS called *Tips on Documentation and Coding for Professional Offices*
- By attending a live webinar

For the full article and information on how to find the information in our website, see **Page 38**.

See also **Complete documentation and appropriate coding, Page 36**.



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## A guide to Medicare preventive visits and physicals

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Medicare beneficiaries are entitled to annual wellness visits and other preventive visits. Here's a guide to these services and how to bill for them.

### “Welcome to Medicare” or Initial Preventive Physical Exam

|                   |  |
|-------------------|--|
| Definition        | This is a comprehensive preventive visit that is a once-in-a-lifetime benefit per Medicare beneficiary. It must occur no later than 12 months after the effective date of the member's Part B coverage.  |
| Services included | <ul style="list-style-type: none"> <li>• Review of the member's medical and family history</li> <li>• Review of the member's risks for depression and other mood disorders</li> <li>• Review of the member's functional ability and level of safety</li> <li>• Physical examination of vital signs and measurements</li> <li>• End of life planning (with member's consent)</li> <li>• Education and counseling</li> </ul> |
| Cost to member    | Free*  |
| Billing code      | G0402  |
| More information  | <b>The ABCs of Providing the Initial Preventive Physical Examination</b>   |

### Annual Wellness Visit, Including Personalized Prevention Plan Services

|                   |  |
|-------------------|--|
| Definition        | This is a preventive visit that is available to Medicare beneficiaries who have had Medicare Part B coverage longer than 12 months and who have not received a “Welcome to Medicare” or annual Wellness Visit within the past 12 months  |
| Services included | <ul style="list-style-type: none"> <li>• Create or update member's medical and family history</li> <li>• Record height, weight, body mass index, blood pressure and other routine measurements</li> <li>• List the member's current medical providers and suppliers and all prescribed medications</li> <li>• Detect any cognitive impairment</li> <li>• Review depression risks</li> <li>• Review of the member's functional ability and level of safety</li> <li>• Establish a screening schedule for the next five to 10 years, including screenings appropriate for the general population and any additional screenings that may be appropriate because of the member's risk factors</li> <li>• Furnish personal health advice and coordinate appropriate referrals and health education</li> </ul> |
| Cost to member    | Free*  |
| Billing code      | G0438 – Used for first visit only. This is a once-in-a-lifetime billing code<br>G0439 – Used for subsequent annual visits  |
| More information  | The Centers for Medicare & Medicaid Services' <b>Providing the Annual Wellness Visit</b> brochure  |

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## Routine Physical Exam or Annual Health Maintenance Examination

|                   |   |
|-------------------|---|
| Definition        | This is an annual comprehensive preventive medical examination. These exams are excluded from coverage under original Medicare but as a Medicare HMO risk plan, BCN Advantage promotes preventive care coverage and will pay for these exams. This is a preventive visit that is available to BCN Advantage beneficiaries who may or may not have received a “Welcome to Medicare” or Annual Wellness Visit within the past 12 months. Per BCN’s payment policy, if more than one E&M service, including one or more preventive visits are performed by the same practitioner at the same visit, only the visit code with the highest RVU will be paid.   |
| Services included | <ul style="list-style-type: none"> <li>• Review of the member’s medical history</li> <li>• Physical examination of vital signs and measurements</li> <li>• Anticipatory guidance, counseling and risk factor reduction interventions</li> <li>• Administration or ordering of appropriate immunizations, laboratory or diagnostic procedures</li> </ul> <p>Note: A health risk assessment is required as part of an annual wellness visit. This is mandated by the Patient Protection and Affordable Care Act and the Centers for Medicare &amp; Medicaid Services. The health risk assessment should be completed by the patient prior to or at the time of the annual wellness visit so the physician can consider this information when creating the patient’s Personalized Prevention Plan Services.</p> <ul style="list-style-type: none"> <li>• For information on the health risk assessment requirement with annual wellness visits, see <b>The ABCs of Providing the Annual Wellness Visit</b>.</li> </ul> |
| Cost to member    | Free*   |
| Billing code      | **99381-99387 and **99391-99397   |
| More information  | Michigan Quality Improvement Consortium’s <b>guidelines</b> for adult preventive services (50-65+ years)  |

\*Additional tests for services not covered by this service as defined by the Centers for Medicare & Medicaid Services may result in a member copay.

\*\*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2012 American Medical Association. All rights reserved.

## Aspirin use prevents heart attacks and strokes

As we announced in the May-June issue of *BCN Provider News*, BCN Advantage HMO-POS<sup>SM</sup> and BCN Advantage HMO<sup>SM</sup> are engaged in a five-year Chronic Care Improvement Program to help prevent cardiovascular disease in BCN Advantage<sup>SM</sup> members. Our program emphasizes member self management strategies and partnership with physicians as well as clinical interventions championed by the Million Hearts<sup>TM</sup> Initiative. Improving management of the ABCS can prevent more deaths than other clinical preventive services.

The Million Hearts ABCS are:

- **A**spirin use
- **B**lood pressure control
- **C**holesterol management
- **S**moking cessation

The “A” of the ABCS stands for “aspirin use for people at risk.” Currently, fewer than half of people with ischemic heart disease take daily aspirin or another antiplatelet agent.\* Daily aspirin use is a simple, low cost therapy that can help

prevent heart attacks and strokes. One goal of the Million Hearts Initiative is to increase aspirin use for people at high risk from 47 percent (baseline) to 65 percent by 2017.

BCN Advantage is also committed to this goal. You can help by talking to your patients about aspirin use, and prescribing it when appropriate. Documenting these discussions in the patient’s medical record will help us measure improvements in aspirin use rates over the next five years. We’ll review the results of your efforts and share the information with you each year.

Preventing one million heart attacks and strokes in the next five years will require the work and commitment to change from all of us. We look forward to working with you. Look for more information about our Chronic Care Improvement Program in future editions.

For more information about the **Million Hearts** initiative, visit their website.

\*The New England Journal of Medicine: *The “Million Hearts” Initiative – Preventing Heart Attacks and Strokes 9/29/2011*



## Blue Care Network introduces CMS Million Hearts Incentive Program

Blue Care Network has introduced our 2013 CMS Million Hearts Incentive Program to address BCN Advantage HMO-POS<sup>SM</sup> and BCN Advantage HMO<sup>SM</sup> members with a history of cardiovascular disease and those with Type 1 or Type 2 diabetes. The focus of the program is to reduce the morbidity and mortality related to cardiovascular disease in these members.

The incentive program incorporates clinical practice guidelines for the management of ischemic heart disease and diabetes mellitus as well as the guiding principles behind the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention’s Million Hearts initiative.

The *2013 CMS Million Hearts Incentive Program* document that explains this program in detail is available in BCN Health e-Blue<sup>SM</sup>. The document is located in the *Resources* section under *Incentive Documents*. If you have any questions, please contact your medical care group leadership or your BCN provider representative. We appreciate your continued support of our physician incentive programs.



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## Notice of Medicare Noncoverage is an important requirement for BCN Advantage skilled nursing facility and home health agency providers

Medicare regulations require providers to use the Medicare approved form, Notice of Medicare Non-Coverage, to notify BCN Advantage HMO-POS<sup>SM</sup> and BCN Advantage HMO<sup>SM</sup> members in writing, that BCN Advantage<sup>SM</sup> or the provider has decided to end their covered skilled nursing facility or home health agency care. The NOMNC form also provides notification to the member of the right to an expedited appeal if the member disagrees with the decision to end covered services. **Blue Care Network must receive copies of all NOMNC forms signed by the member.**

BCN is required to provide copies of signed NOMNC forms during Medicare audits. As we prepare for the audits, we find that not all providers have a complete understanding of Medicare regulations or BCN's process to ensure compliance. Medicare regulations require that providers deliver the NOMNC form to members at least two days before covered services end at skilled nursing facilities and at least two days before the last services end from home health agencies.

It is important to use the correct NOMNC form\*, approved by Medicare that includes:

- The date that covered services are expected to end
- The date that the member's financial liability begins
- A description of special appeal rights for members that allow a fast-track appeal if the member disagrees with the decision to end covered services
- Detailed instructions about how the member may request an immediate appeal directly to MPRO (Michigan's Quality Improvement Organization) including their address and phone number
- Instructions to the member about how to request an expedited review from BCN if they miss the deadline to file for review from MPRO
- The date of the member's signature

### Important facts about the NOMNC

- BCN is required to ensure compliance with Medicare regulations by BCN Advantage contracted providers.
- Medicare requires that SNF and HHA providers deliver the NOMNC form to **all** members at least two days before covered services end, regardless of whether the member agrees with the plan to end services.
- BCN encourages providers to deliver the NOMNC no earlier than four days prior to the last day that covered services end.
- Members are requested to sign and date the form, acknowledging its timely delivery. If members refuse to sign the form, the facility must document the time and date it was delivered to the member.
- Providers are expected to keep a copy of the signed NOMNC form and fax a copy to BCN Care Management at 1-877-372-1635, attention: medical records.

For more information about the form see the **BCN Advantage chapter** of the *BCN Provider Manual*. To obtain a copy of the form see the Forms chapter of the *BCN Provider Manual*. This is available in two places:

- Go to **ereferrals.bcbsm.com** and click on *Provider Manual Chapters*.
- Go to web-DENIS, click on *BCN Provider Publications and Resources* and then click on *Provider Manual*.

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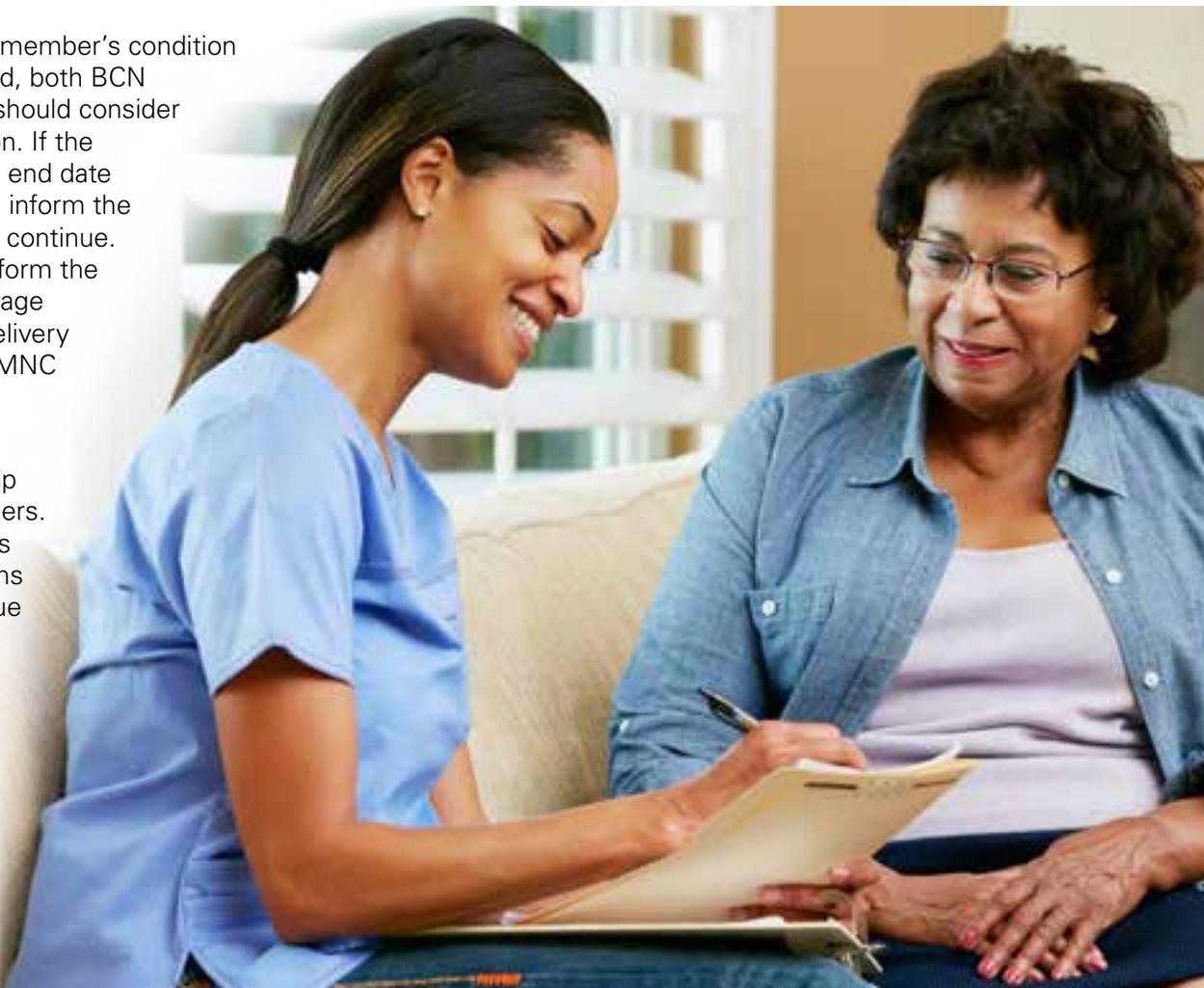
Please note that BCN may issue a next review date when authorizing skilled nursing facility services. The next review date does not mean BCN is denying further coverage. Please submit an updated clinical review on the next review date. If, upon review of the updated clinical information, a denial decision is given, BCN will allow for two additional days for the provider to supply the member with the NOMNC.

The form should only be given to members when SNF criteria are no longer met and no further days are authorized by BCN **or** two days prior to a scheduled discharge date.

If there is a change in the member's condition after the NOMNC is issued, both BCN Advantage and providers should consider the new clinical information. If the effective date of coverage end date changes, providers should inform the member that services will continue. The provider must then inform the member of the new coverage end date either through delivery of a new or amended NOMNC at least two days before services end.

BCN values our partnership with our contracted providers. We trust that our providers will adhere to the provisions in our contract and continue to provide us with the required NOMNC forms.

**\*Note:** Contracted facilities should be using the appropriate NOMNC forms. The forms are available in PDF or Word format on BCN's **e-referral** home page. Click on *Forms*, then scroll down to the BCN Advantage section. The forms are also available on web-DENIS by clicking on *BCN Provider Publications and Resources* and then clicking on *BCN Advantage* or *Forms*. Providers should insert their name, address and phone number in the spaces provided at the top of the form. NOMNC forms with the BCN Advantage logo at the top should not be used by SNF or home care agency providers.



## Blue Cross Complete changes effective August 1

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By the first week in July, your office should receive a printed copy of *Blue Cross Complete Provider News*, a special 8-page newsletter that highlights some important changes that are effective Aug. 1.

We're making these changes because we're preparing to grow as a Michigan Medicaid health plan and respond to changes that are coming with National Health Care Reform in 2014 and the years ahead. Blue Cross Complete has a strong commitment to Medicaid and to providing the complete care and support our members need.

An electronic copy of the newsletter is attached for your convenience.

Some of the big changes include the following:

- Referral, plan notification and clinical review requirements change Aug. 1
- New phone number and online tool for authorization requests begin Aug. 1
  - On or after Aug. 1, if you need authorization for services that require plan notification, call 1-888-312-5713 and select prompt 1.
- Blue Cross Complete has a new pharmacy benefit manager, PerformRx, and a new prior authorization form, effective Aug. 1
- Providers must bill with XYU prefix
- Claims address changes effective Aug. 1
- Register with Emdeon for electronic payments
- Blue Cross Complete will use NaviNet beginning Aug. 1 for member eligibility and benefits, claim status, authorization requests and patient gaps in care reports.
- New website for Blue Cross Complete: [MiBlueCrossComplete.com/providers](http://MiBlueCrossComplete.com/providers).

Please read *Blue Cross Complete Provider News* to learn how to register for and access NaviNet. Watch web-DENIS for more information.

### Blue Cross Complete phone number changes as of Aug. 1, 2013

| Department  | Phone                    | Fax            |
|---|--------------------------|----------------|
| Provider Inquiry (Eligibility Inquiry/ Claims Status) | 1-888-312-5713           | 1-888-987-6395 |
| Utilization Management (Authorization Requests)       | 1-888-312-5713, prompt 1 | 1-888-989-0019 |
| PerformRx   | 1-888-989-0057           | 1-855-811-9326 |

### Important information about NaviNet

Please note that you must access NaviNet through Internet Explorer 7.0 or above. Older versions of Internet Explorer may not work appropriately. Firefox, Safari and Google Chrome browsers do not work with NaviNet.

If you need technical assistance, please contact NaviNet Customer Care on [NaviNet.net](http://NaviNet.net). Users can log in, enroll or contact NaviNet through the website. The Customer Care number is 1-888-482-8057.

User Guides are located in the Help section. You need to be logged into access the Help menu.

If you can't register for NaviNet by Aug. 1, please remember you'll still be able to check member eligibility on web-DENIS through the state Medicaid files.



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## Blue Cross Complete providers must use a new form for medication authorization requests

Effective Aug. 1, 2013, Blue Cross Complete will have a new pharmacy benefit manager, PerformRx. Providers will use a different form for medication authorization requests. The new *Blue Cross Complete Medication Prior Authorization Request* form will be available at [MiBlueCrossComplete.com/providers](http://MiBlueCrossComplete.com/providers) on Aug. 1. The form will be used in the following circumstances:

- To request prior authorization for any medication requiring it
- To request an override of one of Blue Cross Complete's drug utilization management tools
- When the member needs a brand-name medication (dispensed as written) rather than the available generic version. This need may arise because a serious quality issue occurred when the member tried the generic version or because the generic version was not effective. With this type of request, you must

also forward a copy of the completed *FDA MedWatch* form you submitted to document that the generic version did not work. Information about the FDA's MedWatch Program and the related online forms are available at the FDA's MedWatch Program website at [www.fda.gov/medwatch](http://www.fda.gov/medwatch); click on **Report a Serious Medical Product Problem Online**.

The completed *Blue Cross Complete Medication Prior Authorization Request* form can be submitted by mail to PerformRx for Blue Cross Complete, 200 Stevens Drive, Philadelphia PA 19113. The form can also be faxed to Perform Rx at 1-855-811-9326.



## Providers can help improve prenatal and postpartum care outcomes

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Blue Cross Complete recommends that all women who have a confirmed pregnancy receive their first prenatal exam within six to eight weeks of pregnancy and subsequent prenatal exams.

Please remind patients considering pregnancy to make an appointment as soon as pregnancy is suspected.

At these prenatal visits it is important to document education about nutrition, prenatal vitamins with folic acid, substance abuse, alcohol consumption, smoking cessation and expectant parent classes.

The first postpartum visit should occur 21 to 56 days following a vaginal or cesarean delivery, and physicians should document education about family planning, postpartum depression, activity and monthly self-breast examination, as well as the importance of immunizations.

Please instruct your staff to schedule postpartum visits within this timeframe.

### Blue Cross Complete programs

Blue Cross Complete is committed to timely and comprehensive prenatal and postpartum care visits and offers the following resources and programs to address barriers to healthy perinatal outcomes:

- Call Care Management for Blue Cross Complete, weekdays from 8 a.m. to 5 p.m.
  - Before Aug. 1, call 1-800-392-2512
  - On Aug. or after, call 1-888-312-5713

- Blue Cross Complete Maternal Infant Health Program (MIHP) – Blue Cross Complete pregnant members and infants are eligible for additional preventive health services provided by an agency that is certified by the Michigan Department of Community Health. MIHP services are billed directly to the Michigan Department of Human Services. MIHP services are intended to supplement regular prenatal and infant care and to help providers manage the member's health and well being. These services may extend 60 days after delivery. It is the objective of the MDCH and Blue Cross Complete to enroll all pregnant women in a Maternal Infant Health Program. Additional information on how to access these services is available through Blue Cross Complete Provider Inquiry, 8 a.m. to 5 p.m. Monday through Friday.
  - Before Aug. 1, call 1-800-688-3290
  - On or after Aug. 1, call at 1-888-312-5713
- text4baby - This is a national free educational text message information service designed to promote maternal and child health. BCN and Blue Cross Complete encourage members to participate in this program to learn about health and pregnancy and the importance of prenatal and postpartum care. Members receive three free text messages a week about topics important during pregnancy and their baby's first year of life, timed to their due date or the baby's date of birth. The educational text messaging is available in English and Spanish. For more information, visit [text4baby.org](http://text4baby.org). To subscribe, text BABY to 511411 (BEBE for Spanish message). Members can unsubscribe at any time by texting STOP to 511411.

## Michigan Certificate of Need process has a formal advisory role for industry stakeholders, employers, consumers

By Robert Goodman, D.O.



The Michigan Certificate of Need Commission is a regulatory branch of the state of Michigan that is intended to balance the cost, quality and access of Michigan's health care system by limiting unnecessary health facility construction and constraining the acquisition of major medical equipment.

As background, health care expenditures per capita more than tripled between

1940 and 1970. In particular, hospital expenditures more than tripled in about the 10 years from 1960 to 1970. Three main factors contributed to the rising costs of health care: the implementation of Medicare, the widespread adoption of a traditional fee-for-service payment system and the diffusion of new medical technology.

In an effort to halt rising costs of health care, the federal government and the states implemented a health care regulation model originally initiated in Rochester, New York. The Comprehensive Health Planning and Services Act signed by Lyndon Johnson in 1966 authorized the states to establish planning processes that would allocate federally granted health related funding. About half of the states adopted CON laws by 1974. The National Health Planning and Resources Development Act of 1974 required the remaining states to establish CON programs. A few years later CON programs came under criticism and were later abandoned by the federal government. During the early 1980s, CON was dismissed by policy makers as an unjustified federal imposition on states and a barrier to competitive dynamics. Congress let the NHPRDA expire in 1986, and federal funding of state CON programs ended the following year. While most states have chosen to keep CON, nearly all of them have modified their CON programs to exempt some medical services.

**Robert Goodman, DO, MHSA, FACEP, is a medical director at Blue Care Network.**

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



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From the medical director, continued from Page 17

A series of separate systematic reviews undertaken by General Motors, Ford and Chrysler of their employees' and their insured dependents' health care costs found substantially lower costs in CON states as opposed to non-CON states. A recent study attempted to assess the effectiveness of the CON programs and was conducted by the National Institute for Health Care Reform by comparing the CON programs in Connecticut, Georgia, Illinois, Michigan, South Carolina and Washington. The researchers used telephone interviews with health care stakeholders from each of the six states. In five of the six states studied, the CON approval process is perceived to be highly subjective.

The state of Michigan is an exception to this finding. Michigan is the only state in the study with a formal advisory role for industry stakeholders, employers, consumers and other interested parties through a CON Commission of 11 members, appointed by the governor. By law, the members of the CON Commission include the following representation: M.D. representative, D.O. representative, M.D. or D.O. medical school, two hospital representatives, nursing home, nurse, self-insured purchaser, non-self-insured purchaser, labor union and nonprofit health care organization. The role of the commission is to establish the rules (called "standards") by which individual CON applications are evaluated.

The Michigan CON Commission relies on issue-specific standards advisory committees (SACs) to recommend changes to the standards for specific CON-covered services (for example, cardiac catheterization, MR imaging, surgical services). Membership on the SACs is determined using an open nomination process. By law the composition of a SAC must include a two-thirds majority of subject matter experts, and representatives of health care provider organizations, health care consumer organizations, health care purchasers and health care payers. All meetings of the

SACs and the Commission are open meetings. Considering recommendations from the SACs and after opportunity for public input, the CON Commission sends proposed CON Review Standards to the state legislature and the governor. Either branch of state government can veto the proposed standards. After the specified review period, the new CON Review Standards have the force of law. The CON Commission does not participate in the review of individual CON applications. Rather, project analysts with the Michigan Department of Community Health evaluate CON applications for compliance with the standards established by the CON Commission. This distribution of responsibility tends to promote greater objectivity and transparency: The appointed commission is responsible for setting CON review standards, and the state Department of Community Health is responsible for the actual review of CON applications.

An overview of the **CON application process** in the state of Michigan is available at the Michigan Department of Community Health website.

CON laws remain in effect in 36 states and the District of Columbia, despite substantial changes in the health care arena over the last 40 years. Opinions about the effectiveness of CON vary widely, from concerns about undue government interference in the health care market, to the belief that CON programs help to restrain health care cost increases.

Source:

Meesa IR, Meeker RA, Mukherji SK. Certificate of need. *Neuroimaging Clin N Am.* 2012 Aug;22(3):443-50.

## Back-to-school tips for children with asthma, diabetes

As kids prepare to return to school, there are important steps primary care physicians and staff can take to help ensure students begin the school year well prepared to manage their chronic conditions. The following checklists can help you do just that.

### For children with asthma

- Establish an Asthma Action Plan and provide the school with a copy for the child's record. The plan can be developed to fit the needs of the child.
- Obtain a copy of the Asthma Action Plan template. Go to *BCN Provider Publications and Resources* in web-DENIS. Then go to Forms. The Asthma Action Plans are in the Chronic Condition Management section.
- Instruct the child and parents on all medications and on the importance of having access to them at all times, especially rescue inhalers. Refill prescriptions as needed.
- Discuss the child's asthma condition and triggers that may occur.
- Provide the necessary documentation for the school support staff to keep on file in the event of an emergency. Information should be accessible to teachers, coaches and other adults who supervise children at school.
- Talk with the child about how to manage his or her asthma while at school.

### For children with diabetes

- Establish a Diabetes Action Plan and provide the school with a copy for the child's record. The plan can be developed to fit the child's needs. To obtain a copy of the plan, go to *BCN Provider Publications and Resources* in web-DENIS. Then go to *Forms*. The Diabetes Action Plan is in the Chronic Condition Management section.
- Instruct the child and parents on the diabetes medication and its storage and on the importance of having access to the medication and monitoring supplies at all times. Refill prescriptions as needed.

- Make sure the child knows how and when to check blood sugar if he or she is old enough to learn, or advise the parents to make sure the school is aware of the Diabetes Action Plan.
- Have the child write down his or her blood sugar levels in a diary. A school nurse may be able to assist younger children.
- Make sure the child knows what the symptoms are for low blood sugar and high blood sugar.
- Encourage parents to pack healthy snacks that can be eaten if the child has symptoms of low blood sugar. Kids should also have a rapid-sugar-release type of food such as juice, hard candy or glucose tablets.
- Instruct the child to wear a medical alert bracelet, if necessary.
- Provide the necessary documentation for the school support staff to keep on record in the event of an emergency. Information should be accessible to teachers, coaches and adults that interact with the child at school. You can use the Diabetes Care Plan for School for that purpose, which is also found on the web-DENIS Forms page, in the Chronic condition management section.
- Instruct the child about healthy eating and refer to a registered dietician as necessary.
- Talk with the child about his or her diabetes. Sometimes a child can become overwhelmed with managing his or her diabetes and needs to discuss the changes he or she is experiencing.

The Michigan Quality Improvement Consortium guidelines include information on the assessment and treatment of acute and chronic conditions and on preventive services. To access MQIC guidelines, including those for diabetes and asthma, go online to [mqic.org](http://mqic.org) and click on **Guidelines**.



# BCN's Case Management Program helps you care for patients

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Feedback

Your patients with complex medical needs can receive personalized support from Blue Care Network's Case Management department. Registered nurse case managers work with you and your patients to develop a case management plan of care and promote self management. Our case managers contact members by phone to provide education on disease, nutrition, medication and managed care processes as well as facilitate access to BCN and community resources as needed.

We identify members for case management through a variety of sources including inpatient admissions, physician and physician group referral, member and caregiver referral, chronic condition management referral and employer group referrals. BCN Advantage HMO-POS<sup>SM</sup> and BCN Advantage HMO<sup>SM</sup> members may be identified through completion of health appraisals. BCN also uses a predictive modeling approach to identify members from the entire BCN population who may benefit from case management.

Members enrolled in case management consistently report high satisfaction with the program and a willingness to recommend the program to other members.

We offer case management services as a benefit at no cost to BCN commercial and BCN Advantage<sup>SM</sup> members. The following programs are available for adult and pediatric members:

- Asthma (commercial members only)
- Complex conditions
- Chronic obstructive pulmonary disease
- Heart failure
- Diabetes
- High risk pregnancy
- Ischemic heart disease
- Kidney health management (adult members only)
- Oncology
- Transplants – bone marrow, stem cell and solid organ

## Case Management in 2013

BCN made changes to our case management program this year to increase the number of members identified as potentially eligible for case management services. BCN revised internal case management triggers to include a broader scope of members, including those discharged from skilled nursing facilities and rehabilitation centers. We also modified predictive model indicators to increase the focus on those members with high utilization of health care resources, readmissions to the inpatient setting, gaps in medical care, medication compliance issues or inpatient admissions for ambulatory care sensitive conditions.

Members with complex conditions and the need for care coordination will continue to be enrolled in case management. Our case managers work with these members and their families to develop an individualized plan of care based on member and caregiver goals and desired level of involvement. Members with chronic conditions who require less care coordination are enrolled in a chronic condition management program and receive education about their condition, diet, exercise, medication and managed care processes from a nurse case manager.

You can look on Health e-Blue<sup>SM</sup> for information about your patients enrolled in case and chronic condition management. The case managers may also call physicians with any significant change in the member's health status, compliance issues or any potential urgent or emergent situation that needs immediate physician attention.

To learn more about BCN's case management program or refer a member to one of our programs, call us at 1-800-392-2512 from 8:30 a.m. to 5 p.m. Monday through Friday.

Please see [Case management](#), continued on Page 21

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## Case management, *continued from Page 20*

BCN values and recognizes the importance of provider's rights. We respect your right to:

- Have information about BCN's case management programs, case management staff and staff qualifications relative to the management of your patient when requested
- Be informed of how BCN coordinates its interventions with treatment plans for individual patients
- Know how to contact the person responsible for managing and communicating with your patients
- Communicate complaints to the organization

- Be supported by the organization to make decisions interactively with patients regarding their health care
- Receive courteous and respectful treatment from the organization's staff

Note: Case managers may receive requests for services specifically excluded from the member's benefit package. Member benefits are defined by the limits and exclusions outlined by the individual member's certificate and riders. BCN does not make benefit exceptions and informs the member of alternative resources for continuing care and how to obtain care, as appropriate, when a service is not covered or when coverage ends.

## Training is available on documentation and professional coding

Sharon Bonner, a registered nurse and certified coder who is a senior auditor in the Utilization Review department at Blue Cross Blue Shield of Michigan, provided valuable tips on documentation and professional coding at the May 16 BCN Provider Partnership Open House. If you weren't able to attend, you can access Bonner's expertise one of three ways:

- By watching a computer-based training program on web-DENIS
- By downloading a series of reference cards on web-DENIS called *Tips on Documentation and Coding for Professional Offices*
- By attending a live webinar

For webinar dates and other important documentation tips, see **Page 38**.

## COPD diagnosis should include spirometry

Comprehensive care of people with chronic obstructive pulmonary disease includes diagnosing the condition through spirometry, smoking cessation support if indicated, periodic assessment of the disease, and management of stable COPD and exacerbations. Pharmacologic therapy is pivotal as it provides important options for improvement of symptoms and treatment of exacerbations.

COPD remains underdiagnosed and should be considered in smokers with symptoms or with a history of exposure to other COPD risk factors. This includes smokers older than 60 presenting with a chronic cough, or smokers with diagnosis and treatment for respiratory tract infections or asthma.

A written COPD management plan can facilitate COPD care in your office and helps patients manage their symptoms. BCN asks physicians to complete the management plan during office visits and provide a copy to the member. To obtain a copy of BCN's COPD management plan, please log in to web-DENIS. Go *BCN Provider Publications and Resources*; then click on *Forms* under *Resources*. Click on *COPD Action Plan* under *Chronic condition management*.

According to BCN's clinical practice guidelines for the diagnosis and management of COPD, spirometry is needed to establish a diagnosis of COPD and provides a useful diagnostic tool for those patients with symptoms suggestive of COPD. (See table below). A post-bronchodilator FEV1/FVC less than 70 percent confirms the presence of airflow limitation that is not fully reversible. If the characteristic symptoms of COPD, including cough, sputum production and dyspnea on exertion are present in individuals older than 40, spirometry should be performed.

| I: Mild COPD         | II: Moderate COPD          | III: Severe COPD           | IV: Very Severe COPD  |
|----------------------|----------------------------|----------------------------|---|
| FEV1/FVC <0.70       | FEV1/FVC <0.70             | FEV1/FVC <0.70             | FEV1/FVC <0.70  |
| FEV1 ≥ 80% predicted | 50% ≤ FEV1 < 80% predicted | 30% ≤ FEV1 < 50% predicted | FEV1 < 30% predicted or FEV1 < 50% predicted plus chronic respiratory failure |

The 2013 Healthcare Effectiveness Data Information Set® measure specifies spirometry testing should be performed within 730 days (two years) prior to the initial diagnosis through 180 days after the initial diagnosis of COPD. CPT codes used to identify spirometry testing for this measure include \*94010, \*94014–\*94016, \*94060, \*94070, \*94375 and \*94620.

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

**\*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2012 American Medical Association. All rights reserved.**

See [Jackson doctor uses spirometry testing to motivate smokers to quit](#), Page 29.

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## Criteria corner

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

**Question:**

**What is the definition of “preserved left ventricular function”?**

**Answer:**

Systolic heart failure is clinically associated with inadequate myocardial contraction with a significant reduction of left ventricular function and ejection fraction. In contrast, diastolic heart failure is associated with inadequate filling despite adequate myocardial contraction and an ejection fraction of at least 40 to 50 percent. Therefore, patients with diastolic heart failure are considered to have preserved left ventricular function. The preserved left ventricular function patient will present with shortness of breath, but will not have the associated edema or weight gain with right heart failure. Echocardiograms are a useful tool in the diagnosis of preserved LVF.

**Question:**

**If a medication has been given and discontinued prior to the current hospitalization, but is restarted during the current hospitalization, would it be considered an initial dose?**

**Answer:**

“Initial” refers to the first time a medication or treatment (such as anti-arrhythmics, TPN or anti-infectives) is used. During the period of initiation, if the medication or treatment is temporarily discontinued up to 24 hours (therapeutic pause), it is still considered initial. If a tolerated medication or treatment is discontinued for more than 24 hours and then restated, it is not considered initial.

## Introducing change in your practice

Chris Radford, an independent consultant in Grand Rapids, discussed the importance of change in a practice at the recent Provider Partnership Open House.

It's no secret that a multitude of changes are on the horizon for those in health care. Many providers are searching for ways to prepare themselves and their office staffs. An important aspect of preparation when facing such a large amount of change is to recognize not only your relationship to change, but also that of those around you. Are you and those in your office active and eager in embracing change, do you use a wait-and-see approach, or are you simply resistant, endeavoring to block change? There's no wrong answer or single best method of dealing with change. All of these approaches to change are different, and it helps to be aware of how the individuals you work with handle change; such information can help you decide how change can be introduced.

Change can be presented as an idea, and everyone in your office should be encouraged to submit their own idea (no matter how big or small). Radford defines an idea as something that affects one of four things:

- Safety
- Quality
- Productivity
- Cost

Ideas must be captured or documented, followed by creating ownership for the implementation of the idea. Barriers should then be removed, so change can be implemented. Finally, the change should be celebrated.

The attached *Idea Form* can be used in a practice to have staff submit suggestions for changes. Feel free to take the *Idea Form* and make it yours.

Feel free to contact Chris via email ([chris@next-hill.com](mailto:chris@next-hill.com)) if you have any questions.



[Idea Form PDF](#)

## 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

- Intraoral Bone Conduction Hearing Devices
- Proteomics-based testing for the evaluation of ovarian (adnexal) masses (OVA1® and ROMA™ testing)
- Sublingual immunotherapy as a technique of allergen-specific therapy

### Covered services

- Dopamine transporter imaging with single photon emission computed tomography (DaTscan™)
- Outpatient use of limb pneumatic compression devices for venous thromboembolism prophylaxis
- Transcatheter aortic valve implantation for aortic stenosis
- Fecal microbiota transplantation (fecal bacteriotherapy)



[Medical policy updates PDF](#)





# We need your help to improve prenatal and postpartum care outcomes

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Feedback

To help ensure healthy perinatal outcomes, Blue Care Network recommends that all women who have a confirmed pregnancy receive their first prenatal exam within six to eight weeks of pregnancy and subsequent prenatal exams, according to the Clinical Practice Guidelines available on web-DENIS and in the *Blue Care Network Provider Manual*.

Please remind patients considering pregnancy to make an appointment as soon as pregnancy is suspected.

At these prenatal visits it is important to document education about nutrition, prenatal vitamins with folic acid, substance abuse, alcohol consumption, smoking cessation and expectant parent classes.

BCN case management nurses can provide support to members identified as high risk for complications during the prenatal period. These interventions include:

- Initial assessment and care plan development
- Ongoing telephone support
- Written educational materials about identified risks, condition, medications and other interventions
- Referral to home health care, social worker or behavioral health as indicated
- Reports to practitioners about all case management interventions

The first postpartum visit should occur 21 to 56 days following a vaginal or cesarean delivery, and physicians should document education about family planning, postpartum depression, activity and monthly self-breast examination, as well as the importance of immunizations.

Please instruct your staff to schedule postpartum visits within this timeframe.

## BCN programs

BCN remains committed to timely and comprehensive prenatal and postpartum care visits and offers the following resources and programs to address barriers to healthy perinatal outcomes:

- Postpartum checkups — Following delivery, BCN Case Management sends a reminder letter encouraging the member to schedule a postpartum check-up 21 to 56 days after delivery. This letter includes information about postpartum depression and contact information for BCN’s behavioral health services. BCN’s Behavioral Health department can be reached at 1-800-482-5982 for BCN members.
- Maternal (or paternal) substance abuse — BCN’s behavioral health care professionals are available 24 hours a day, seven days a week to address mental health and substance abuse concerns. BCN members call 1-800-482-5982.
- Maternal (or paternal) tobacco use — BCN’s Quit the Nic smoking cessation program is available to all BCN members at 1-800-811-1764.
- Nutrition and weight management after delivery — BCN members receive a more than 20 percent discount on Weight Watchers® program membership. Call 1-800-651-6000 to find a nearby Weight Watchers location.
- Postpartum depression — BCN’s Depression Management Program focuses on member education about depression and the importance of adhering to a prescribed medication regimen. Practitioners and members can speak to registered nurse about the program by calling 1-800-392-4247 from 8:30 a.m. to 5 p.m. weekdays.
- text4baby — Text4baby is a national free educational text message information service designed to promote maternal and child health. BCN encourages members to participate in this program to learn about health and pregnancy and the importance of prenatal and postpartum care. Members receive three free text messages a week about topics important during pregnancy and their baby’s first year of life, timed to their due date or the baby’s date of birth. The educational text messaging is available in English and Spanish. For more information, visit [text4baby.org](http://text4baby.org). To subscribe, text BABY to 511411 (BEBE for Spanish message). Members can unsubscribe at any time by texting STOP to 511411.



# Well child care includes education about healthy eating and physical activity

With the rise in childhood obesity seen in the past few years, there has been a national urgency to educate children and parents about eating healthy in the home and increasing the physical activity of our kids.

Anticipatory guidance, an integral part of well care, must include education for both eating healthy and physical activity. Encourage your patients and their parents to visit websites to find out more. These sites also have useful handouts that, when cited in the medical record, meet these requirements.

Blue Care Network endorses the Michigan Quality Improvement Consortium guidelines for well child visits. You can find the guidelines by age group at [MQIC.org](http://MQIC.org).

Find **immunization news**, forms you can use and catch-up schedules at The Centers for Disease Control and Prevention.

**Websites for counseling about physical activity and nutrition**

[LetsMove.gov](http://LetsMove.gov)

[BrightFutures.aap.org](http://BrightFutures.aap.org)

[HealthyChildren.org](http://HealthyChildren.org)

[cdc.gov/vaccines/parents](http://cdc.gov/vaccines/parents)

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## Referral to BCN not needed for diabetic retinopathy exam

Blue Care Network encourages its members who have diabetes to have a yearly eye exam for retinopathy.

Southeast and East region providers, like those in the rest of the state, do not need to submit a referral to BCN for the annual eye exam when the exam is performed by a contracted BCN provider. A referral between the primary care physician and specialist must be documented in the member records at both offices.

If the member exceeds the one exam per year, a referral will need to be on file. Please follow your regional referral requirements. If you have questions regarding provider referrals, contact your BCN provider representative.

BCN also encourages diabetic members to talk to their physician about:

- A yearly physical exam, including foot exam, blood and urine tests

- Special blood tests including hemoglobin A1c blood glucose tests at least twice a year and urine testing for kidney damage at least once a year
- Diabetes education classes (members need a referral from their primary care physician)

Claims will pay for contracted providers (ophthalmologists and optometrists) when billed with the diagnosis and procedure codes listed below.

### Procedure codes:

\*92002, \*92004, \*92012, \*92014, \*92225, \*92226, \*92250, S0620, S0621 and S3000

### Diagnosis codes:

249.5x, 250.xx, 648.0x

Note: Diagnosis codes 362.0x and 366.41 may be reported secondary, in addition to the diagnosis codes listed above.

\*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2012 American Medical Association. All rights reserved.



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## 2013 InterQual® criteria take effect July 1

Blue Care Network’s Care Management staff uses McKesson Corporation’s InterQual criteria when reviewing requests for Blue Care Network, BCN Advantage HMO-POS<sup>SM</sup> and BCN Advantage HMO<sup>SM</sup> members. InterQual criteria have been a nationally recognized industry standard for 20 years. Other criteria resources that may be used are BCN medical policies, the member’s specific benefit certificate and clinical review by the BCN medical directors for the most appropriate level of care.

McKesson Corporation’s CareEnhance<sup>TM</sup> solutions include InterQual clinical decision support tools. McKesson is a leading provider of supply, information and care management products and services designed to manage costs and improve health care quality.

BCN will begin using the following 2013 InterQual criteria on July 1, 2013:

| Criteria/Version  | Application  |
|---|--|
| InterQual Acute – Adult and Pediatrics<br>Exceptions – local rules                          | <ul style="list-style-type: none"> <li>Inpatient admissions</li> <li>Continued stay discharge readiness</li> </ul>     |
| InterQual Level of Care - Subacute and Skilled Nursing Facility<br>Exceptions – local rules | <ul style="list-style-type: none"> <li>Subacute and skilled nursing facility admissions</li> </ul>                     |
| InterQual Rehabilitation – Adult and Pediatrics<br>Exceptions – local rules                 | <ul style="list-style-type: none"> <li>Inpatient admissions</li> <li>Continued stay and discharge readiness</li> </ul> |
| InterQual Level of Care – Long Term Acute Care<br>Exceptions – local rules                  | <ul style="list-style-type: none"> <li>Long term acute care facility admissions</li> </ul>                             |
| InterQual Level of Care – Home Care<br>Exceptions-local rules                               | <ul style="list-style-type: none"> <li>Home care requests</li> </ul>   |
| InterQual Imaging   | <ul style="list-style-type: none"> <li>Imaging studies and X-rays</li> </ul>   |
| InterQual Procedures – Adult and Pediatrics   | <ul style="list-style-type: none"> <li>Surgery and invasive procedures</li> </ul>                                      |
| BCBSM/BCN medical policies  | <ul style="list-style-type: none"> <li>Services that require clinical review for medical necessity</li> </ul>          |
| Plan developed imaging criteria   | <ul style="list-style-type: none"> <li>Imaging studies and X-rays</li> </ul>   |

## Blue Care Network 2013 Local Rules

Effective July 1, 2013

In applying InterQual® 2013 criteria to different benefit packages, Blue Care Network has adopted local rules. These local rules apply to all BCN commercial, BCN Advantage HMO-POS<sup>SM</sup> and BCN Advantage HMO<sup>SM</sup> members statewide whose care is coordinated by BCN’s Care Management department.

Changes to the Local Rules include:

- Added a Local Rule for the following:
  - Toxic exposure or ingestion
  - Diabetes
  - Pyelonephritis
  - Infection
  - Neurological added intermediate subset
- Revised the following Local Rule:
  - Infectious disease
- Deleted the following Local Rule:
  - Syncope



[Blue Care Network InterQual Local Rules PDF](#)

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## Using atypical antipsychotics as add-on treatment in refractory depression

Based on clinical studies, Blue Care Network has implemented prior authorization criteria for the use of Abilify® in major depressive disorder. Requirements for coverage include a previous trial with combination therapy consisting of a selective serotonin reuptake inhibitor (SSRI) or a norepinephrine-serotonin reuptake inhibitor (SNRI) and one adjunctive agent such as bupropion, lithium or a generic second generation antipsychotic.

Please see full article on [Page 32](#).

## Follow-up guidelines for children taking ADHD medication

After prescribing medication to children for attention deficit and hyperactivity disorder, health care practitioners should carefully assess their young patients for response to the medication, necessary titration of the medication and potential side effects.

Regular monitoring thereafter of ADHD medication dosage is essential to ensure effectiveness and continued response to treatment. The Healthcare Effectiveness Data and Information Set® measure, Follow-Up Care of Children Prescribed Attention Deficit Hyperactivity Disorder Medication, requires that a child between 6 and 12 years old who has an ambulatory prescription for ADHD medication has at least one follow-up visit with the practitioner during the initiation phase — the first 30 days that the child is taking the ADHD medication.

If the child remains on the prescribed medication for at least 210 days, the practitioner should have at least two additional follow-up visits with the child within nine months after the end of the initiation phase. The period following the initiation phase constitutes the continuation and maintenance phase of treatment.

For additional information on ADHD, please call Blue Care Network’s Behavioral Management department at 1-800-688-3290. We appreciate our physicians’ cooperation in scheduling the follow-up visits as Blue Care Network strives to improve the care provided to our members.

## Blue Care Network offers support for members with depression

Blue Care Network’s Depression Management Program provides members diagnosed with depression with education and self-management strategies to deal with this potentially disabling condition.

BCN also offers practitioner support through patient-specific reports identifying missed refills of antidepressants, case management reports and program assistance from a registered nurse chronic condition management specialist.

To learn more about BCN’s Depression Management Program or to refer a member, contact a chronic condition management specialist at 1-800-392-4247, 8:30 a.m. to 5:00 p.m. Monday through Friday.

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Best Practices

Jackson doctor uses spirometry testing to motivate smokers to quit



Gary Lynd, D.O.

For Gary Lynd, D.O, coaching and education go hand-in-and with a spirometry test. “I explain to patients that they’re not getting enough air in or out and explain how they can make changes by losing weight, exercising, quitting smoking and using medications appropriately,” he said.

“We programmed our spirometer machines to provide a lung age. If the patient has mild lung disease, he or she may be able to improve lung function. With a smoker who’s about 55 years old, they see the graphs and charts and are still not motivated to stop smoking. But when they see they have a lung age of 80, the light goes on. That is single-handedly the best tool to get people to quit.”

To demonstrate, Dr. Lynd relates the story of a 50-year-old patient who had said he would never quit smoking. The patient is thin and exercises, but he smokes. “The patient said he didn’t

have problems breathing, but he met the criteria for testing,” said Dr. Lynd. “He also said he wasn’t going to quit smoking because he’s been smoking his entire life. I tested him two months ago and, sure enough, his lung age came in at 64. When the patient saw that, the color ran out of his face.”

With a combination of nicotine patches and muscle relaxers, the patient has remained smoke-free for a month.

According to the Agency for Healthcare Research and Quality, COPD is the fourth leading cause of death in the United States. And it may be under diagnosed.

Dr. Lynd uses specific criteria to decide who gets spirometry testing in his office. High-risk patients include those who already have COPD, smokers over 50, and patients with a strong family history of COPD or unusual patterns of respiratory disease, such as bronchitis or pneumonia that doesn’t get better quickly, said Dr. Lynd.

He also administers a spirometry test to obese patients who have trouble breathing. “The biggest cause of restrictive lung disease is obesity,” he said. Issues with restrictive breathing can lead to fluid in the lungs as well as scarring of lung tissue, says Dr. Lynd.

He acknowledges that there are challenges with spirometry testing. The equipment is expensive. Equipment needs to be calibrated. The people administering the test need to be trained.

“So we have our nurses do what we call catch-up training to help them administer the test correctly and help patients empty their lungs,” said Dr. Lynd. “There’s a certain amount of patient coaching we do during the test to do it properly.”

The office has also invested in a spirometer that has individual parts that are automatically calibrated. “It’s more expensive because you use a new part each time, but it’s easier to use.”

Helping patients see improvement is one reason to re-administer the test. “A lot of my job is being a coach to my patients,” said Dr. Lynd. “We tell patients if they can catch their lung disease early enough, it’s not always irreversible. We check on how they are doing with efforts to quit smoking and ask about their exercise regimen.”

But the best motivator is feedback, he said. “If I retest a patient after a year of not smoking, losing weight or starting an exercise program, that patient might see slight improvement. But the following year they might see dramatic improvement,” he said.



# Focus ...on patient satisfaction

*This article is part of a series on patient satisfaction, intended to help providers increase their CAHPS® scores.*

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## Collaboration with specialists helps patients receive better care

Diana Dillman, D.O, helps to coordinate care for her patients by ordering tests ahead of time when she refers them to a specialist. "I ask the specialist if there are other tests they want before they see the patient," she says.

There's a lot that can be done to make a specialist visit more productive, said Dr. Dillman. "If the specialist is not on the same electronic medical record system, I always remind patients to bring their films if they had X-rays or an MRI. I also tell them to remind the specialist to review blood work results that have already been faxed to their office."

Dr. Dillman's office in Jenison, Mich. uses electronic medical records that allow the office to post blood work results and radiology reports for patients to view. If the specialist is using the same EMR system, Dr. Dillman can send the specialist a message. If not, she sends a fax. Beth Prince, the office medical assistant, touches base with specialists to make sure results are at their office before the patient visit.

The office is also more specific when it makes referrals to specialists. "If we do a referral, I list everything the patient is being seen for instead of leaving it up to the patient to remember," said Dr. Dillman.

Coordinating care with specialists makes the visit more productive, Dr. Dillman noted. "It's getting harder to see specialists, so it's important to maximize the patient's visit. I want to make sure everything I can do before the visit gets done," she said. For a recent visit, a patient had a possible diagnosis of multiple sclerosis. When Dr. Dillman notified the specialist, the neurologist asked for a MRI of the neck so that test could be available before the specialist visit.

For an acute visit, "I call the specialist and ask if it's something he or she can handle in the office," said Dr. Dillman. "If I have to send the patient to the emergency room, a surgeon might already have a resident at the hospital to check on that patient."

Emergency room visits are another opportunity to coordinate care. If a patient visits the emergency room with uncontrolled asthma, for example, the primary care doctor should receive a report. "But it's also important for the specialist to know if the patient went to the ER three times," says Dr. Dillman. "So I send a report to the specialist so he or she knows specifically what's going on in that patient's case."

Not only does her approach help patients manage their care; specialists appreciate the extra effort, too. "Specialists are often busy, so they're starting to look at more information before the patient comes in for a visit."



Diana Dillman, D.O.

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## Blue Care Network to require prior authorization for certain prescriptions containing acetaminophen

In response to the safety concerns expressed by the U.S. Food and Drug Administration, Blue Care Network is taking steps to ensure the safe use of acetaminophen by our members by monitoring its use. If a new prescription for an acetaminophen-containing product results in a total daily dose of acetaminophen exceeding 4 grams per day, the new prescription will be blocked at the pharmacy and require a prior authorization before coverage will be granted. The change does not apply to BCN Advantage HMO-POS<sup>SM</sup> or Blue Cross Complete members.

Acetaminophen is widely valued for its efficacy as an antipyretic and analgesic, making it one of the most commonly used drugs in the United States. Many over-the-counter and prescription medications contain the agent and are considered safe when used properly and within the recommended 4 gram maximum per day. When taken inappropriately, serious injury can occur, particularly hepatotoxicity.

In the United States, a large percentage of acetaminophen-induced liver injury results from unintentional overdose.

In many cases, the patient unknowingly ingests more than the recommended daily dose of the drug or takes multiple products which each contain the analgesic. Data published by the FDA indicate even slightly higher doses of 5 to 7.5 grams of acetaminophen per day are associated with some level of hepatotoxicity. Furthermore, a study released in 2006 found accidental overdose accounts for approximately 56,000 emergency room visits, 26,000 hospitalizations and 458 deaths per year.

In an attempt to reduce the risk of accidental acetaminophen overdose, the FDA made a safety announcement on Jan. 13, 2011, asking manufacturers to limit the strength of acetaminophen in prescription products to 325 mg per dosage unit. In an effort to draw attention to the risk of severe liver injury, the FDA also recommended that a boxed warning be added to all acetaminophen-containing prescription products.

Ultimately, BCN's new measure should lead to increased medication safety and improved patient care.

### References:

1. United States Food and Drug Administration. FDA. Advisory committee: June 29-30, 2009: Joint Meeting of the Drug Safety and Risk Management Advisory Committee with the Anesthetic and Life Support Drugs Advisory committee and the Nonprescription Drugs Advisory committee: Meeting announcement [Internet]. Silver Spring (MD): U.S. Food and Drug Administration (FDA). [cited 2013 May 9]. Available from: <http://www.fda.gov/AdvisoryCommittees/Calendar/ucm143083.htm>.
2. United States Food and Drug Administration. FDA drug safety communication: FDA Drug Safety Communication: Prescription Acetaminophen Products to be Limited to 325 mg Per Dosage Unit; Boxed Warning Will Highlight Potential for Severe Liver Failure [Internet]. Silver Spring (MD): U.S. Food and Drug Administration (FDA). [cited 2013 May 9]. Available from: <http://www.fda.gov/Drugs/DrugSafety/ucm239821.htm>.
3. Kaufman, D.W., J.P. Kelly, L. Rosenberg, et al., "Recent Patterns of Medication Use in the Ambulatory Adult Population of the United States: The Slone Survey," *Journal of the American Medical Association* 2002, Jan 16;287(3) 337–44.
4. Larson AM, Polson J, Fontana RJ, Davern TJ, Lalani E, Hynan LS, et al. Acute Liver Failure Study Group (ALFSG). Acetaminophen-induced acute liver failure: results of a United States multicenter, prospective study. *Hepatology*. 2005; 42:1364-72.
5. Nourjah P, Ahmad SR, Karwoski C, Willy M. Estimates of acetaminophen (Paracetamol)-associated overdoses in the United States. *Pharmacoepidemiol Drug Safety* 2006;15:398-405.



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## Using atypical antipsychotics as add-on treatment in refractory depression

Treatment resistance affects approximately 30 percent to 45 percent of patients with depression and prolongs their degree of suffering and disability. A number of pharmacotherapy options exist for clinicians to address treatment-resistant depression, including maximizing the antidepressant dose, swapping one agent within a drug class for another, switching to a different class of medications or augmenting a patient's current therapy with an atypical antipsychotic.

Adding low-dose Abilify® (aripiprazole) to existing treatment in patients with refractory depression has become a common practice since the U.S. Food and Drug Administration approved the indication in 2007. While Abilify is the only atypical antipsychotic indicated in treatment-resistant depression, Zyprexa® (olanzapine), Seroquel® (quetiapine), and Risperdal® (risperidone) have also been studied as adjunct therapy.

A 2010 review by The Cochrane Collaboration, an independent organization that provides information about the effectiveness of health care, concluded evidence is limited for the use of atypical antipsychotics in treatment-resistant depression with only 28 studies available to evaluate. All the drugs investigated showed slight symptom reduction when used as adjunctive agents and did not suggest one medication works better than another. Generally, regimens with atypical antipsychotics were

less tolerated due to adverse events, such as weight gain, sedation or prolactinemia.

Based on the clinical studies, Blue Care Network has implemented prior authorization criteria for the use of Abilify in major depressive disorder. Requirements for coverage include a previous trial with combination therapy consisting of a selective serotonin reuptake inhibitor (SSRI) or a norepinephrine-serotonin reuptake inhibitor (SNRI) and one adjunctive agent such as bupropion, lithium or a generic second generation antipsychotic.

It is important to choose an antidepressant treatment option that best fits a patient's needs. Single-treatment regimens with antidepressants can be effective and have a more favorable adverse effect profile compared to therapy that includes atypical antipsychotics. In the case of patients in whom atypical antipsychotic side effects would preferably be avoided, dose optimization or trials with an alternative single agent are reasonable options that maintain efficacy while reducing the risk of polypharmacy and the patient's pill burden.

### References:

Komossa K, et al. Second-generation antipsychotics for major depressive disorder and dysthymia. *Cochrane Database of Systematic Reviews* 2010. Issue XII. No: CD008121. DOI: 10.1002/14651858.CD008121.pub2

## Updated BCBSM and BCN Custom Formulary Quick Guide now available

Please help us ensure our members get the care they need by talking with them about their drug copayment or coinsurance. Nearly all Blue Care Network members have a tiered pharmacy benefit. This means that they pay their lowest copayment for Tier 1 (mostly generic) drugs. Tier 2 drugs require a higher cost share (either copayment or coinsurance) and Tier 3 (nonformulary) drugs are either not covered or require the highest cost share.

For a listing of commonly prescribed Tier 1 and Tier 2 drugs on our formulary, please refer to our BCBSM and BCN July 2013 Formulary Quick Guide. Additional pharmacy resources for selecting affordable and effective drug

therapy, including the complete Blue Cross Blue Shield of Michigan and Blue Care Network Custom Formulary, are available online.

Please go to [bcbsm.com/RxInfo](http://bcbsm.com/RxInfo) for additional information for BCN, BCN Advantage HMO-POS<sup>SM</sup> and BCN Advantage HMO<sup>SM</sup>. If you have any questions, call the BCN Clinical Pharmacy Help Desk at 1-800-437-3803.



[BCBSM and BCN Custom Formulary Quick Guide PDF](#)

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# Crestor removed from Blue Care Network Custom Formulary

Effective July 1, 2013, Crestor® will no longer be on the Blue Care Network Custom Formulary. The change will not apply to BCN Advantage HMO-POS<sup>SM</sup> and Blue Cross Complete members. The availability of low-cost generic statins, including Lipitor (g), has prompted BCN to enact measures to help manage drug costs and keep premiums in check for our customers.

Members currently on Crestor can continue to receive their medication, but depending on their drug benefit, may be required to pay a higher copayment. To help members avoid higher out-of-pocket costs, physicians can switch their patients from Crestor to a generic statin, including Lipitor (g). Lipitor (g) and Crestor are considered the most effective statins for lowering low density lipoprotein (LDL) and have been compared in a 2011 head-to-head trial. When measured against one another, the two drugs proved similar in their ability to limit progression or induce regression of coronary artery disease and achieved cholesterol targets specified by the current hyperlipidemia guidelines. **BCN will provide a free 90-day supply to members who switch from Crestor to a generic statin on prescriptions filled before Nov. 1, 2013.**

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| Drug                    | Formulary Status | Step Therapy | Monthly Cost |
|-------------------------|------------------|--------------|--------------|
| Atorvastatin (Lipitor)  | Preferred        | Not required | \$20 – 25    |
| Fluvastatin (Lescol)    | Preferred        | Not required | \$70 – 150   |
| Lovastatin (Mevacor)    | Preferred        | Not required | \$6 – 18     |
| Pravastatin (Pravachol) | Preferred        | Not required | \$4 – 9      |
| Simvastatin (Zocor)     | Preferred        | Not required | \$3 – 5      |
| Crestor, Livalo         | Nonformulary     | Required     | \$118 – 155  |

## Approximate dosage conversion between Crestor and generic statins

| Percent LDL Reduction | Lescol (g) | Mevacor (g) | Pravachol (g) | Zocor (g) | Lipitor (g) | Crestor |
|-----------------------|------------|-------------|---------------|-----------|-------------|---------|
| 25 – 30%              | 40 mg      | 20 mg       | 20 mg         | 10 mg     |             |         |
| 30 – 40%              | 80 mg XL   | 40 – 80 mg  | 40 mg         | 20 mg     | 10 mg       |         |
| 40 – 45%              |            | 80 mg       | 80 mg         | 40 mg     | 20 mg       | 5 mg    |
| 45 – 50%              |            |             |               | 80 mg     | 40 mg       | 10 mg   |
| 50 – 55%              |            |             |               |           | 80 mg       | 20 mg   |
| > 55%                 |            |             |               |           |             | 40 mg   |

Our new step-therapy requirements for Crestor require the use of two generic statins, one of which is Lipitor (g) at a dose of 40 mg or greater. For patients who require treatment with a statin, please consider prescribing a generic statin which is available to members at their lowest copayment.

### References:

1. Nicholls S et al. Effect of two intensive statin regimens on progression of coronary disease. *New England Journal of Medicine* 2011;365:2078-87.
2. Greater Rochester Independent Practice Association. Approximate Dose Conversions. Updated 9/2006.

## Blue Cross Complete gets new pharmacy benefit manager as of August 1

Blue Cross Complete has a new pharmacy benefit manager, PerformRx, effective Aug. 1. The formulary is not changing.

To request pharmacy prior authorizations starting Aug. 1, fax the *Blue Cross Complete Medication Prior Authorization Request* form to 1-855-811-9326. The form will be available Aug 1. at [MiBlueCrossComplete.com/providers](http://MiBlueCrossComplete.com/providers). The turnaround time for requests is 24 hours.

For questions about pharmacy prior authorizations, call 1-888-989-0057, beginning Aug. 1.

## Blue Cross Complete providers must use a new form for medication authorization requests

Effective Aug. 1, 2013, Blue Cross Complete providers must use a different form for medication authorization requests. The *Blue Cross Complete Medication Prior Authorization Request* form will be available on Aug 1. at [MiBlueCrossComplete.com/providers](http://MiBlueCrossComplete.com/providers).

For more information, see article on [Page 15](#).

## BCN publishes list of medications that may be inappropriate for the elderly

Blue Cross Blue Shield of Michigan and Blue Care Network have put together a list of medications that may be inappropriate for some older members. The chart is organized by drug class and offers alternatives that doctors can prescribe.

The Centers for Medicare & Medicaid Services and Blue Care Network encourage prescribers to carefully consider use of these medications in their elderly patients. They are associated with severe adverse effects in the elderly. Open the PDF at right to access the document.



[Inappropriate medications for the elderly PDF](#)

## BCBSM and BCM Custom Formulary updates

The Blue Cross Blue Shield of Michigan and Blue Care Network Pharmacy and Therapeutics Committee reviewed the pharmaceutical products listed in the PDF below for inclusion in the BCBSM/BCN Custom Formulary 2013 and the 2013 BCN Advantage HMO-POS<sup>SM</sup> Comprehensive Formulary. Note that most members with a commercial BCN drug benefit do not have coverage for Tier 3 drugs.



[BCBSM and BCN Custom Formulary updates PDF](#)

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## BCN manages prescription drug claims to help prevent fraud, waste and abuse

Blue Care Network has established a robust program to help manage the overuse and abuse of controlled substances. Through its multi-disciplinary Controlled Substance Workgroup, BCN provides ongoing review and management of member use and prescribing patterns of these drugs.

Since 2005, this program has helped ensure that prescriptions for controlled substances are covered only when medically necessary. Prescriptions written by providers who have been sanctioned by the Office of the Inspector General, the Michigan Department of Community Health or by Blue Care Network (after review by the Controlled Substance Workgroup and our Quality Management department) are not covered for BCN members.

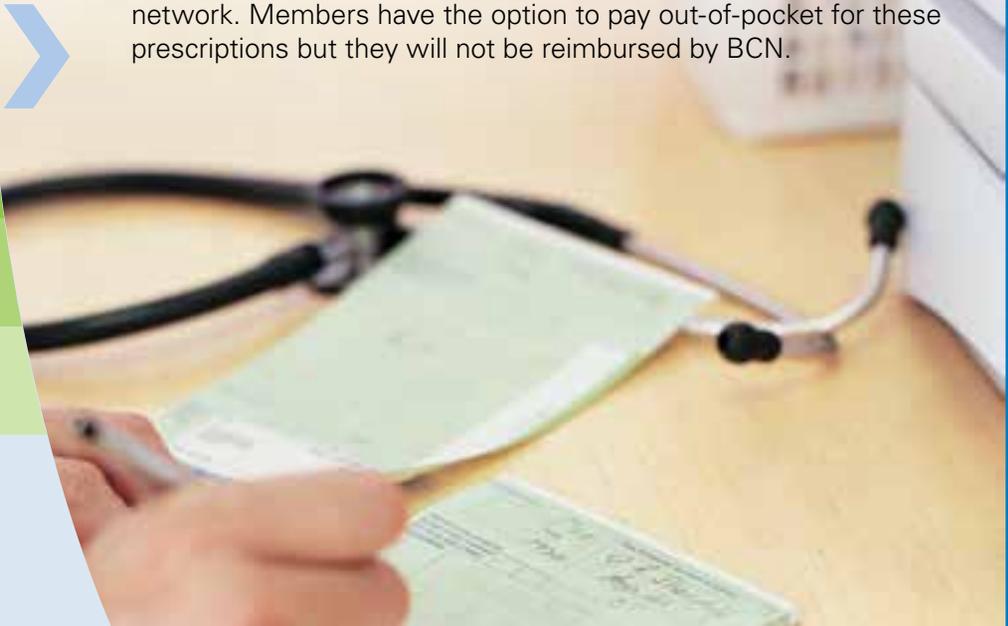
In advance of implementing a claims restriction against a prescriber, BCN notifies affected members that future prescriptions written by that provider will no longer be covered. The member is asked to work with their primary care physician to coordinate their prescription needs. Following member notification, BCN works with its pharmacy claims processor to establish a restriction so that future prescriptions written by the sanctioned provider will be blocked at the pharmacy. BCN sends the pharmacy a message that the provider is out of network. Members have the option to pay out-of-pocket for these prescriptions but they will not be reimbursed by BCN.

### Helping to protect patient and public safety

Blue Cross Blue Shield of Michigan and Blue Care Network take the health and safety of our members seriously. That’s why we investigate potential prescription fraud and abuse for our members through programs that continually review prescriptions submitted for payment.

Taking prompt action in situations where providers are prescribing large numbers of controlled substances is necessary to help ensure patient and public safety. It also ensures that the group or member’s benefits are being used in an appropriate manner, as outlined in a member’s pharmacy rider or plan description documents.

In addition, BCN has tightened its drug processing logic for controlled substances to help decrease potential abuse and diversion. Our new refill processing logic allows a refill on a controlled substance prescription (such as hydrocodone/acetaminophen or diazepam) after 80 percent of the prescription supply has been exhausted. For example, a prescription for #90 tablets in a 30-day supply can be refilled after 24 days have elapsed (80% x 30 days = 24 days) since the previous script was dispensed.



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## Complete documentation and appropriate coding

“Success in a medical office is all about coding, caring and collaborating,” according to Laurie Latvis, manager of provider relations for Blue Cross Blue Shield of Michigan. “Blues providers already do a tremendous job of caring for their patients and collaborating with each other to provide the best care. What we need to work on is making sure provider medical records contain complete documentation and claims are submitted with appropriate codes.”

Latvis spoke at the May 16 BCN Provider Partnership Open House where she gave several reasons why complete documentation and appropriate coding are important.

- It provides a comprehensive view of the patient’s health which helps guide the ongoing care you provide.
- It helps your office comply with quality measures, including those needed for physician incentive programs.

- It assists you in meeting government program requirements and could reduce the need for, or greatly simplify, on-site reviews.
- It provides a true picture of population health for research and analysis.
- It helps ensure the Blues apply the correct covered benefits and payment.
- It allows the Blues to offer appropriate supportive case management, health education and chronic condition management programs.

The Blues have found that health care providers in Michigan report fewer diagnoses than providers in other areas. While in some cases it is possible that our patients could be healthier, it is more likely that we need to improve our documentation and coding practices. Another observation Latvis made is that the diagnoses that are reported often lack specificity. A general diagnosis

is given, like diabetes, rather than including complicating factors such as kidney failure or nerve damage.

Latvis urges providers to submit complete diagnoses and code to the highest level of specificity following national coding guidelines. The first step in achieving this is to make sure the medical record contains documentation of all of the patient’s existing health conditions and diagnoses. It is important to review chronic conditions with the patient during a face-to-face visit at least annually and then document these in the medical record. The medical record must document that the condition was managed, evaluated, assessed and treated on the date of service. The medical record must also be signed, credentialed and dated by the physician and each diagnosis must conform to ICD-9 coding guidelines.

Please see [Complete documentation](#), continued on Page 37

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### Complete documentation, *continued from Page 36*

The Centers for Medicare & Medicaid Services requires that chronic conditions are addressed and coded annually. Latvis gives the following example, “If a patient is an amputee and this is not coded at all during a calendar year, according to CMS the patient’s limb has grown back.”

Latvis recommends following the federal **Centers for Medicare & Medicaid Services Internet Only Manual** (Publication 100-04, Chapter 23, Section 10.A) which provides information on the appropriate diagnosis codes to include on your claim. Here is the pertinent language from that section:

Rules for reporting diagnosis codes on the claim are:

- Use the ICD-9-CM code that describes the patient’s diagnosis, symptom, complaint, condition or problem. Do not code suspected diagnosis.
- Use the ICD-9-CM code that is chiefly responsible for the item or service provided.
- Assign codes to the highest level of specificity. Use the fourth and fifth digits where applicable.
- Code a chronic condition as often as applicable to the patient’s treatment.
- Code all documented conditions that coexist at the time of the visit that require or affect patient care or treatment. (Do not code conditions that no longer exist.)

For more information, see *Training is available on documentation and professional coding on **Page 38**.*

You can review the complete *It’s all about coding, caring and collaborating* presentation on web-DENIS in *BCN Provider Publications and Resources* on the *Learning Opportunities* page.





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Sharon Bonner

## Training is available on documentation and professional coding

Sharon Bonner, a registered nurse and certified coder who is a senior auditor in the Utilization Review department at Blue Cross Blue Shield of Michigan, provided valuable tips on documentation and professional coding at the May 16 BCN Provider Partnership Open House. If you were not able to attend, you can access Bonner's expertise one of three ways:

- By watching a computer-based training program on web-DENIS
- By downloading a series of reference cards on web-DENIS called *Tips on Documentation and Coding for Professional Offices*
- By attending a live webinar (dates and times listed below)

Here's how to find the computer-based training and tip cards:

- Go to **bcbsm.com**
- Log in to *Provider Secured Services*
- Click on web-DENIS
- Click on *BCN Provider Publications and Resources*
- Click on *Learning Opportunities*

Printed copies of the tip cards are available by contacting your BCN provider representative. The computer-based training is also available directly without going through web-DENIS by going to **brainshark.com/bcbsm/codinginitiative**.

The live webinars cover the same information as the computer-based training sessions and allow the opportunity to ask questions of certified coders.

To register, send an email to **SE-professionaleducationregistration@bcbsm.com** and include the date and time of the class you wish to attend. You will receive a confirmation within 72 hours of registering.

It's important to register so that we can send you information about the webinar and the conference call-in number. This information may vary, depending on the session.

Please contact your provider representative with questions related to the webinars or computer-based training.

Here are the documentation and coding webinars being hosted by BCBSM throughout 2013:

| Date                | Time      |
|---------------------|-----------|
| Wednesday, July 10  | 9-10 a.m. |
| Wednesday, July 17  | 9-10 a.m. |
| Wednesday, July 24  | 9-10 a.m. |
| Wednesday, July 31  | 9-10 a.m. |
| Tuesday, Aug. 13    | 12-1 p.m. |
| Wednesday, Aug. 21  | 9-10 a.m. |
| Wednesday, Aug. 28  | 9-10 a.m. |
| Wednesday, Sept. 4  | 12-1 p.m. |
| Wednesday, Sept. 11 | 9-10 a.m. |
| Tuesday, Sept. 17   | 12-1 p.m. |
| Thursday, Sept. 26  | 12-1 p.m. |
| Tuesday, Oct. 1     | 9-10 a.m. |
| Wednesday, Oct. 9   | 9-10 a.m. |
| Wednesday, Oct. 16  | 9-10 a.m. |
| Wednesday, Oct. 23  | 12-1 p.m. |
| Tuesday, Oct. 29    | 9-10 a.m. |
| Wednesday, Nov. 6   | 9-10 a.m. |
| Wednesday, Nov. 13  | 9-10 a.m. |
| Wednesday, Nov. 20  | 9-10 a.m. |
| Tuesday, Dec. 3     | 9-10 a.m. |
| Wednesday, Dec. 11  | 9-10 a.m. |

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Mary Lefief

## Helpful information about submitting electronic claims

During her presentation at the May 16 BCN Provider Partner Open House, Mary Lefief, specialist with Blue Cross Blue Shield of Michigan Electronic Data Interchange, included these helpful tips on filing electronic claims.

### Avoid these common file errors:

- P.O. Box at billing provider level – TR3 requirements prohibit the reporting of a P.O. Box address in loop 2010AA of 837 transactions.
- Subscriber information – If the subscriber is different from the patient, the TR3 direction is to report an address at the patient level only, not for the subscriber.
- Zip Codes – TR3 requirements direct that Zip codes be reported with nine digits and without spaces or special characters.
- FEP claims received with old “OF” claim filing indicator, rather than “FI.”
- Inpatient 8371 claim files received without value codes 80-83 indicating covered and non-covered days
- Redundant data – TR3 requirements instruct the sender not to send if not needed or noncompliant.

For a list of additional common reporting errors, visit our [HIPAA 5010](#) Web page.

### Electronic claim exclusions

BCBSM recommends hard copy claim submission for the following professional claims:

- BCBSM, Federal Employee Program and BCN claims requiring hard copy documentation
- BCBSM, FEP and BCN tertiary claims
- BCN status inquiry for secondary claims
- FEB COB claims
- BCBSM COB claims that are auto or employment related
- Commercial secondary or tertiary claims submitted for payers denoted as “Print and Mail” on the Commercial Payer Listing.

### Institutional claim submissions

BCBSM cannot accept hard copy submission of facility claims. We are also currently unable to accept electronic claims for:

- Commercial payers
- FEP when billing tertiary payer COB claims
- Nonparticipating out-of-state hospitals for Blue Cross, BCN and FEP.

Note: Submit out-of-state claims to the home Blues plan.

## How to get help with your claim issues

**Call the EDI Help Desk at 1-800-542-0945 if you experience the following issues:**

- Electronic claims received 277CA edits
- 835 is not in sync with EOB or voucher
- 835 is missing

**Call the Web Support Help Desk at 1-877-258-3932 for assistance with the following:**

- Electronic funds transfer
- Electronic vouchers
- Facility claim correction

**Contact your BCN provider representative if:**

- You have an issue with a claim you submitted on paper
- Your claim was rejected due to billing errors
- Your claim received a non-payment rejection on EOB from the claims processing systems.

**Contact your software vendor if:**

- You are experiencing 835 posting issues
- You are unable to view or read your reports

You can review the complete *EDI Process and Information for Providers* presentation on web-DENIS in *BCN Provider Publications and Resources* on the *Learning Opportunities* page.

## Clinical editing appeals now made easier

Submitting a clinical editing appeal just became a little easier. You now have the option to submit an appeal via fax or by U.S. mail. We hope this change will allow you easier tracking of your appeal request as you will be able to document when you sent it, as well as when we receive it.

The clinical editing form has been modified slightly to accommodate the change. The most current form can be accessed on web-DENIS. Just go to *BCN Provider Publications and Resources*, click on *Forms*, and then *Clinical Editing Appeal Form* under *Claims*. It is also available on the web-DENIS *Billing* page under *Forms*. Accessing the form in this way will insure you have the most current version. Additionally, the versions are dated in the lower right hand corner of the appeal form. The most current version is January 2013.

When submitting an appeal, either by fax or mail, there are some key points that you need to be aware of:

- Appeals must be received within 180 days of the original clinical editing denial. The clinical editing denials can be identified by explanation (EX) codes beginning with N, QN, QO or QP. The EX codes are three digits; examples include N01, N76, QOO and QPB.
- Include all pertinent documentation to support the appeal. This may include office notes, radiology reports, surgical reports, and prior service records. Documentation required depends on the type of edit received. For example, if a service denies as a duplicate, records for both the paid and the denied services may be needed to indicate there is not duplication.
- Fill out all required fields on the appeal form completely and correctly. Whenever possible, appeals should be typed. This facilitates processing of your appeals. Incomplete and illegible forms *will be returned*.
- While not required, it is strongly encouraged that you include a contact name and phone number. This information may make the difference in us being able to process an appeal.
- There is only one level of appeal. Make it count!

Our goal is to process your appeal accurately and quickly. By following the appeal guidelines, including the key points noted above, you will help us to resolve your appeal.

More information on clinical editing, including the appeal process, is located in the *BCN Provider Manual*. Go to *BCN Provider Publications and Resources* in web-DENIS and click on *Provider Manual*. Go to the "Clinical editing appeal process" section in the Claims chapter.

## 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 we receive reporting of the performed procedure. To view the full content of any of the tips, click on Clinical editing tips below.

- Correct use of modifier 24
- Reporting add-on codes
- Location of service
- Multiple procedure reductions for ophthalmology and cardiovascular services



[Clinical editing billing tips PDF](#)



## Reminder: Bill V codes with appropriate procedure codes

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Certain encounters and screenings should be billed with appropriate procedure codes according to HEDIS® specifications. The following services should not be reported with a V code only.

- Breast cancer screening — mammogram
- Cervical cancer screening — Pap smear
- Colorectal cancer screening — FOBT
- Glaucoma screening
- Diabetic eye exams
- Osteoporosis screening — bone mineral density test

These V codes have not been accepted by the National Committee for Quality Assurance for Healthcare Effectiveness Data and Information Set® measures since 2012.

NCQA explained this decision in the *HEDIS 2012 Technical Specifications for Physician Measurement* under the list of changes from 2011.

“Deleted V codes that identify an *encounter or screening*. Per the *ICD-9-CM Official Guidelines for Coding and Reporting*, V codes indicate a reason for an encounter and separate procedure codes must be billed for any procedures that are performed. V codes are deleted because they do not indicate that a service was actually performed.”

Therefore, in complying with these guidelines, a procedure code should be reported along with the V code that indicates a planned screening. This will confirm the screening was performed.

BCN appreciates your assistance in complying with NCQA guidelines.

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

## Clarification: Revenue code 0255 not valid for IVT-chemotherapy services

Blue Care Network recently announced that revenue code 0255, pharmacy drugs incident to radiology, would be added to the IVT-chemotherapy category as part of the Hospital Outpatient Pricing Strategy changes that take effect Oct. 1, 2013. The revenue code will **not** be added to that category, but will remain in the radiology category.

The rest of the chart has been reprinted at the right for your convenience.

### Additional IVT-chemotherapy services

Bill revenue codes as you bill other IVT-chemotherapy services revenue codes today. The revenue codes below are being added to the already existing revenue codes for IVT-chemotherapy services.

|      |  |
|------|--|
| 0250 | Pharmacy general classification                      |
| 0251 | Pharmacy generic drugs                               |
| 0252 | Pharmacy non-generic drugs                           |
| 0253 | Pharmacy take-home drugs                             |
| 0254 | Pharmacy drugs incident to other diagnostic services |
| 0256 | Pharmacy experimental drugs                          |
| 0257 | Pharmacy non-prescription                            |
| 0258 | Pharmacy IV solutions                                |
| 0259 | Pharmacy other pharmacy                              |
| 0631 | Pharmacy single source drug                          |
| 0632 | Pharmacy multiple source drug                        |
| 0633 | Pharmacy restrictive prescription                    |
| 0634 | Pharmacy erythropoietin < 10,000 units               |
| 0635 | Pharmacy erythropoietin ≥ 10,000 units               |
| 0637 | Pharmacy self-administrable drugs                    |
| 0771 | Vaccine administration                               |

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## Billing Q&A

**Question:**

**When trying to identify why a procedure code is denied, how do I identify the correct EX code so that I can fill in the appeal form?**

**Answer:**

On your remittance advice there is a heading in the center of the row, "Explanation." Under this heading, there are three boxes:

- BCN code
- Reason code
- Remark code

The BCN Code column will contain the EX code related to the clinical editing denial, if applicable. As a crosscheck, the EX code section on the appeal form contains a drop-down list. The code on the RA should match one of the codes in the drop-down list for it to be submitted to clinical editing as an appeal.

Below is a sample of the portion of the RA containing the EX codes:

| Allowed Amount | Disallow/ Contractual Adjustment | Explanation              |             |                   | Member Copay/ Deductible | Additional Member Liability |
|----------------|----------------------------------|--------------------------|-------------|-------------------|--------------------------|-----------------------------|
|                |                                  | BCN Code                 | Reason Code | Remark Code       |                          |                             |
|                |                                  | Member No. xxxxxxxxxx xx |             | IPA: xxxxxxxxxx   |                          |                             |
|                |                                  | Claim No. xxxxxxxxxxxxxx |             | Product ID: xxxxx |                          |                             |
| \$0.00         | \$125.00                         | <b>Q00</b>               | 58          | N97               | \$0.00                   | \$0.00                      |

### Ask a 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.

Please do not include any personal health information, such as patient names or contract numbers, in your question to us.



**Question:**

**How do I know which revenue code is appropriate to use with the HCPCS or CPT code I am reporting? Occasionally, I have received a denial stating that the procedure code is not appropriate.**

**Answer:**

BCN follows correct coding guidelines, which includes procedure code and revenue editing. In general, as with HCPCS and CPT coding, we recommend you use the revenue code that is most specific to and best represents the service provided. To identify which revenue codes require HCPCS/CPT codes, please refer to the list maintained on web-DENIS. Go to *BCN Provider Publications and Resources*. Under *Resources*, go to *Billing* and then *General Information*.

To ensure that the revenue code and procedure code are in alignment, we recommend that you refer to the current version of the *Uniform Billing Editor*, published by Optum Coding. For example, we have received claims for procedure code A9585 reported under revenue code 0349. This combination receives an edit because it is not a valid revenue code/procedure code combination. If procedure code A9585 is reported with either revenue code 0254 or 0255, it will not receive this edit in our system.

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## Bundling readmissions guidelines at same DRG facility

Blue Care Network reviews inpatient readmissions that occur within 14 days of discharge from a facility that is reimbursed by diagnosis-related groups (DRGs) when commercial HMO, BCN Advantage HMO-POS<sup>SM</sup>, BCN Advantage HMO<sup>SM</sup> and Blue Cross Complete members have the same or a similar diagnosis.

BCN reviews each readmission to determine whether it resulted from one or more of the following:

- A premature discharge or a continuity of care issue
- A lack of, or inadequate, discharge planning
- A planned readmission
- Surgical complications

In some instances, BCN will combine the two admissions into one for purposes of the DRG reimbursement. BCN requests that inpatient facilities complete the *Readmission Checklist* when a member is readmitted within 14 or 15 days of discharge from the initial admission with the same or a similar diagnosis. This checklist will help ensure that all the necessary information is available when a decision must be made as to whether to bundle the two admissions together or approve the second admission separately. The checklist is one of the Care Management forms that can be accessed from web-DENIS. Go to *BCN Provider Publications and Resources* and click on *Forms* under *Resources*.

Guidelines to determine if a readmission will be combined for payment purposes are listed in the table below:

| Readmission, Part One: Bill as separate admissions  |  |                    |                        |   |
|---|--|--------------------|------------------------|---|
| Description   | Billing  | Financial Recovery | Provider Appeal Rights | Comments  |
| Member leaves against medical advice and requires subsequent readmission.   | Separate   | None               | Cannot be appealed     | The documentation should show that the member signed out against medical advice.<br><b>Examples include:</b> <ul style="list-style-type: none"> <li>• Physician writes "discharged AMA" in physician orders.</li> <li>• Patient signs AMA form when leaving facility.</li> <li>• Written notation in progress notes that indicate member left against medical advice. This is acceptable from either physician or nurse.</li> </ul> Any other discharge will be considered a regular discharge. |
| Member requests discharge because of uncertainty about whether or not to undergo further treatment or for other personal reasons. | Bill admissions separately if the medical record documentation shows the member initiated the interruption | None               | Cannot be appealed     | A readmission will be considered separate if the member needs to return home or requests time to make a major health care decision.   |

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## Bundling readmissions, continued from Page 43

| Readmission, Part One: Bill as separate admissions  |   |  |                        |  |
|---|---|--|------------------------|--|
| Description   | Billing   | Financial Recovery   | Provider Appeal Rights | Comments   |
| Member is discharged to allow resolution of a medical problem that, unless resolved, is a contraindication to the medically necessary care that will be provided during the second admission.   | Separate  | None   | Cannot be appealed     | <b>Example:</b> Discharge to await normalization of clotting times prior to a surgical intervention. The medical necessity for the interruption of care must be clearly documented.  |
| Member meets discharge criteria and has an appropriate discharge plan, but requires readmission due to an unrelated condition or a new occurrence of some condition.  | Separate  | None   | Cannot be appealed     | Documentation must include a discharge plan that is appropriate and reasonable. Discharge plans should include the member's ability to follow the treatment plan after discharge.  |
| Member is discharged before all medical treatment is rendered, and care during the second admission should have occurred during the first admission. Criteria for bundling will be assessed for the hospital readmission when members are discharged to the following settings: <ul style="list-style-type: none"> <li>• Home</li> <li>• Skilled Nursing Facility</li> <li>• Inpatient Rehab Facility</li> <li>• Inpatient Psychiatric facility</li> <li>• Basic nursing home</li> <li>• Long-term acute care facility</li> </ul> | Combine admissions as continuation of care, unless plans are appropriately made for outpatient follow-up of medical conditions identified at admission. | If a hospital bills both as separate admissions, an audit adjustment will be made to combine the admissions. | Yes                    | <b>Example:</b> Member is treated for pneumonia, responds and meets discharge criteria. But a fecal occult blood test is positive, Hgb 10.9 grams. The hospital record does not support that this was recognized and appropriately determined not to require investigation during the first admission. No follow-up of the fecal occult blood test is documented. The member is readmitted five days later with gastrointestinal bleeding. Combine the admissions as continuation of care. |

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| Readmission, Part One: Bill as separate admissions  |  |  |                        |   |
|---|--|--|------------------------|---|
| Description   | Billing                                    | Financial Recovery   | Provider Appeal Rights | Comments  |
| <p>Member is discharged without discharge screens being met, including the clinical and level of care criteria.</p> <p>Criteria for bundling will be assessed for the hospital readmission when members are discharged to the following settings:</p> <ul style="list-style-type: none"> <li>• Home</li> <li>• Skilled Nursing Facility</li> <li>• Inpatient Rehab Facility</li> <li>• Inpatient Psychiatric facility</li> <li>• Basic nursing home</li> <li>• Long-term acute care facility</li> </ul>   | Combine admissions as premature discharge. | If the hospital bills both as separate admissions, an audit adjustment will be made to combine the admissions. | Yes                    | If the facility acknowledges that the member did not meet the discharge screens, the admissions can be combined without clinical review by BCN. If the facility does not acknowledge this, BCN must perform a clinical review to assess whether the member met the discharge screens. |
| <p>Member is discharged from the hospital with a documented plan to readmit within appropriate timeframe based on product line for additional services.</p> <p>Criteria for bundling will be assessed for the hospital readmission when members are discharged to the following settings:</p> <ul style="list-style-type: none"> <li>• Home</li> <li>• Skilled Nursing Facility</li> <li>• Inpatient Rehab Facility</li> <li>• Inpatient Psychiatric facility</li> <li>• Basic nursing home</li> <li>• Long-term acute care facility</li> </ul> | Combine admissions as planned readmission. | If a hospital bills as separate admissions, an audit adjustment will be made to combine the admissions.        | Yes                    | The care rendered during the subsequent admission was anticipated.<br><b>Example:</b> A discharge for hospital or physician convenience — the surgeon is away or the operating room is booked until the following week.   |

## Bundling readmissions, continued from Page 45

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| Readmission, Part One: Bill as separate admissions   |                    |   |                        |  |
|--|--------------------|---|------------------------|--|
| Description  | Billing            | Financial Recovery  | Provider Appeal Rights | Comments   |
| <p>Member is discharged from the hospital after surgery but is readmitted within 14 days with a direct or related complication from the surgery.</p> <p>Criteria for bundling will be assessed for the hospital readmission when members are discharged to the following settings:</p> <ul style="list-style-type: none"> <li>• Home</li> <li>• Skilled Nursing Facility</li> <li>• Inpatient Rehab Facility</li> <li>• Inpatient Psychiatric facility</li> <li>• Basic nursing home</li> <li>• Long-term acute care facility</li> </ul> | Combine admissions | If a hospital bills as separate admissions, an audit adjustment will be made to combine the admissions. | Yes                    | <p>The monitoring, evaluation and treatment of the patient for known sequel or common complications following surgery is an expected part of the 1st admission post operative period.</p> <p><b>Example:</b> Member returns in three to five days with a wound infection requiring IV antibiotics. Admissions are evaluated for bundling base on continuation of care, discharge plan and discharge screens.</p> |
| <p>Member is discharged but there was not a well documented, reasonable and appropriate discharge plan.</p> <p>Criteria for bundling will be assessed for the hospital readmission when members are discharged to the following settings:</p> <ul style="list-style-type: none"> <li>• Home</li> <li>• Skilled Nursing Facility</li> <li>• Inpatient Rehab Facility</li> <li>• Inpatient Psychiatric facility</li> <li>• Basic nursing home</li> <li>• Long-term acute care facility</li> </ul>  | Combine admissions | If a hospital bills as separate admissions, an audit adjustment will be made to combine the admissions. | Yes                    | Documentation does not show that the member had a well documented, reasonable and appropriate discharge plan.  |



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Coding corner

## Follow these coding tips to improve medical record documentation for fractures, osteoporosis

Coding for fractures can be a challenge considering the different types of fractures and certain bone diseases that can impact a fracture. These conditions can vary from serious (requiring immediate treatment) to chronic conditions that may call for treatment other than just a cast or strapping procedure.

In this article, you'll find coding tips for traumatic and pathologic fractures (including aftercare for both) and osteoporosis, the most common bone disease.



### Documentation and coding tips for traumatic fractures

Traumatic fractures are classified using ICD-9-CM categories 800 to 829. The three digits identify the bone involved, while a fourth digit indicates whether the fracture was open or closed and a fifth digit distinguishes the part of the bone affected. Review the information on coding fractures in the ICD-9-CM official guidelines in Section 1.C.17.b. A diagnosis is invalid if it has not been coded to the full number of digits required for that code.

### Common fracture terms

- Closed fracture: Commonly used terms may include simple, comminuted, depressed, elevated, fissured, greenstick, impacted, linear, slipped epiphysis or spiral.
- Open fracture: Terms may include compound, infected, puncture or "with foreign body."

To code multiple fractures, make sure the specific sites are coded individually and first list the most serious fracture, as determined by the attending physician. If the note is not clear, please don't assume and assign an incorrect code; ask the physician.

Please see [Coding tips](#), continued on Page 48

### About ICD-9-CM

ICD-9-CM is the national coding language used to translate a patient's clinical condition into three- to five-digit codes. When reporting ICD-9-CM and current procedural terminology codes on claims, it's critical that they're supported by proper documentation in a patient's medical record. Accurate coding starts with correct documentation.

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## Coding tips, continued from Page 47

Pathologic fractures are assigned codes from ICD-9-CM 733.10-733.19. These codes are used for acute or a newly diagnosed pathologic fracture, and while the patient is receiving active treatment for it. Unlike fractures of normal bone, pathologic fractures occur during normal activity or from minor trauma due to weakening of the bone by disease, such as osteoporosis, neoplasms and osteomalacia.

Review the information on coding pathologic fractures in the ICD-9-CM Official Guidelines in Section 1.C.13.a. It's important to note that just because the patient has a bone weakening disease does not mean a fracture is pathologic. Only the physician can determine whether the fracture is traumatic or pathologic.

## Coding tip

### Coding tip: When term 'rule out' used

A challenge in the outpatient setting occurs when the term "rule out" is used. For example, a patient presents with swelling and pain in the wrist and is sent to a radiologist to rule out a fracture. **It would be inappropriate to code a fracture until the condition is confirmed by the radiology report and the attending physician makes the determination.** The physician also can determine whether the fracture is traumatic or pathologic. Coding signs and symptoms is only acceptable when a definitive diagnosis has not been confirmed by the health care provider in the outpatient setting.

Terms synonymous with pathological fractures may include spontaneous fracture, non-traumatic compression, non-traumatic fracture or insufficiency fracture.

## Coding for fracture aftercare

Aftercare codes for fractures are found in the supplementary classification V codes, located at the end of the tabular list.

- The range for traumatic fracture aftercare is V54.10-V54.19.
- The range for pathologic fracture aftercare is V54.20-V54.29.

The fourth digit distinguishes between traumatic and pathologic, and the fifth digit specifies the fracture site being treated. These codes are not assigned when treatment is directed at a current acute injury, but after active treatment of the fracture is completed and for routine care of the fracture during the recovery phase.

Examples of fracture aftercare include:

- Change or removal of cast
- Removal of external or internal fixation device
- Medication adjustment

## Proper coding for osteoporosis

Osteoporosis is the most common bone disease. It's an abnormal loss of bone tissue that results in fragile or porous bones. It typically has no symptoms until a fracture occurs, usually in the wrist, hip or vertebra. The code selection for osteoporosis is 733.00-733.09. Review the ICD-9-CM manual for the appropriate code selection.

## Global referrals automatically entered with new BCN minimum requirements

Last fall, we announced changes to the global referral process for Blue Care Network, effective Jan. 1, 2013.

- Global referrals should be written for a minimum of 90 days.
- For three chronic conditions — oncology, rheumatology and renal management — global referrals should be written for one year.

We have been manually correcting the end dates of referrals written for less than the required minimum days until system changes were in place.

Effective May 3, 2013, our system automatically corrects referrals that are not written for the 90- and 365-day requirements. If you attempt to enter a referral for less than the minimum requirement, you will receive a warning message and the system will automatically enter the correct minimum.

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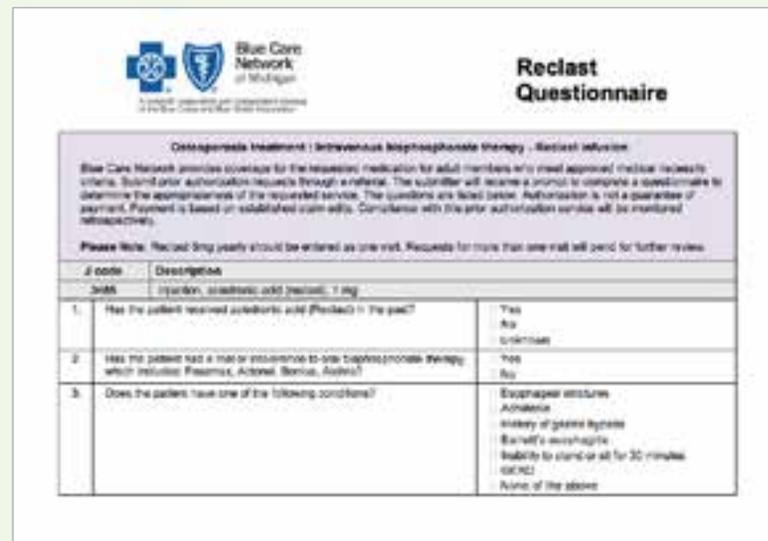
## Osteoporosis: Intravenous bisphosphonate therapy — Reclast infusion questionnaire

Bisphosphonates are currently the most predominately prescribed therapy for osteoporosis. Because there is no reliable evidence demonstrating one bisphosphonate is more effective or safe over another, the generic form of Fosamax® brings the most value for prevention and treatment of osteoporosis.

For members who do not have the option of oral therapy, Reclast is available as an intravenous bisphosphonate indicated for treatment and prevention of osteoporosis. Blue Care Network requires clinical review for all Reclast requests for both BCN commercial and BCN Advantage HMO-POS<sup>SM</sup> members to ensure safe and appropriate use of the medication.

Coverage for Reclast requires documentation that adequate trials of oral bisphosphonates (such as generic alendronate) have been ineffective based on objective documentation, not tolerated despite taking it as recommended or contraindicated.

A new **Reclast questionnaire** is available on the e-referral website to allow for efficient processing of requests. When requesting authorizations for Reclast on e-referral, the system will prompt the submitter to complete a questionnaire to determine the appropriateness of the request. If clinical criteria are met, approval will be granted for **one visit** for Reclast 5mg yearly.



**Reclast Questionnaire**

Osteoporosis treatment: Intravenous bisphosphonate therapy - Reclast infusion

Blue Care Network provides coverage for the requested medication for adult members who meet approved medical necessity criteria. Submit prior authorization requests through a referral. The submitter will receive a prompt to complete a questionnaire to determine the appropriateness of the requested service. The questions are listed below. Authorization is not a guarantee of payment. Payment is based on established contract rules. Compliance with the prior authorization service will be monitored retroactively.

Please Note: Reclast 5mg yearly should be entered as one visit. Requests for more than one visit will pend for further review.

| J code | Description   |  |
|--------|---|--|
| J0500  | Intravenous, bisphosphonate acid (Reclast), 5 mg  |  |
| 1.     | Has the patient received oral bisphosphonate (Fosamax) in the past?   | Yes<br>No<br>unknown   |
| 2.     | Has the patient had a trial or experience to oral bisphosphonate therapy, which includes Fosamax, Aclasta, Boniva, Actonel? | Yes<br>No<br>No  |
| 3.     | Does the patient have one of the following conditions?  | Esophageal stricture<br>Achalasia<br>History of gastric bypass<br>Barrett's esophagitis<br>Inability to stand or sit for 30 minutes<br>GERD<br>None of the above |

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## Blue Care Network announces questionnaire update for sleep management

Clinical review is required for Blue Care Network commercial, BCN Advantage HMO-POS<sup>SM</sup> and BCN Advantage HMO<sup>SM</sup> members for all home, outpatient facility and clinic-based sleep studies.

Two new sleep study codes for attended sleep studies in children younger than 6 years old have been added to the Outpatient Treatment Setting Sleep Study Questionnaire. These codes — \*95782 and \*95783 — will also be reflected in the near future in the updated medical policy for Sleep Disorders, Diagnosis and Medical Management.

Detailed information about BCN's Sleep Management Program is available on the e-referral home page at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Click on **Sleep Management**.

**\*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2012 American Medical Association. All rights reserved.**

## Blue Care Network announces delay in changes for sleep management

Clinical review is required for BCN commercial, BCN Advantage HMO-POS<sup>SM</sup> and BCN Advantage HMO<sup>SM</sup> members for all home, outpatient facility and clinic-based sleep studies. BCN recently announced that a non-diagnostic home sleep study will be required to be considered for coverage of a sleep study in the outpatient facility or clinic for adult members with symptoms of obstructive sleep apnea without certain other comorbid conditions with an effective date of July 1, 2013. There has been a delay in these changes and an updated effective date will be communicated in the near future.

## Referral to BCN not needed for diabetic retinopathy exam

Blue Care Network encourages its members who have diabetes to have a yearly eye exam for retinopathy.

Southeast and East region providers, along with those from the rest of the state, do not need to submit a referral to BCN for the annual eye exam when the exam is performed by a contracted BCN provider. A referral between the primary care physician and specialist must be documented in the member records at both offices.

For details, see **Page 26**.



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