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...from the  
medical  
director

*Guest column*

## Treating the newly insured and Medicaid patients

*In this issue, our medical director column has a different format. BCN Provider News interviewed Dr. Jerome Frankel, medical director at Oakland Southfield Physicians, a physician group. Dr. Frankel practices with two other physicians at Northside Medical Center, a primary care practice in Detroit. Approximately half of the practice's patients are covered by Medicaid.*

*In preparation for health care reform, Dr. Frankel spoke with us about what providers can expect as well as the challenges and opportunities associated with treating Medicaid patients and those who have lacked health coverage.*

### **BCN: What is unique about caring for Medicaid patients?**

**Dr. Frankel:** What it comes down to is many Medicaid patients have never had regular contact with a physician. There are social issues they have to contend with, one of the biggest being access to transportation. Their outlook on the emergency room, understandably, is that they can get all their care at the same place at one time.



**Dr. Jerome Frankel**

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## Blue Care Network receives “excellent” rating from NCQA

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Blue Care Network received an “excellent” rating, the highest possible, from the National Committee for Quality Assurance. Receiving an “excellent accreditation” tells BCN members that we continue to consistently meet high industry standards for HMOs.

NCQA uses a standard set of criteria, including Healthcare Effectiveness Data and Information Set measures and Consumer Assessment of Healthcare Providers and Systems scores, to rank the health plans in important aspects of care, such as improving members’ health and customer satisfaction.

“I am happy to say that after hard work and dedication, BCN was able to receive excellent accreditation again. For 12 years, with the exception of last year, we received the highest rating from NCQA, whose accreditation is the gold standard in evaluating health care quality. This improvement is an indicator that the work we’re doing is improving our members’ experiences with us,” said Mary McFarlane, director, Quality Management for BCN.

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CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality

Here is a look at how each of the products scored in each category (on a star scale of one to four):

Commercial HMO: Excellent	
Accreditation	NCQA rating (scale of 1 to 4)
Access and Service	
Qualified Providers	
Staying Healthy	
Getting Better	
Living with Illness	

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**BCN: What are the social issues doctors need to be aware of when treating Medicaid patients or those who have not had insurance before?**

**Dr. Frankel:** Think about what might happen if you had a limited income and difficulty supporting basic needs like getting food on the table. With this comes a host of issues, many of which are psychological and behavioral health.

Some of the behavioral issues are related to social conditions – getting food on the table, as I already mentioned, not having a place to live or living with family in crowded conditions with little or no privacy. This is a hard way to live and places a significant amount of stress on individuals and families, including children. Many of our Medicaid patients are frightened, and physicians need to recognize these social vulnerabilities. While there are certainly limitations to what a physician can do to change these circumstances, as long as you are aware, you can often mitigate their effects.

**BCN: What do you do to help them communicate better with doctors?**

**Dr. Frankel:** We have a care coordinator in our office. She is a registered nurse and is available to our patients 24/7. She is in the office two full days each week, and a cornerstone of her daily activity is dealing with behavioral or social issues beyond what the doctors do.

**BCN: What does the care coordinator do?**

**Dr. Frankel:** A care coordinator is able to support the primary care in so many ways, such as review medications and help educate patients about their conditions. Patients have somebody they know they can reach if there's something they don't feel comfortable discussing with the doctor. For example, if they need help getting into substance abuse treatment, the care coordinator can facilitate this with the physician and support the patient to ensure they follow through with recommended treatment. Patients tend to feel like they now have a personal ally they can contact about an issue.

**BCN: How do you introduce the concept of the care coordinator to patients?**

**Dr. Frankel:** If they need a coordinator, we tell them who the person is and let them know they will be getting a phone call from someone so they aren't alarmed. Sometimes people can be frightened by getting a phone call from a doctor's office, so personally explaining the concept in advance is key.

**BCN: What advice would you offer other providers who may soon be taking care of some of these patients?**

**Dr. Frankel:** A lot of Medicaid patients have historically had spotty care. They probably never had a good relationship with a physician because it's been difficult, whether due to financial or transportation barriers. It really comes down to spending that extra time to understand who that patient is and where they are coming from, especially if a patient has a significant medical disease. Through this thoughtful dialogue, you will learn essential information, such as the level of support at home, that will help you provide the best possible care.

**BCN: What about older patients without insurance?**

**Dr. Frankel:** Older patients without insurance have probably not gotten any sort of routine care, even with the availability of free mammograms and Pap smears. And if they suffer from diabetes, they most likely have not had an appropriate work-up.

Often doctors are afraid of the time element in treating older patients. It's not as daunting as it sounds, but you do have to be aware. Utilizing your nurses and medical assistants, and possibly care coordinators, is a huge help in getting those more difficult problems addressed.

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## **BCN: How are newly insured patients going to be different from the Medicaid population?**

**Dr. Frankel:** People don't understand that the vast bulk of patients without insurance include the working poor. Patients who have had Medicaid are fairly well cared for. This is going to be a somewhat different population. Folks who are earning less than a certain amount are already on Medicaid. Others who are now eligible for insurance are making low salaries, but they are working people.

It's important to understand that a large segment of our newly-insured patients will be those working people who have just not had access to or enough money to purchase health insurance. It's not talked about enough and is poorly understood.

## **BCN: What advice do you have for doctors who have to play catch-up and treat patients who may have a backlog of issues, for example, missing immunizations or a chronic disease?**

**Dr. Frankel:** Immunization is relatively easy. You can catch up with a couple of visits and often it can be done at the patient's convenience.

As far as a backlog of health issues for those who haven't seen a doctor in a while, well that's our job. You have to explain everything and make sure they understand the treatment plan, especially with diabetes or hypertension. This is where a care coordinator helps enormously. We will bring the patient back for labs and screening tests and deal with as many issues as we can. Also, involve the care coordinator to help with patient education. People often don't want to look unintelligent and don't ask the doctor questions, but a care coordinator is usually seen as a safe person to ask just about anything.

## **BCN: Do you provide any patient education? How would you target that specifically for Medicaid patients or those who've never had insurance?**

**Dr. Frankel:** That's the nice thing about electronic medical records. They're not just billing systems any longer. Once

a diagnosis is in and the medical assistants can see what the diagnosis is, they can give the patients some basic information about their disease state.

But you can't just hand them a piece of paper. Physicians need to go over things with them. For example, with diabetes, you need to explain why they're testing their sugar several times a day. The care coordinator can also support this process, but it does take time. Unless you spend the necessary time, you end up with patients coming back with their sugars, saying "You told me to write it down, but why and what am I supposed to do about it?" You need to clearly explain these are actionable items. We discuss what we are doing and what action the patient needs to take.

## **BCN: Doctors are expecting a large influx of new patients needing services. How should they be prepared to deal with that?**

**Dr. Frankel:** We know there will be more patients coming in. We use physician assistants and nurse practitioners as practice expanders. Most doctors want to see what the influx is going to be before hiring new staff. From the experience in Massachusetts, we know it's going to be a problem. However, we'll just have to wait and see and figure out how to deal with it. If our practice grows, we can add more physicians.

If you prefer practice expanders without hiring more doctors, physician assistants and nurse practitioners do a great job. Bringing them into the office can solve a lot of problems.

I look at the glass as half full. There's a tremendous opportunity for practices to expand.

Initially, when Medicaid was implemented, the things people said were beyond belief. We need to step back. Yes, there will be bumps in the road. We're radically changing our delivery system. But this is something most people understand has to be done.

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## Focus on health care reform: Advanced Premium Tax Credit grace period explained

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As we've previously mentioned in our newsletters and through various informational sessions, health care reform brings many changes to the industry and these changes will impact your daily business.

The Patient Protection and Affordable Care Act mandates a three-month grace period for Marketplace-purchased individual health care policies that receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year.

The health plan is only obligated to pay claims for services rendered during the first month of the grace period. PPACA specifies that the health plan may hold claims during the second and third months of the grace period.

If this happens, health care providers will notice this special message, during months two and three of the grace period, when they check eligibility on web-DENIS or on CAREN:

Contract is active but not current. Claims will be held until the member makes the appropriate payment to bring the contract to current status, or until payment is no longer accepted and the coverage is terminated. There is no guarantee of payment for services rendered during this time.

The Blues' policy for the grace period is as follows:

- For claims with dates of service during the first month of delinquency, Blue Cross Blue Shield of Michigan and Blue Care Network will process and pay otherwise covered claims as though the premium had been paid.

- For claims with dates of service during months two and three of delinquency, BCBSM and BCN will hold claims for members who are receiving the Advanced Premium Tax Credit and are delinquent with premium payments.
  - If the member pays the premium payment in full by the end of the grace period, BCBSM and BCN will process the pended claims in accordance with the member's benefits.
  - If the member fails to pay by the end of the grace period, their coverage will be terminated effective the end of the first month of the grace period. All claims that are held during months two and three will be rejected as "member ineligible".

Here are the direct impacts to health care providers:

- During months two and three of the grace period providers will see the special message noted above on the first web-DENIS eligibility screen. When this happens, providers may require these members to make payment in full at the time a covered service is rendered, up to BCBSM's (or BCN's) allowed amount.
- If the member pays the premium in full before the end of the third month of the grace period, the Blues will pay the pended claims to the provider. The provider will then need to refund the member any payments for covered services in excess of the liability communicated on the remittance advice (within 60 days, as per BCBSM and BCN policy).

Because this **only** applies to members who purchase health insurance through the Health Insurance Marketplace **and** receive a federal premium subsidy, you won't see this until 2014. However, we wanted to be sure you were aware of the change in advance. We'll continue to provide updates on issues related to reform.

The information in this article does not apply to pharmacy providers.

Continue to watch *The Record* and *BCN Provider News* for more reform information in the coming months.

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One of the key areas of focus of national health care reform is improving the quality and reducing the costs of treating Medicare patients. To meet these objectives, the Centers for Medicare & Medicaid Services is emphasizing coordinated care between health care providers by encouraging the creation of accountable care organizations.

CMS defines ACOs as groups of doctors, hospitals, and other health care providers who come together voluntarily to coordinate high quality care for their Medicare patients. In addition to increasing the quality of care (which is expected to contribute to healthier beneficiaries and reduce costs), CMS believes that coordinated care will improve communication among different providers, eliminate redundant treatment and testing for patients, and reduce cost by cutting out waste.

CMS is offering monetary incentives to ACOs that “spend health care dollars more wisely.” CMS will share some of the money saved through effective implementation of coordinated care. This model was created in an effort to replace the current Medicare fee-for-service system by adding an emphasis on patient outcomes and cost containment.

To be eligible for the Medicare Shared Savings program, ACOs have to:

- Meet several quality standards across five domains of population health
- Join an ACO and apply to CMS
- Agree to participate in the program for three years and serve a minimum of 5,000 Medicare patients
- Use electronic medical records and be able to collect and evaluate data, as well as establish at least 50 percent of all participating PCPs as “meaningful electronic health record users” by the second year of participation
- Have a governing body and be responsible for routine self-assessment, monitoring and reporting of the care delivered

The Blues have already begun taking steps toward reimbursement based on improved hospital-based efficiency and better patient health outcomes achieved through hospitals working in a coordinated fashion with affiliated physicians. The goal is to move away from the traditional fee-for-service payment approach, which is not improving quality nor lowering costs, toward a value-based reimbursement system.

“The current system is best described as fee-for-service without a focus on improved health outcomes,” said Susan Barkell, senior vice president of Health Care Value for Blue Cross Blue Shield of Michigan. “Insurers pay for every treatment, no matter how effective. However, we don’t pay physicians and hospitals for some things that really improve patient health, like proactively contacting people about their follow-up care or medication compliance,” she said.

Under the new value-based system of reimbursement, the Blues would provide incentives for physicians to use practices that really do improve patient health and contain costs through a shared savings program not unlike the one used by CMS. The program would also provide hospitals with funding for infrastructure improvements needed to better coordinate care between hospitals and physicians. The Blues have already implemented such a model through a **partnership with Trinity Health**.

Trinity Health is not the only organization in Michigan embracing value-based reimbursement and shared Medicare savings. According to *Crain’s Detroit Business* other ACOs in Michigan include Oakwood Accountable Care Organization, Southeast Michigan Accountable Care (part of United Outstanding Providers), the University of Michigan Health System, and Genesys PHO.

For more information on ACOs, Medicare Shared Savings, and how you can participate, please visit the **CMS** website. Information about ACOs and the shared savings program is also available in a **Reform Alert** on the Blues’ website.



## What members may ask about 2014 insurance plan taxes and fees

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When Blue Care Network members ask about the taxes and fees charged by their 2014 health plan, you can refer to the information we're offering here to help you understand their questions and offer some guidance.

When members who have individual coverage receive a January 2014 bill or renewal from us, or get a quote for a 2014 plan, they'll see a line for federal and state taxes and fees. Members start paying these taxes and fees in their January 2014 premium bills.

#### What are the taxes and fees?

The taxes and fees we're talking about are the ones established under the Affordable Care Act to support health care reform. That's the general answer you can give members asking about them – that they are mandated under national health care reform to support the costs of the infrastructure that makes affordable health care more widely available.

To the extent possible, BCN members' bills will reflect the taxes and fees separate from the monthly premium rates, so members can identify them.

Businesses that provide insurance to their employees also have to pay most, if not all, of these taxes and fees. Depending on the number of full-time employees a business has, not every tax and fee applies.

#### Where BCN members can get more information

BCN members can go to [bcbsm.com](http://bcbsm.com) and, under the *Help* menu, select *Calculators and Tools*. Then, click on *Health Insurance Tax Estimator* and **Health Insurance Taxes and Fees FAQ for Individuals**. They'll find a tax calculator to use in estimating their 2014 taxes and fees. Members can also call BCN Customer Service at 1-800-662-6667, Monday through Friday between 8 a.m. and 5:30 p.m.

For additional information, here's a table showing the specific taxes and fees and some details about them:

Tax or fee	Type		What it's for
	Federal	State	
Federal Insurance Premium Tax	X		Generates federal revenue to support health care reform
Comparative Effectiveness Fee	X		Funds the <b>Patient-Centered Outcomes Research Institute</b> , which compares how well different medical treatments work
Reinsurance Fee	X		Supports the Transitional Reinsurance Program, created to stabilize the cost of insurance during the early years of health care reform
Marketplace Fee	X		Pays for the <b>Health Insurance Marketplace</b> , where members purchase insurance, to make it self-sustaining
Risk Adjustment Fee	X		Supports the administrative costs related to the Risk Adjustment Program created to compensate health insurance companies that have a less healthy membership
Michigan Claims Tax		X	1 percent tax on certain health insurance claims. It went into effect Jan. 1, 2012. It replaces the 6 percent tax on Michigan's Medicaid services.
State Insurance Premium Tax		X	Quarterly tax on Michigan-based health insurance premiums (applies to Blue Cross Blue Shield of Michigan products; Blue Care Network is currently exempt from this tax.)

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## Health reform spurs Healthy *Blue Living* product changes



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Blue Care Network is changing its Healthy *Blue Living*<sup>SM</sup> products to comply with the Affordable Care Act.

We will no longer offer Healthy *Blue Living Rewards*<sup>SM</sup> for groups who renew on or after Jan. 1, 2014. Large groups enrolled in Healthy *Blue Living Rewards* that renew before January will be able to renew with that plan, but this will be their final run-out period and they will not be able to renew with the product in 2014. Therefore, providers should expect to see some Healthy *Blue Living Rewards* members through the end of 2014. Members in the Healthy *Blue Living Rewards* plan renewing Jan. 1 and after, will be migrated to a Healthy *Blue Living* plan with similar benefits.

We have changed the name of the remaining product to Blue Care Network Healthy *Blue Living*<sup>SM</sup> HMO, effective Jan. 1, 2014. Additional changes include:

- Renewing members who began the plan year at the standard level and achieve the enhanced level during the qualification period, will be retroactively moved to the enhanced level effective the first day of their plan year. Previously, these members would move to the enhanced benefit level effective the 91st day of the plan year.
- Providers should be aware that BCN will process claims for members who move to an enhanced benefit level after the first 90 days in the plan. That means providers may be responsible for returning money to some members because their deductibles, copayments and coinsurance will retroactively be adjusted. We are conducting a claims analysis to ensure that our claims are adjusted in a way that minimizes the impact to members and providers.

### BCN eliminates some requirements for members with “A” scores

It’s important to note that Blue Care Network does not limit the number of physicals for plan members. Therefore, providers may schedule physicals for members at any time, even if a physical is not required for that member.

BCN relaxed the rules for 18 to 39 year-olds. Members under 40 who score all As on the qualification form only need to visit their primary care physician every three years. The online health assessment requirement for these members also changes from annually to every three years.

For members age 40 or older scoring all As, BCN requires a PCP visit and online health assessment every two years.

BCN is also making sure we have an alternative option available for members who can’t meet the health measure goals. There are six wellness targets: tobacco cessation, weight control, blood pressure, cholesterol, blood sugar and depression. An “A” grade means the member is meeting the wellness target. A “B” grade means the member has a health condition that might not be controlled, but is actively participating in treatment to improve the condition. And a “C” grade means the member is not meeting the wellness target and has not committed to treatment to improve his or her condition. As long as members meet the wellness targets or they are taking steps to improve their conditions, they are eligible for the enhanced benefit level.

Please see [Healthy \*Blue Living\*](#), continued on Page 9

### Reminder: Only electronic qualification forms accepted

Blue Care Network only accepts and reimburses providers for electronic Healthy *Blue Living*<sup>SM</sup> qualification forms. Providers must file a claim with Blue Care Network to be paid for completing the forms. Claims should be billed in the amount of \$40 using the CPT code \*99080. Make sure you use diagnosis code V70.0.

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## Medicaid expansion and reform signed by Governor Snyder

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In September, Governor Snyder signed the **Healthy Michigan Plan** into law. The Healthy Michigan Plan expands Medicaid coverage to individuals within 133 percent of the federal poverty level and reforms the Medicaid program. After application of an automatic 5 percent income disregard, this means that individuals up to 138 percent of the federal poverty level who are not already eligible for Medicaid will become eligible for the program.

The Medicaid reforms include increased cost-sharing through new health care accounts, healthy behavior

incentives and a 48-month time limit on Medicaid eligibility for certain populations. After 48 months, individuals will have the choice of increased Medicaid cost-sharing or private coverage on the Health Insurance Marketplace. Some of these reforms will require special approval in the form of Section 1115 waivers from the federal government before they can be implemented.

The legislation was not given immediate effect, which means that Medicaid expansion will begin on or around April 1, 2014.

*The information in this document is based on preliminary review of the national health care reform legislation and is not intended to impart legal advice. The federal government continues to issue guidance on how the provisions of national health reform should be interpreted and applied. The impact of these reforms on individual situations may vary. This overview is intended as an educational tool only and does not replace a more rigorous review of the law's applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice. As required by US Treasury Regulations, we also inform you that any tax information contained in this communication is not intended to be used and cannot be used by any taxpayer to avoid penalties under the Internal Revenue Code.*

### Healthy Blue Living, continued from Page 8

In compliance with health care reform guidelines, even members who cannot meet the wellness target will be able to qualify for the enhanced level if they agree to participate in a BCN-sponsored program, such as *Quit the Nic* for tobacco users, or if they agree to follow a doctor's treatment plan for other health measures.

Because we offer various benefit options to all group sizes, Healthy Blue Living will be available with different cost-sharing levels. Providers should check web-DENIS for eligibility and benefits.

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## Blue Cross Partnered product offered in West region

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Blue Cross Blue Shield of Michigan is offering a new product that takes advantage of Blue Care Network’s agreement with Mercy Health. Blue Cross® Partnered offers gold, silver, bronze and value product options for individuals under 65. The network is for residents of Kent, Muskegon and Oceana counties.

This product is one of several Blues products that will provide access to quality health care services coordinated through Mercy Health’s more than 700 local doctors and four local hospitals.

All members must select a Blue Cross Partnered primary care physician. The Blue Cross Partnered network primarily consists of providers affiliated with Mercy Health. If a Blue Cross Partnered provider refers out of the Partnered® network, including providers within the BCN HMO network who are not affiliated with Mercy Health, they must have clinical review from BCN.

BlueCard services are available under Blue Cross Partnered products.

		Blue Care Network of Michigan	Blue Cross® Partnered
<b>Enrollee Name</b> <b>FIRST M LASTNAME JR</b>		<b>Plan</b>	<b>HMO</b>
<b>Enrollee ID</b> <b>XYK888888888</b>		<b>RxBIN</b>	<b>610014</b>
<b>Issuer (80840)</b> <b>9101000021</b>		<b>RxGRP</b>	<b>MiBCNRX</b>
<b>Group Number</b> <b>12345006</b>			
			

In the **Sept.-Oct. issue**, BCN announced that we have joined with Mercy Health to introduce a partnership that offers low-cost health products in three West Michigan counties.

The MyChoice Wellness product for BCN Advantage<sup>SM</sup> members is also a result of this partnership. (See **Page 20** for details about MyChoice Wellness.)

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## Habilitative therapy benefits covered under health care reform-compliant plans

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Beginning in 2014, health care reform-compliant plans for individuals and small groups will cover both rehabilitative and habilitative care for physical, occupational and speech therapy. There is a therapy limit of 30 visits for rehabilitative care (30 visits for PT/OT combined and 30 visits for ST) and a separate limit of 30 visits for habilitative care (30 visits for PT/OT combined and 30 visits for ST).

This is the first time Blue Care Network is covering habilitative care. Habilitative services are defined as health care services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech language pathology or other services for people with disabilities in a variety of inpatient or outpatient settings.\* Rehabilitative and habilitative therapy are considered essential health benefits under the Patient Protection and Affordable Care Act.

Not all BCN members will have this benefit. Members with coverage through a large group will not have this coverage unless requested. Members with small group coverage whose renewal date is later in 2014 will not have this coverage until their renewal date. In addition, members of Personal Plus, an individual product available through 2014, will not have this coverage. Personal Plus is not a health care reform-compliant product.

Providers will be able to tell who has this benefit by checking eligibility and benefits in web-DENIS or CAREN. Web-DENIS and CAREN will indicate separate 30-visit limits for habilitative and rehabilitative therapy.

Beginning in January 2014, when BCN therapy providers submit a treatment plan to Landmark, they will need to indicate if the therapy is habilitative or rehabilitative. Otherwise, there is no change in the way referring providers submit referral requests or therapy providers submit their claims.

\*[http://www.Michigan.gov/documents/lara/1.7.13\\_Order\\_No\\_13-003-M\\_EHB\\_Habilitative\\_Services\\_407955\\_7.pdf](http://www.Michigan.gov/documents/lara/1.7.13_Order_No_13-003-M_EHB_Habilitative_Services_407955_7.pdf)



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Blue Cross Blue Shield of Michigan and Blue Care Network have a number of provider resources on health care reform.

The following articles were published in the Sept.-Oct issue of *BCN Provider News*:

- Navigating through health reform, **Page 1**
- The Health Insurance Marketplace: A new way to shop and purchase health coverage, **Page 3**
- A look at essential health benefits, **Page 6**
- Checking member eligibility and benefits is crucial with health reform, **Page 7**
- Affordable Care Act forges new partnership between Blue Care Network and Mercy Health to offer low-cost health products in West Michigan, **Page 8**
- PCP Focus expands to 21 counties, **Page 9**
- Additional preventive medications available at \$0 cost-sharing, effective with plan years Jan. 1 and after, **Page 41**
- New Custom Select Drug List available Jan. 1, 2014, **Page 42**

Also see our **BCN Alert** for information about Blues products offered on the Health Insurance Marketplace, health reform webinars and the discontinuation of paper remittance advices.

In addition, this issue includes extensive health reform coverage, including articles about Advanced Premium Tax Credit grace periods, Accountable Care Organizations and what members may ask about insurance plan taxes and fees. Look for the health reform banner throughout the issue.

Here are some additional online resources where you can learn more:

- Blue Cross Blue Shield of Michigan and Blue Care Network **health reform website**.
- The **Blues' health reform basics** website
- The **Marketplace** website

You can also check web-DENIS for more information about health reform. Go to *BCN Provider Publications and Resources* and click on *Health Reform* under Resources.

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## Web-DENIS enhancements enable physicians to identify patient gaps in care

To help identify gaps in patient care, we have enhanced web-DENIS. Now, when physicians or health care professionals click on a member care alert, they'll be brought to a page in web-DENIS that will display a printable list of diagnosis gaps and treatment opportunities by patient.

### Primary care physicians

When you click on a diagnosis gap or treatment opportunity on the list, you'll be brought to the Health e-Blue<sup>SM</sup> home page if you have access. Once in Health e-Blue, if the patient is in your panel, you may navigate to the *Diagnosis Evaluation* panel or *Treatment Opportunities by Condition/Measure* panel to close patient gaps.

If you don't have access to Health e-Blue, download an **application** from **bcbsm.com**.

### Specialists and other health care providers

If you aren't eligible for access to Health e-Blue, you can still close patient gaps by providing the service and billing for that service on a claim. Check our website for a **list of provider types** who are eligible for access.

### New member gap details screen

Blues providers will see a list of diagnosis and treatment opportunity gaps by patient with a status symbol indicating whether diagnosis gaps are open, pending or closed. Treatment opportunity gaps will be listed as not met, pending met or met.

Diagnosis Gaps:					
Diagnosis Gaps ID	Status	HCC Code	HCC Description	ID Type	Edit
1	X	80	Congestive Heart Failure	CLAIMS	<a href="#">Link to Update</a>
2	✓	105	Vascular Disease	Possible Condition	<a href="#">Link to Update</a>
3	✓	15	Diabetes with Renal or Peripheral Circulatory Manifestation	Previously Reported	<a href="#">Link to Update</a>

- X Open Gap
- ✓ Gap Closure Pending
- ✓ Previously Confirmed Gap

Please see [Web-DENIS](#), continued on Page 14

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## Web-DENIS, continued from Page 13

The Member Care Alert buttons will appear for BCN commercial and Medicare Advantage patients and BCBSM Medicare Advantage patients covered under the following products: BCBSM Medicare Plus Blue PPO<sup>SM</sup>, BCN Advantage<sup>SM</sup> and BCN commercial. Diagnosis gaps will only be available for Medicare Advantage patients.

See the **July-August** of *BCN Provider News* for a previous article about new member care alert buttons. The color-coded buttons were added to the web-DENIS member eligibility screen in July to quickly assist physicians in identifying patient needs.

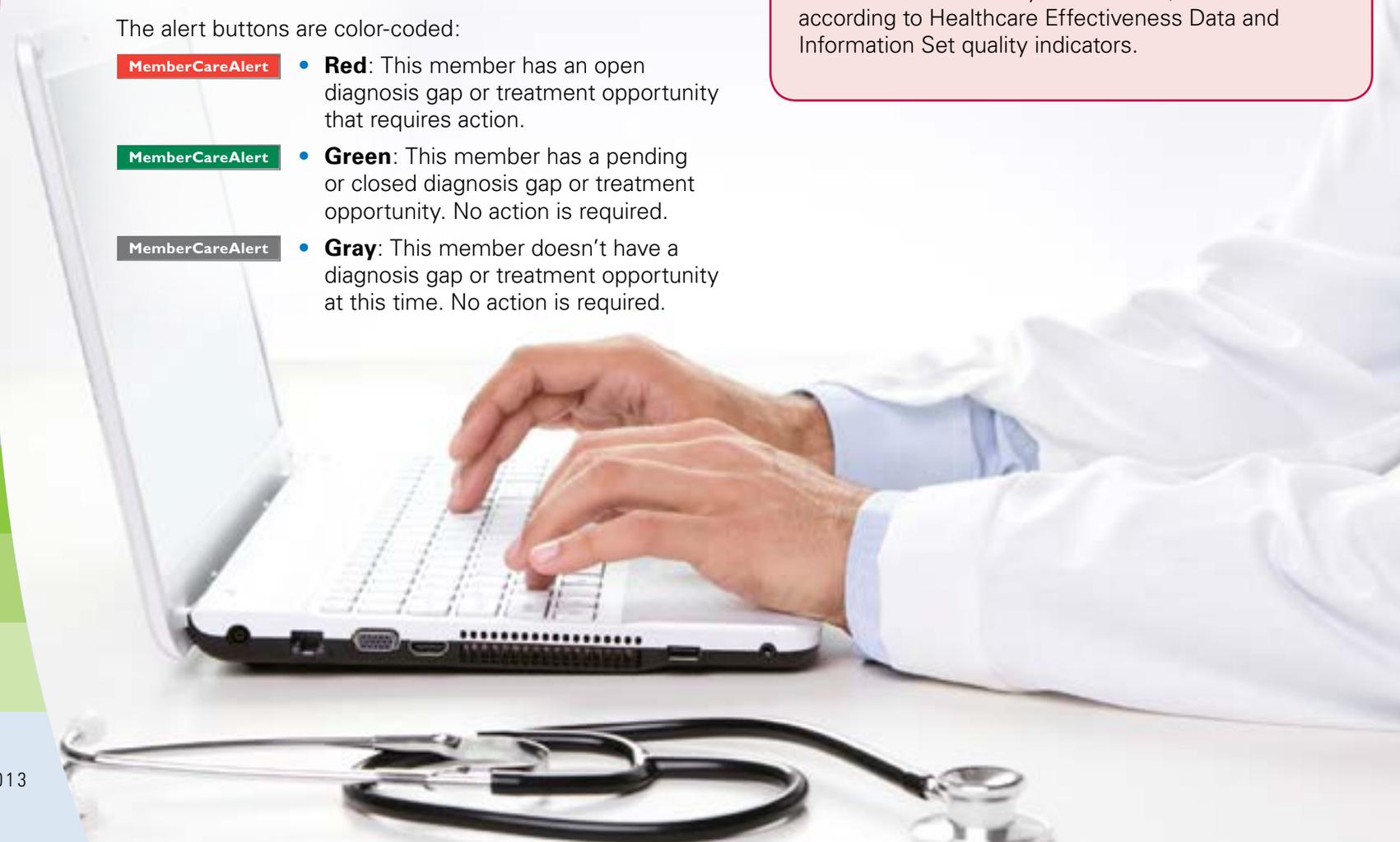
The alert buttons are color-coded:

-  **Red:** This member has an open diagnosis gap or treatment opportunity that requires action.
-  **Green:** This member has a pending or closed diagnosis gap or treatment opportunity. No action is required.
-  **Gray:** This member doesn't have a diagnosis gap or treatment opportunity at this time. No action is required.

If you have questions regarding these enhancements, please contact your Blues provider affairs representative or provider consultant.

**Diagnosis gap:** A suspected or historical condition that hasn't been documented and coded in the current calendar year or hasn't been confirmed as not applicable to the member.

**Treatment opportunity:** A preventive service or treatment needed by the member, measured according to Healthcare Effectiveness Data and Information Set quality indicators.





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## Providers must reattest to keep CAQH current

Blue Cross Blue Shield of Michigan's and Blue Care Network's enrollment and credentialing system is consistent with the Council for Affordable Quality Healthcare database. To ensure that you have no interruption in your network affiliation, please remember to keep your CAQH® current. Providers must log into CAQH at least every 120 days to reattest.

All providers, even hospital-based providers and nurse practitioners, need to be registered with CAQH.

Please be aware if you let your CAQH expire, you will not appear in provider directories or our online search. If your CAQH application is not current at the time of recredentialing, your Blues affiliation will end and you must go through the enrollment and credentialing process again. This can affect the claims you submit to BCN.

Here are some other tips for entering information into CAQH.

### Add email addresses

It's important to provide an email address so CAQH can send you reminders when it's time to reattest. You can add up to three email addresses in **CAQH**. Click on the "edit Account" tab.

### If you practice in a hospital setting

Under the "Start" tab, enter your credentialing information. If you practice exclusively in an inpatient hospital setting, confirm your status by clicking on this tab. (If you practice in a hospital setting, it means you do not see members outside the hospital setting.)

Hospital-based practitioners may see a pop-up message when they confirm their hospital affiliation. Please bypass the message to enter your address location.

If you change your hospital-based status, please update CAQH in a timely manner.

### Changing practice location

Please remember to update CAQH when you change your practice location.

If you have any questions about CAQH, contact the CAQH help desk at 1-888-599-1771. For questions about the credentialing process, call your provider representative.

## Separate DEA registration required in each state

Practitioners need to obtain a separate DEA registration in each state where they plan to administer, dispense or prescribe controlled substances. Failing to do so can delay your credentialing.

Refer to the credentialing chapter of the *BCN Provider Manual* for more information.

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## Update on credentialing of BCBSM and BCN organizational providers and facilities

Blue Care Network's Corporate Credentialing & Program Support department now processes all credentialing for hospital and non-hospital facilities for the Blues enterprise. This encompasses all Managed Care Networks and Traditional.

### Minimum credentialing requirements include:

- Completed and signed credentialing/recredentialing application
- Medical director (MD or DO or PT for OPTs) with valid state license and in good standing
- Valid facility state license
- Valid pharmacy license (for AICs)
- Both general and professional liability malpractice insurance
- Accreditation or a current CMS survey

Failure to meet these requirements could result in affiliation denial or termination from all networks.

## Blue Care Network and BCN Advantage provider contracts amended

The following professional provider agreements are amended effective Dec. 1, 2013:

- BCN commercial contracts are updated to reflect revised regulatory requirements and language clarification.
- BCN Advantage<sup>SM</sup> contracts are updated to include compliance requirements mandated by the Centers for Medicare & Medicaid Services.

The amendments are available on the web-DENIS *BCN Provider Publications and Resources* site on the *Policies and Information* page.

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## BCN offices closed for holidays

Blue Care Network offices will be closed Nov. 28 and 29 for Thanksgiving and Dec. 23, 24, and 25 for Christmas. When BCN offices are closed, call the BCN After-Hours Care Manager Hotline at 1-800-851-3904 and listen to the prompts for help with:

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

Do not use this number to notify BCN of an admission for commercial or BCN Advantage<sup>SM</sup> HMO-POS and BCN Advantage<sup>SM</sup> HMO members. Admission notification for these members can be done by e-referral, fax or phone the next business day.

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

## Speech-language pathologists should register early for licensing

Michigan Department of Licensing and Regulatory Affairs, Board of Speech-Language Pathology has issued licensing requirements for Speech-Language Pathologists.

All speech-language pathologists practicing in Michigan must have a license by **December 7, 2013**. It can take six to eight weeks for the Bureau of Health Care Services to process an application and issue a license. We are encouraging SLPs to apply in advance to ensure they meet the deadline.

Questions regarding license applications can be directed to the Michigan Board of Speech-Language Pathology at 517-335-0918 or by email at [bhphelp@Michigan.gov](mailto:bhphelp@Michigan.gov).

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## BCN Advantage introduces plan changes for 2014

BCN Advantage<sup>SM</sup> has made some changes in its plans for 2014. Most of the changes are plan improvements, including a free routine vision exam, enhanced transportation benefits for plans that offer it, and an increased vision allowance under the optional dental/vision supplemental coverage.

Some benefit adjustments were required in order to ensure our plan member premiums continue to be affordable. An important benefit change for our Individual plans only is that we increased copayments on Part B drugs to 20 percent, except for Part B immunizations and home infusion drugs. BCN Advantage pays in full for immunization and home infusion drugs. BCN Advantage pays other Part B drugs at 100 percent after out-of-pocket maximums are reached. Members enrolled in group coverage were not affected by this change.

### Vision

Improved vision benefits are available. For all Individual plans, members are now entitled to a routine vision exam with no payment if the member sees a VSP provider. The glaucoma exam continues to be covered at no cost.

Enhanced vision benefits through VSP are still covered in Classic and Prestige. The plans have a \$100 VSP allowance on glasses (lenses and frames) or contact lenses every 24 months.

### Supplemental dental and vision

Optional individual supplemental dental and vision coverage is available in all BCN Advantage plans for a minimum monthly fee. This optional coverage provides restorative dental services and an additional \$200 allowance for frames and lenses or contact lenses every 24 months, an increased allowance of \$100 from the 2013 plan year.

### Other changes

- Transportation benefit has increased to 36 round-trip visits. The vendor is Medical Transportation Management. All plans have this benefit except for BCN Advantage Basic.
- We have reduced copayments for physical therapy, occupational therapy and speech therapy. Copayments vary by plan.
- We have increased the copayment for ambulance service in alignment with other Medicare Advantage Plans.
- For all members in the gap (donut hole) we pay 28 percent of generic drug costs; the member pays 72 percent. The member portion will decrease as the Centers for Medicare & Medicaid Services continues to close the coverage gap. Classic, Prestige and MyChoice Wellness members have enhanced drug coverage in the gap.

### Formulary changes

BCN Advantage has also made important formulary changes for 2014, including:

- Deleted high-risk medications for the elderly
- Increased member copayments
- Added prior authorization for some medications
- Added quantity limits for some medications

Complete details on formulary changes can be found on **Page 19**.



## BCN Advantage announces formulary changes for 2014

The BCN Advantage<sup>SM</sup> HMO-POS plan formulary for individual and group members will change for 2014. We will notify BCN Advantage members who may be affected by these changes. We are recommending that members meet with their primary care physician prior to refilling a prescription in 2014 to discuss medication alternatives.

The table below summarizes the types of formulary changes for 2014. Please refer to the **2014 Formulary** for more details.

Formulary Change	Examples of Change for 2014
Deletion of high risk in the elderly medications	<ul style="list-style-type: none"> <li>All oral and transdermal / topical estrogen products.</li> <li>All glyburide containing products</li> <li>Zolpidem (Ambien)</li> </ul>
Increase in member copayment	<ul style="list-style-type: none"> <li>Some generics are moving from preferred to nonpreferred status. For most members, copayments will increase from \$3 to \$10 for a 34-day supply.</li> <li>However, most generic maintenance medications, including cholesterol lowering therapy, oral diabetes medications, angiotensin converting enzyme inhibitors and angiotensin receptor blockers will remain at the lowest copayment, which is \$3 for most members.</li> </ul>
Addition of prior authorization	<ul style="list-style-type: none"> <li>Most new prior authorization requirements are for specialty drugs and apply to new starts only.</li> <li>Members using these medications in 2013 will be grandfathered.</li> </ul>
Addition of quantity limits	<ul style="list-style-type: none"> <li>Addition of quantity limits to many narcotics</li> </ul>

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## BCN Advantage expands service area in 2014

BCN Advantage adds 17 Michigan counties to its network, effective Jan. 1, 2014. We will then have a 59-county service area.

BCN Advantage serves more than 55,000 members, including 28,000 individual members and 26,000 group members. Retired autoworkers comprise the majority of group membership with 21,000 members.

Applications for 2014 Medicare Advantage enrollment will be accepted Oct. 15 through Dec. 7 for coverage effective Jan. 1, 2014.

The following 17 counties are new for 2014:

- Alcona
- Antrim
- Arenac
- Branch
- Cheboygan
- Hillsdale
- Iosco
- Lake
- Manistee
- Mason
- Montmorency
- Ogemaw
- Osceola
- Oscoda
- Ostego
- Presque Isle
- Wexford

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## BCN Advantage offers new MyChoice Wellness product

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BCN Advantage<sup>SM</sup> is offering a new Medicare Advantage plan for 2014, called MyChoice Wellness. This product is available exclusively to residents of Kent, Muskegon and Oceana counties. Members in this plan must select a MyChoice Wellness primary care physician. The MyChoice Wellness network primarily consists of providers affiliated with Mercy Health.



Enrollee Name <b>FIRST M LASTNAME JR</b>	RxBIN: <b>610014</b>
Enrollee ID <b>XYK888888888</b>	RxPCN: <b>MEDDPRIME</b>
Issuer (80840) <b>9101000021</b>	RxGrp: <b>BCNRXPD</b>
Group Number <b>12345000</b>	Rx ID: <b>XXXXXXXXXX</b>
	CMS Plan <b>H5883 006</b>

MEDICARE ADVANTAGE HMO MedicareRx Prescription Drug Coverage

Care within BCN's entire HMO network but outside of the MyChoice Wellness network requires clinical review. MyChoice Wellness was developed as part of Blue Care Network's partnership with Mercy Health as announced in our **Sept-Oct issue**.

Members benefit from having no copayments for PCP office visits and no medical deductible.

Other plan features include the following:

- No copayment for routine eye exams
- No copayment for preventive dental services
- No Part D deductible
- Worldwide coverage for emergency and urgent care
- Non-emergency medical transportation (36 round-trip visits)
- Silver Sneakers<sup>®</sup> fitness benefit
- Part D coverage gap (donut hole) benefits for tier 1 generics with a \$7 copayment

## BCN Advantage Focus becomes BCN Advantage Local

BCN Advantage<sup>SM</sup> Focus has changed its name to BCN Advantage<sup>SM</sup> Local to avoid confusion with the Blue Care Network PCP Focus network. BCN Advantage<sup>SM</sup> Local is available in Wayne County only.

BCN Advantage currently offers six plans for 2014:

- BCN Advantage<sup>SM</sup> Local (formerly BCN Advantage<sup>SM</sup> Focus)
- BCN Advantage<sup>SM</sup> MyChoice Wellness (See article above for details)
- BCN Advantage<sup>SM</sup> Basic
- BCN Advantage<sup>SM</sup> Elements (no Part D coverage)
- BCN Advantage<sup>SM</sup> Classic
- BCN Advantage<sup>SM</sup> Prestige



## @HOME Support Program pilot begins for Medicare Advantage members

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Medicare Plus Blue<sup>SM</sup> PPO members living in southeast Michigan and BCN Advantage<sup>SM</sup> members living in Saginaw, Flint, Bay City or Midland, who have been diagnosed with advanced or terminal illness may participate in a pilot program designed to provide them with specialized health care services and support. The pilot started in August 2013 and ends December 2015.

The @HOME (At Home) Support Program, a subsidiary of Hospice of Michigan, focuses on supporting members with advanced illness, along with their family and caregivers in the home by providing home-based clinical services including coordination of care, assessment and counseling associated with advanced illness, informed decision-making, and 24/7 phone access to a registered nurse. @HOME support staff have extensive training in palliative management. Copayments for members receiving home care service by @HOME Support are waived.

Disease-specific criteria include the following:

- Cancer: Any Stage IV disease
- CHF: New York Heart Association Stage III or IV
- COPD: GOLD Stage III or IV; Cor Pulmonale
- Debility: Multiple comorbid conditions contributing to declining status and limited life expectancy

The Blues identifies members based on claims and pharmacy data. @HOME Support will contact physicians to obtain primary care physician consent before contacting members. Members may opt out of the program.

While there are no direct physician referrals to this program, if you have a BCN Advantage member you think may benefit from this program, please call the Chronic Condition Management nurse line at 1-800-392-4247 and ask to speak with a case manager.

## MyBlue Medigap changes

Due to low enrollment, Blue Care Network is discontinuing MyBlue Medigap<sup>SM</sup> Plan M, effective Jan. 1, 2014 for current members. To ensure there is no lapse in coverage, we are enrolling these members in Plan N, with the option to choose different coverage.

We are sending letters to members affected by this change to notify them of their options and enrollment period. Members will have a special enrollment period with no medical underwriting.

## BCN Advantage updates compliance requirements

Blue Care Network is amending its BCN Advantage<sup>SM</sup> contracts to update compliance requirements mandated by the Centers for Medicare & Medicaid Services. The amendments are available on the web-DENIS *BCN Provider Publications and Resources* section on the *Policies and Information* page. Scroll down to the bottom to find the latest amendments posted Sept. 24, 2013. These amendments become effective Dec. 1, 2013.

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## Cholesterol management an important part of Million Hearts program



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This is the fourth installment in our series of articles about BCN Advantage's Chronic Care Improvement Program. The program, designed to prevent cardiovascular disease in BCN Advantage<sup>SM</sup> members emphasizes member self-management strategies and partnership with physicians. Our program focuses on clinical interventions championed by the Centers for Medicare & Medicaid Services Million Hearts<sup>TM</sup> Initiative.

The Million Hearts ABCS are:

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

In this edition, we'll discuss cholesterol management. It's an important topic because high cholesterol affects many Americans and is a risk factor for heart disease, the leading cause of death in the United States. Here are a few facts about the prevalence of high cholesterol:

- Seventy-one million American adults (33.5 percent) have high low-density lipoprotein (LDL), or "bad," cholesterol.<sup>1</sup>
- Only one out of every three adults with high LDL cholesterol has the condition under control.<sup>1</sup>
- Fewer than half of adults with high LDL cholesterol get treatment.<sup>1</sup>

We recognize that our physicians and their staffs are the first line of defense in the battle against high cholesterol in our members. We are committed to supporting you in your efforts to manage high cholesterol levels and prevent

cardiovascular disease in our members. Here are a few tools from the American Heart Association website that you can download and share with your patients who are working on cholesterol management:

- **Cholesterol Tracker** – A tool that patients can use to record cholesterol levels, goals, commitments to healthy eating and physical activity
- **Medicine Chart** – A one-page tool that patients can use to record their medications
- **How can I monitor my cholesterol, blood pressure and weight?** – A patient friendly fact sheet from AHA that has information about cholesterol management, controlling blood pressure and the importance of healthy eating and weight control

In addition, the Michigan Quality Improvement Consortium **guidelines** provide up to date evidence-based recommendations for cholesterol management.

### Performance Recognition

BCN's Performance Recognition Program for BCN Advantage rewards primary care physicians who encourage their patients to get preventive screenings and procedures and those who achieve patient outcomes such as cholesterol control. More information about this program 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.

1 - CDC. *Vital signs: prevalence, treatment, and control of high levels of low-density lipoprotein cholesterol*. United States, 1999–2002 and 2005–2008. *MMWR*. 2011;60(4):109–14.



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## Blue Cross Complete ranked second in Michigan and No. 10 in nation by NCQA

Blue Cross Complete of Michigan, the Blues' Medicaid HMO, has been ranked the No. 2 Medicaid plan in the state and the No. 10 Medicaid plan in the nation by the National Committee for Quality Assurance. The ranking is out of 131 Medicaid plans nationally.

"Our plan continues to provide the highest level of service and value to our members, and we're pleased to again be recognized on a national level for the commitment we've made to our members," said Nancy Wanchik, vice president at BCBSM and CEO of the company's Medicaid program.

Blue Cross Complete has also earned its fifth-consecutive "Excellent" accreditation for a managed care organization, which reflects service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

NCQA uses a standard set of criteria, including Healthcare Effectiveness Data and Information Set\* measures, to rank the health plans in important aspects of care such as improving members health and customer satisfaction. Prevention and treatment measures make up 60 percent of the total score, consumer satisfaction accounts for 25 percent and NCQA accreditation scores make up the remaining 15 percent of NCQA's *Medicaid Health Insurance Plan Rankings 2013-2014*.

"We proactively find ways to give our members the right care at the right time, and make sure their experiences with us are positive," Wanchik said. "As part of their health care team, we want to make sure they get the preventive care that's right for them and the right treatment when they need it. The recognition we receive from NCQA reflects how well we meet these goals."

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

## Blue Cross Complete ranks high on CAHPS survey

Blue Cross Complete ranked highly on rating of health care and personal doctor among other measurements in the 2013 Consumer Assessment of Healthcare Providers and Systems Improvements survey.

Some of the highlights include the following:

- We ranked in the 75th percentile in customer service, an improvement from 2012.
- We ranked in the 90th percentile in overall rating of health plan.
- We ranked first among Michigan competitors on how well doctors communicate.
- Members ranked us second among our competitors in these areas:
  - Rating of health plan
  - Rating of health care
  - Rating of personal doctor

The survey indicated that we could benefit from improvements in some areas, including "getting needed care" and "getting care quickly."

The number one service improvement members want is additional providers and specialists in the network.

For the 2013 CAHPS survey, we received 541 responses, for a 32 percent response rate.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

### Blue Cross Complete formulary updates

Review the **Blue Cross Complete Online Drug List** (Formulary) Updates document for changes that will be effective Dec. 1, 2013.

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## Medicaid expansion and reform signed by Governor Snyder

In September, Governor Snyder signed the Healthy Michigan Plan into law. The Healthy Michigan Plan expands Medicaid coverage to individuals within 133 percent of the federal poverty level and reforms the Medicaid program. For full details, see article on **Page 9**.



## 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

- Genetic testing for the diagnosis of inherited peripheral neuropathies
- Implantable cardiac defibrillator
- Continuous intraocular pressure monitoring
- Genetic cancer susceptibility panels using next generation sequencing
- Magnetic esophageal ring to treat gastroesophageal reflux disease (GERD)

### Covered service

- Open treatment of rib fractures using internal fixation



[Medical Policy Updates PDF](#)

## BCN creates flier about BMI assessment for children and adolescents

Blue Care Network has created a flier to remind providers about the importance of the HEDIS® measure, “Weight assessment and counseling for nutrition and physical activity for children and adolescents.”

The flier includes information about billing codes and what is considered acceptable documentation for the measure.

It is available in the “Helpful HEDIS hints” section of the HEDIS page in the *BCN Provider Publications and Resources* section of web-DENIS.

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



[BMI flier PDF](#)

## Type 2 diabetes in children can be prevented

While type 2 diabetes is usually diagnosed in adults, it is increasingly diagnosed in children and adolescents, particularly in American Indians, African-Americans and Hispanic or Latinos, according to the Centers for Disease Control and Prevention.

Obesity is a major risk factor for type 2 diabetes in children. Type 2 diabetes mellitus can remain asymptomatic for a long time. According to the National Institutes of Health, obesity in children may be attributed to the following modifiable habits:

- High-calorie food choices
- Lack of physical activity
- Parental obesity
- Irregular eating habits that include skipping meals and overeating
- Parents with poor nutritional habits and sedentary lifestyles

The Michigan Quality Improvement Consortium guidelines recommend that children be assessed at each periodic health exam and these key components should be addressed:

- Education of parents with children under 2 years old about obesity risk and prevention
- Assessment of body mass, risk factors for overweight and excessive weight gain relative to linear growth in children age 2 or older
- Prevention to promote healthy weight in children age 2 years or older with a body mass index less than the 85th percentile for age

For children 2 years or older, guidelines recommend that the general assessment include:

- Performing a history (including focused family history) and physical exam
- Measuring and recording weight and height on CDC BMI-for-age growth chart
- Assessing risk factors, including pattern of weight change. Watch for increases of three to four BMI units/year.

For additional information about prevention and identification of childhood overweight and obesity refer to the updated **MQIC guidelines**.

Overweight or obese children may benefit from weight loss supervision from their health care practitioners. Studies in adults have indicated that if an individual can reduce his or her body weight by 5 to 7 percent and maintain at least moderate activity for 30 minutes most days of the week, they can reduce the risk of diabetes.

Young people and their families should receive counseling about nutrition, weight control and physical activity, as well as an individualized plan of care. The child may also need treatment for hypertension and hyperlipidemia, including follow-up every three months. Pharmacologic therapy for weight loss is not recommended for children until more safety and efficacy data are available.



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## Diabetes patients require certain tests

Blue Care Network is commemorating American Diabetes Month in November by reminding physicians about the assessment and treatment of their diabetic patients.

The Michigan Quality Improvement Consortium guidelines recommend periodic medical assessments, laboratory tests and education to guide effective self-management in patients with Type 1 and Type 2 diabetes mellitus. The following tests are recommended:

- Hemoglobin A1C (two to four times annually based on individual therapeutic goal)
- Urine microalbumin measurement (annually)
- Serum creatinine and calculated glomerular filtration rate (annually)
- Fasting lipid profile (annually)
- Dilated eye exam by ophthalmologist or optometrist or digiscope evaluation

For more information about treating diabetic patients, refer to the **MQIC guidelines**.

The level of HbA1c may be reduced with lifestyles choices of diet, weight loss and physical activity. Members that continue to be challenged with HbA1c levels >9 percent may benefit from working with a BCN nurse case manager.

Blue Care Network’s Chronic Condition Management program provides members with tools they need to make informed health choices and manage their conditions. To refer members to the diabetes chronic condition management program, call Chronic Condition Management at 1-800-392-4247, TTY 1-800-257-9980. Our chronic condition management specialists are available Monday through Friday, from 8:30 a.m. to 5 p.m.



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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 and local rules, BCN provides clarification on various topics related to the 2013 Acute Criteria and Local Rules.

**Question:**

What criteria do I use for a postoperative complication after an ambulatory procedure?

**Answer:**

An outpatient procedure typically includes a recovery period of up to 23 hours for postoperative care and monitoring. If a patient experiences a complication for an ambulatory procedure usually done on an outpatient basis, and requires care or monitoring beyond 23 hours, the user should apply criteria for Postoperative Day 1.

The reviewer should not be applying criteria for a post ambulatory procedure on operative day as the 23-hour observation period built into the outpatient procedure has not yet lapsed. The only exception to this rule is when the patient develops a complication that is severe enough to warrant inpatient admission, such as cardiac arrest or profound hypotension. In that case, criteria for admission at a higher level of care on operative day should be applied.

Additionally, for anyone who has a postoperative complication following a percutaneous coronary intervention (urgent or elective), it would be more appropriate to apply the criteria located in the Intermediate level of care of the general medical subset for “Post PCI complication and continuous cardiac monitoring (excludes Holter).”

*Informational Notes:*

Complications requiring intermediate care admission for cardiac monitoring may include transient occlusion of a coronary vessel, arrhythmia, chest pain or dyspnea.

### BCN’s local rule pertaining to neurological deficits

The following is to clarify the criteria and documentation we need to approve certain neurological admissions.

Local rules: General Medicine, page 541 Acute Neurological and page 545 Intermediate Neurological:

- Rule 1: Acute criteria for neurologic deficit, new onset (excludes TIA/Stroke): BCN can approve up to 48 hours of observation to complete work-up and obtain a definitive diagnosis and/or stabilize the member for discharge.
  - **Supporting documentation:** Documentation must include the presenting neurological deficit. If using **paresis or paralysis**, documentation must indicate the reduction in voluntary movement or loss of movement. General weakness or inability to move limbs from a non-neurologic cause are excluded from this criteria.
- Rule 2: Intermediate criteria for neurologic impairment or condition and finding of deterioration:
  - **Supporting documentation:** Documentation must indicate no improvement of symptoms after 24 hours from onset before the inpatient admission will be considered.
    - » Examples include: lethargy, coma, stupor, confusion, delirium, ataxia, paralysis, aphasia, dysarthria, unresponsiveness to pain or pin-prick
    - » Required documentation must include status on admission and after 24 hours of treatment/observation (i.e. no change, continued deterioration or improvement.)

## Screen kids early to avoid cardiovascular disease

Atherosclerosis begins in childhood and progresses slowly into adulthood, leading to coronary heart disease. Children are also at risk for developing hypertension, metabolic syndrome and type 2 diabetes.

The American Academy of Pediatrics recommends that all children be screened for high cholesterol at least once between the ages of 9 and 11 years, and again between ages 17 and 21 years\*.

Michigan Quality Improvement Consortium guidelines recommend screening for children older than 2 who are at increased risk for genetic forms of hypercholesterolemia. The best method for testing is a fasting lipid profile. If the child has values within the normal range, testing should be repeated in three to five years. Children 8 years and older with abnormal cholesterol readings may be considered for cholesterol-reducing medications. Younger children with abnormal readings should focus on weight reduction, healthy eating habits and food selection, and an active exercise program.

For younger patients who are overweight or obese and have a high triglyceride concentration or low HDL concentration, weight management is the primary treatment.

During the office visit, the primary care physician should address the following risk factors with the child and his or her family:

- Family history of heart disease
- Family history of obesity
- Family history of high blood pressure
- Family history of diabetes
- Height and weight and body mass index calculations
- Blood pressure measurement at age 3, then yearly if normal
- Lipid screening if indicated
- Child's diet and daily physical activity
- History of tobacco use by parents and by the child (beginning at age 12); offer counseling for smoking cessation

Blue Care Network's Care Management team provides parents and caregivers of overweight children with information about hypertension, nutrition and other factors related to cardiovascular disease. Your patients may call the Care Management nurse line at 1-800-392-4247 and ask to speak with a nurse.

\*Guidelines sponsored by the National Heart, Lung and Blood Institute

## Encourage patients to quit smoking

The American Cancer Society is marking the 38th Great American Smokeout on November 21, 2013 by encouraging smokers to use this date to make a plan to quit, or to plan in advance and quit smoking that day. By doing this, smokers will be taking an important step toward a healthier life, one that can lead to reducing cancer risk.

The growing public support of smoke-free environments also helps make the Great American Smokeout a perfect day to initiate new nonsmoking policies. The Great American Smokeout challenges people to stop using tobacco and help make people aware of the many tools that they can use to quit. This is a good opportunity for you to discuss the negative health risks related to smoking and cessation strategies with your patients.

Tobacco use remains the single largest preventable cause of disease and premature death in the United States.

Each year, smoking results in an estimated 443,000 premature deaths; 49,000 of these deaths are nonsmokers who are exposed to secondhand smoke.

Smoking also accounts for \$193 billion in health care expenditures and productivity losses annually, according to the American Cancer Society. Next to cigarettes, the most commonly used tobacco products among high school students were cigars (13.1 percent) and smokeless tobacco (7.7 percent). Quitting is difficult, but your patients can increase their chances of success with your help.

The American Cancer Society has a number of smoking cessation brochures you can obtain online for your patients. Blue Care Network members are eligible for the award winning *Quit the Nic* Smoking Cessation Program by calling 1-800-811-1764.

## Eligibility criteria outlined for prophylaxis palivizumab (Synagis) for high-risk infants and young children

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Respiratory syncytial virus season is here. Synagis®, an immune prophylactic, can be administered in the physician's office in five doses beginning each October or November. To coordinate service for your patient, please call Walgreen Specialty Pharmacy at 1-888-282-5166 or fax your request to 1-866-515-1356.

The American Academy of Pediatrics recommends that prophylactic treatment begin in October or November and continue through March or April of every year.

Specific eligibility criteria\* for infants and young children at high risk for severe RSV for whom palivizumab may be considered are:

- Infants and children younger than 24 months with chronic lung disease of prematurity (CLD was previously known as bronchopulmonary dysplasia) receiving medical therapy within six months of the start of the RSV season
- Infants born before 35 weeks of gestation, even if they do not have CLD
- Infants born at 32 weeks to less than 35 weeks gestation, particularly when the infant attends child care or one or more siblings or other children younger than 5 live permanently in the same household
- Infants with congenital abnormalities of the airway or neuromuscular disease
- Infants and children 24 months or younger with hemodynamically significant cyanotic or acyanotic congenital heart disease

BCN Care Management's case manager provides the parents and caregivers of high-risk infants and children with information regarding immunization against RSV and encourages them to discuss it with the child's physician. You may contact Care Management directly at 1-800-392-4247 and ask to speak with a pediatric case manager.

\*Source: American Academy of Pediatrics





## Blue Care Network to launch Behavioral Health Incentive Program

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Blue Care Network is launching a Behavioral Health Incentive Program, effective Jan. 1. The incentive program, exclusively for behavioral health providers, specifically psychiatrists, fully-licensed psychologists and clinically-licensed master social workers, is designed to reward excellent patient care.

BCN staff conducted a multi-step process in 2012 to develop final measures for the incentive program. This process included literature reviews, feedback from providers through surveys and internal discussions regarding the feasibility of proposed measures. Feedback from our provider community directly influenced our final decisions for the measures.

The process resulted in a concise set of measures which will:

- Align behavioral health practices with evidence-based therapeutic methods
- Reward behavioral health specialists who are providing exceptional care to our members
- Serve as an avenue for providers to receive feedback regarding performance

There are two types of measures included in the program:

- BCN-assessed measures based on claims received
- Self-reported measures based on provider responses.

Providers do not need to submit data for BCN-assessed measures, other than submitted claims, to receive an incentive. However, providers must submit information for self-reported measures to receive incentive as this data cannot be collected through claims. We'll explain how to submit this information as the January launch date approaches. Below are the components of the BHIP program.

#### 2014 BCN-assessed measures

- Follow-up after hospitalization for mental illness
- Anti-depressant medication management
- Generic substitution rate
- Pharmacotherapy adherence for bipolar disorder

#### 2014 Self-reported measures

- Therapeutic alliance
- Primary care provider contact

More information regarding scoring methodology, criteria for each measure and payment amounts is forthcoming. BCN plans to officially launch the program in January 2014. Administrative documents, technical specifications, and an explanation booklet will be available by December 2013 on web-DENIS.

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## Applied behavior analysis limits change in 2014 for autism

Blue Cross Blue Shield of Michigan and Blue Care Network will be making some changes to benefits covering autism spectrum disorder beginning in 2014. The current \$50,000 per member, per calendar year limit for applied behavior analysis will be replaced with a new limit of up to 25 hours of direct line therapy for ABA per member per week (procedure code H2019.)

Providers should bill for ABA in units based on 15-minute increments. If a member received four and a half hours of ABA treatment, for example, it should be billed as 18 units. More information is available in the Applied Behavior Analysis Billing Guidelines and Procedure Codes document. This can be found on web-DENIS in two locations:

1. *BCN Provider Publications and Resources* – Click on *Autism*.
2. *BCBSM Provider Publications and Resources* – Follow these steps:
  - a. Click on *Newsletters & Resources*.
  - b. Click on *Clinical Criteria & Resources*.
  - c. Click on *Autism*.

Applied behavior analysis to treat autism spectrum disorder is considered an essential health benefit under the Patient Protection and Affordable Care Act. The change from a dollar limit to a frequency limit for ABA services will take place as members move to health care reform-compliant plans in 2014.

The frequency limits takes effect for members when the member's plan year begins. The current \$50,000 per year limit will still apply to some members in 2014 until their new plan year begins. Remember to check member eligibility and benefits before providing services to ensure the member has autism coverage and to determine which of the limits applies for ABA treatment.





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## Managing seasonal affective disorder with early treatment

Seasonal affective disorder, a type of depression that tends to occur as the days grow shorter during the fall and winter months, can seriously affect work and relationships.

Barriers to detection and treatment may include time constraints and competing demands from other medical problems; social stigma; family dysfunction; patient attitude; knowledge and behavior; community factors; and clinician and practice factors.

According to the National Alliance on Mental illness, SAD is sometimes misdiagnosed as hypothyroidism, hypoglycemia, infectious mononucleosis or other viral conditions because of the similarity of some of the symptoms, such as fatigue, lack of energy, concentration problems or memory loss.

All of the above can affect patient presentation and detection by the primary care physician. It is often possible to successfully manage SAD with early intervention and treatment which may include:

- Early assessment using a depression screening tool to clarify diagnosis
- Antidepressant medication
- Monitoring diet, especially carbohydrate intake
- Exercise therapy
- Stress management techniques
- Observation of behavior while on antidepressant medications
- Talk therapy to help identify and change negative thoughts and behaviors that may play a role in bringing about symptoms of SAD

As the seasons change the symptoms usually resolve. Some people may have the disorder throughout their lives, but the outcome is good with continuous treatment.

Blue Care Network's Depression Management Program offers resources for individuals who suffer from SAD. We encourage you to refer your patients with SAD to our Chronic Condition Management department for enrollment in our program. Please call 248-455-3471 Monday through Friday from 8:30 a.m. to 5 p.m.



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Best Practices

Education and tracking ER use helps patients comply with asthma medications



Dr. Carmen Green-Lee and Lilliana Kraepel

The key to getting patients to take asthma medications regularly is to educate them on how the medication helps them and its proper use, and to schedule follow-up visits to discuss symptom management and asthma triggers, says Dr. Carmen Green-Lee, a pediatrician who practices at IHA Child Health – Ann Arbor.

Asthma is the most common chronic childhood disease, affecting an estimated 5 million children, according to the National Committee for Quality Assurance. Approximately 20 million people in the United States have asthma. Collectively, people with asthma have more than 100 million days of restricted activity and 5,000 deaths annually.

When patients come in to her office with new symptoms, Dr. Green-Lee gives patients handouts to help them realize their symptoms are related to asthma. “We try to help them understand the asthma diagnosis and explain how asthma medications work,” says Dr. Green-Lee. Her office administers a spacer with a mask or nebulizer mist treatment machine for all children who have asthma, and a nurse demonstrates how to use them properly. The office also provides an asthma action plan for all caregivers of the child. Parent education includes reviewing the triggers that can cause asthma symptoms and discussing how to avoid them and treat them once they become apparent.

Follow-up visits are important. “We do a check at yearly physicals for children with mild intermittent asthma,” says Dr. Green-Lee. “If the children come for any other visits throughout the year, we use those visits as an opportunity to address how they are managing their asthma symptoms.”

Dr. Green-Lee sees patients with persistent asthma at least every three to six months if the asthma is not well controlled. Usually, they are on inhaled steroids. If the patient’s asthma is not well controlled, the doctor may increase the controller medication or prescribe additional medications. The office also requires frequent follow-up for patients who are stepping down their medication.

Tracking ER visits

Tracking emergency room visits is one way to help asthma patients manage their conditions and check on medication compliance. “We receive a fax within 12 to 24 hours for every patient who has been to the ER,” said Dr. Green-Lee. “Our quality care coordinator and asthma specialist place phone calls to patients who have visited the ER and make appointments for them to have a follow-up visit in our office,” she said. The nursing staff may spend several hours a day calling patients who have visited the ER.

Please see [Asthma](#), continued on Page 34

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At the follow-up visit, Dr. Green-Lee reviews symptoms and triggers and checks to make sure patients are using their medication properly. The office also checks on medication compliance by tracking how often asthma patients get their refills. “If you’re using your controller medicine, you shouldn’t be using albuterol as often,” said Dr. Green-Lee. “If a patient is calling for albuterol refills too frequently, that’s often a red flag.”

If patients have a lot of emergency room visits, they are referred to a pulmonologist. “Children with asthma should have pulmonary function tests every year or two if they have persistent asthma,” says Dr. Green-Lee. Parents can see by the lung function whether they have to step up the medications, she noted. “I have had patients who have had lung function tests and have become more compliant.” For example, patients who had required multiple bursts of oral steroids were able to get under better control after becoming more compliant with their inhaled steroids upon seeing their pulmonary function results.



Medication compliance can become an issue when parents are concerned about the side effects of medications, says Dr. Green-Lee. “Parents may have an overweight child and look for a cause and effect. They may think the inhaled steroid is making the child put on weight,” she says. “But if we put them on the lowest effective dose, most studies show it’s not going to cause weight gain or decrease height. I tell them if you have poorly controlled asthma, the child could end up on oral steroids, which may result in greater side effects.”

Due to the efforts of her office, Dr. Green-Lee says about 80 percent of her asthma patients have their conditions under control. She attributes that to the asthma education nurses and quality care coordinator who follows up with patients with regular phone calls. “When patients come in, we are not accusatory if they haven’t taken their medication as instructed. We try the compassionate approach and more education,” she says.

## 2013 HEDIS Results

Blue Care Network has submitted its Healthcare Effectiveness Data and Information Set® rates to the National Committee for Quality Assurance as part of the accreditation process. HEDIS®, the most widely used set of performance measures in the managed care industry, is part of an integrated system to establish accountability in managed care organizations. It was originally designed to address private employers' needs as purchasers of health care and now has been adopted for use by public purchasers, regulators and consumers. Areas of improvement were noted in the following measures:

Commercial HMO	BCN Advantage
<ul style="list-style-type: none"> <li>Colorectal cancer screening</li> </ul>	<ul style="list-style-type: none"> <li>Breast cancer screening</li> </ul>
<ul style="list-style-type: none"> <li>Antidepressants medication management (acute and continuation)</li> </ul>	<ul style="list-style-type: none"> <li>Osteoporosis management in women who had a fracture</li> </ul>
<ul style="list-style-type: none"> <li>Appropriate testing of children with pharyngitis</li> </ul>	<ul style="list-style-type: none"> <li>Persistence of beta blocker treatment</li> </ul>
<ul style="list-style-type: none"> <li>Appropriate treatment for children with upper respiratory infection</li> </ul>	<ul style="list-style-type: none"> <li>Disease modifying anti-rheumatic therapy in rheumatoid arthritis</li> </ul>
<ul style="list-style-type: none"> <li>Avoidance of antibiotic treatment for acute bronchitis</li> </ul>	<ul style="list-style-type: none"> <li>Adult BMI</li> </ul>
<ul style="list-style-type: none"> <li>Persistence of beta blocker treatment after a heart attack</li> </ul>	
<ul style="list-style-type: none"> <li>Use of imaging studies for low back pain</li> </ul>	
<ul style="list-style-type: none"> <li>Use of spirometry testing for COPD</li> </ul>	
<ul style="list-style-type: none"> <li>Chlamydia screening – Total</li> </ul>	
<ul style="list-style-type: none"> <li>Adult BMI assessment</li> </ul>	
<ul style="list-style-type: none"> <li>Weight assessment and counseling for physical activity – BMI percentile</li> </ul>	

Some measures that need improvement include:

- Breast cancer screening
- Childhood immunizations
- Cholesterol management for patients with cardiovascular conditions
- Controlling blood pressure
- Diabetic eye exams
- Follow-up after hospitalization for mental illness – 7 days
- Follow-up for children with ADHD – Initiation and continuation phase
- Pharmacotherapy management of COPD – Bronchodilators and corticosteroids
- Postpartum care

We would like to take this opportunity to thank all of our affiliated practitioners for their contribution toward providing quality care to our members and allowing the BCN staff to conduct the medical record reviews.

Primary care practitioners can still find opportunities to provide aggressive intervention in the management and care of our members with diabetes, cholesterol management after a cardiovascular condition, controlling high blood pressure and in ordering procedures for breast, cervical and colorectal cancer screenings.

Please see [HEDIS results](#), continued on Page 36

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**HEDIS results**, continued from Page 35

BCN is actively involved in activities throughout the year that positively impact our HEDIS rates, including:

- Physician Performance Recognition Program which is tied to some of the HEDIS measures
- Health e-Blue<sup>SM</sup> Web
- Member reminder telephone calls and cards
- Member and physician education
- Member health fairs
- Chronic Condition Management Programs
- Care Management follow-up telephone calls/letters
- Member incentive programs
- HEDIS/CAPHS Summit Meeting

We look forward to working with you to promote continued improvement in all areas of patient care and service.

If you would like more information about HEDIS, contact Blue Care Network Quality Management department at 248-455-3471.

HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance.



[2013 Commercial HMO HEDIS<sup>®</sup> Results PDF](#)



[2013 BCN Advantage HEDIS<sup>®</sup> Results PDF](#)

## 2013 InterQual<sup>®</sup> acute care criteria takes effect in November

Blue Care Network's Care Management staff will begin using the 2013 McKesson Corporation interim updates related to InterQual criteria for adult and pediatric care on Nov. 4, 2013. The criteria will be used to make determinations on clinical review requests for members with coverage through BCN HMO products, BCN Advantage<sup>SM</sup> HMO-POS and BCN Advantage<sup>SM</sup> HMO Local (formerly known as BCN Advantage HMO Focus<sup>SM</sup>). These criteria apply to inpatient admissions and continued stay discharge readiness.

Other 2013 InterQual criteria were implemented beginning July 1, 2013. Changes to BCN's local rules were also implemented July 1.

You can find additional information about these criteria updates in the July-August 2013 issue of the *BCN Provider News*, **Page 27**.



# BCN pilot program lets members get flu, pneumococcal shots at pharmacies

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Blue Care Network is committed to helping our members stay healthy. We encourage our members to get a flu shot every year, and a pneumococcal vaccine when appropriate.

We also understand that it isn't always easy for members to make time to get those immunizations. On Oct. 1, BCN started a pilot program that allows network pharmacies to process flu and pneumococcal vaccine through the pharmacy claims system. This results in a more efficient process for our pharmacy providers and improves convenience for our members. This program is available to BCN commercial and BCN Advantage<sup>SM</sup> members, regardless of their pharmacy coverage. There is no additional cost to the member.

Members can still choose to visit their doctor for these vaccines. Immunizations given through the pilot program are reported to Health e-Blue<sup>SM</sup>, and will count toward Healthcare Effectiveness Data and Information Set<sup>®</sup> scores.

BCN reimburses participating pharmacies for medical vaccines (flu and pneumococcal) processed through their pharmacy claims system using the current NCPDP format. Vaccines administered under this program require administration by certified, trained and qualified registered pharmacists.

All dosage forms of these flu and the pneumococcal polysaccharide vaccines are covered under this program:

Afluria <sup>®</sup>	Fluvirin <sup>®</sup>
Agriflu <sup>™</sup>	Fluzone <sup>®</sup>
Fluarix <sup>®</sup>	Pneumovax <sup>®</sup> 23
Flucelvax <sup>®</sup>	FluLaval <sup>®</sup>
Single Use EZ Flu 2013-2014	FluMist <sup>®</sup>

Claims for vaccines are billed like any other pharmacy claim.

Pharmacies with questions about billing should contact the Express Scripts Technical Help Desk at 1-800-922-1557.

This program is not available to Blue Cross Blue Shield of Michigan commercial and Medicare Advantage members.

\*HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance.



# Reminder: *Custom Select Drug List* available January 1, 2014

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All Blue Care Network small group and individual members whose plans start on or after January 1, 2014 will use BCN's new six-tier drug benefit and the new *Custom Select Drug List*.

Your BCN patients benefit from significant cost savings – plus all the advantages of a robust pharmacy benefit management program that is fully integrated with the member's BCN medical certificate. BCN reminds prescribers that several drugs and drug categories will be excluded from coverage under the new benefit, including:

- Brand-name drugs that have generic equivalents
- OTC medications (unless considered preventive by United States Preventive Services Task Force)
- Lifestyle drugs (for erectile dysfunction or weight loss)
- Cosmetic drugs
- Drugs used for coughs and colds
- Most nonsedating antihistamines
- Most proton pump inhibitors
- Prenatal vitamins
- Compounded products

BCN will not 'grandfather' coverage for members who have current prescriptions for medications in these classes. We are not able to notify prescribers regarding which of their patients are affected; however, we encourage you to work with patients who have this new drug benefit.

In addition to the changes in coverage, all BCN small group and individual members will see a change in their copayment structure. A six-tier drug benefit will be used for all members who enroll through the Marketplace or whose employers choose the new, less expensive, *Custom Select Drug List*. The *Custom Select Drug List* will be available online before January 1, 2014.

Here's a description of our new six-tier prescription benefit structure:

Tier 1A: Preferred generics	Lowest generic drug copayment – \$4 or \$6, depending on benefit selected
Tier 1B: Generics	Low generic drug copayment
Tier 2: Preferred brand	Higher copayment
Tier 3: Nonpreferred brands	Highest brand-name copayment
Tier 4: Preferred specialty	Lowest specialty drug copayment
Tier 5: Nonpreferred specialty	Highest specialty drug copayment

For more details and examples of drugs in the different tiers, please refer to Page 42 of the **September-October 2013 issue**.

*The information in this document is based on preliminary review of the national health care reform legislation and is not intended to impart legal advice. The federal government continues to issue guidance on how the provisions of national health reform should be interpreted and applied. The impact of these reforms on individual situations may vary. This overview is intended as an educational tool only and does not replace a more rigorous review of the law's applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice.*

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# List of preventive medications available at no copayment expands Jan. 1

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Under the Women’s Preventive Services mandate of the Patient Protection and Affordable Care Act, the Blues currently provide generic oral and injectable prescription contraceptives with no copayment requirement for our female members with commercial pharmacy coverage.

Beginning Jan. 1, 2014, preventive drug coverage with no member copayment will expand to include additional preventive medications as recommended by the U.S. Preventive Services Task Force under the Affordable Care Act.

Additional preventive drugs will be covered beginning Jan. 1, 2014, including select over-the-counter female contraceptives and other mandated preventive medications. Prescriptions are required for both prescription and OTC products. For details, see the **Sept.-Oct. issue**.

Some group health plans sponsored by certain religious employers are exempt from the requirement to cover contraceptive services. In addition, there are some nonprofit employer groups that were granted a delay on the implementation of this benefit until their first plan year on or after Aug. 1, 2013, based on their religious beliefs.

*The information in this document is based on preliminary review of the national health care reform legislation and is not intended to impart legal advice. The federal government continues to issue guidance on how the provisions of national health reform should be interpreted and applied. The impact of these reforms on individual situations may vary. This overview is intended as an educational tool only and does not replace a more rigorous review of the law’s applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice.*

## BCBSM and BCN Custom Select Drug List 2014

Please help ensure that our members get the care they need by talking with them about their drug copayment or coinsurance. Starting in January, many Blue Care Network members have the new *Custom Select Drug List* and a six-tier pharmacy benefit.

For a listing of commonly prescribed drugs on the *Custom Select Drug List*, please refer to the **BCBSM and BCN Custom Select Drug List**.

Additional pharmacy resources for selecting affordable and effective drug therapy are available online. The Custom Drug List will soon be available at **[bcbsm.com/RxInfo](http://bcbsm.com/RxInfo)**.

If you have questions, call the BCN Clinical Pharmacy Help Desk at 1-800-437-3803.

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Feedback

## Help patients with acute bronchitis break the antibiotics habit

Cough is a common symptom bringing patients to the primary care physician’s office and frequently results in a diagnosis of acute bronchitis. This condition occurs commonly in all ages during the winter months and can be precipitated by cold weather, pollution and cigarette smoke. Symptoms can last up to three weeks and include swelling of mucous membranes, increased bronchial secretions, cough and fever.

Almost all acute bronchitis cases are caused by a viral infection. Acute bronchitis is a typically self-limiting condition and is treated with symptomatic, adjunctive therapy.

Well-established guidelines for treatment of bronchitis do not include the use of antibiotics, yet antibiotics are still being prescribed in 65 to 80 percent of cases. Prescribing unnecessary antibiotics may lead to antibiotic drug resistance and medication side effects with no appreciable improvement in the patient’s health.

The American College of Chest Physicians suggests that doctors may be prescribing these antibiotics because patients have come to expect a prescription. Although it takes time and effort to educate patients about the appropriate use of antibiotics, studies have shown that the duration of office visits for acute respiratory infection is unchanged or only one minute longer when antibiotics are not prescribed.

### References

- Centers for Disease Control and Prevention. <http://www.cdc.gov/getsmart/index.html>
  - Rodriguez-Roisin R, Anzueto A, Bourbeau J, et al. Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease, Medical Communications Resources, Inc., [www.goldcopd.org](http://www.goldcopd.org)
- Albert, Ross H. Diagnosis and Treatment of Acute Bronchitis. *Am Fam Physician*. 2010;82(11):1345-1350.

In addition to symptomatic therapies, options for treating acute bronchitis include beta-agonist inhalers for patients with wheezing and high-dose episodic inhaled corticosteroids. Antitussives should not be used for children younger than age 6, and expectorants are not recommended for adults or children with acute bronchitis. For Blue Care Network members whose drug benefit uses the new *Custom Select Drug List*, cough and cold preparations are not covered.

The Centers for Disease Control and Prevention website has free resources to help prescribers educate patients about appropriate antibiotic use and awareness of antibiotic resistance. The CDC’s **Get Smart** page features many tools that can be printed, downloaded and distributed:

- Brochures
- One-page Q&A sheets
- Posters
- *No Antibiotic Prescription* pads

BCN encourages prescribers to avoid the use of antibiotics in patients with acute bronchitis.

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## FDA limits usage of Nizoral (ketoconazole) oral tablets

The U.S. Food and Drug Administration took several actions against Nizoral (ketoconazole) oral tablets to minimize new safety concerns of severe hepatotoxicity along with risks of adrenal insufficiency and harmful drug-drug interactions.

Ketoconazole tablets should no longer be a first-line treatment for any fungal infection because alternative treatments are currently available and are deemed to be safer. Effective July 26, 2013, the FDA approved label changes to ketoconazole tablets.

### Label changes – indications for use

Infections caused by:	Ketoconazole tablets
Candida	No longer indicated for use
Dermatophytes	No longer indicated for use
Mycoses <ul style="list-style-type: none"> <li>• Blastomycosis</li> <li>• Coccidioidomycosis</li> <li>• Histoplasmosis</li> <li>• Chromomycosis</li> <li>• Paracoccidioidomycosis</li> </ul>	Use should be limited to life-threatening endemic mycoses when alternative antifungal therapies are ineffective or not tolerated

A risk-benefit assessment for ketoconazole tablets from the European Medicines Agency concluded that the benefits of ketoconazole tablets do not outweigh the risk of liver injury for fungal infections, and these oral products are being removed from the European market.

#### References

1. U.S. Food and Drug Administration. *FDA Drug Safety Communication: FDA Limits Usage of Nizoral (ketoconazole) Oral Tablets Due to Potentially Fatal Liver Injury and Risk of Drug Interactions and Adrenal Gland Problems*. Press Release, 26 July 2013. Web. 5 Sept. 2013. <<http://www.fda.gov/Drugs/DrugSafety/ucm362415.htm>>.
2. European Medicines Agency. *European Medicines Agency Recommends Suspension of Marketing Authorisations for Oral Ketoconazole*. Press Release, 26 July 2013. Web. 05 Sept. 2013. <[http://www.ema.europa.eu/ema/index.jsp?curl=pages/news\\_and\\_events/news/2013/07/news\\_detail\\_001855.jsp](http://www.ema.europa.eu/ema/index.jsp?curl=pages/news_and_events/news/2013/07/news_detail_001855.jsp)>.

Liver toxicity is a known class effect with azole antifungals; however, studies revealed the incidence and severity of liver injury appeared higher with oral ketoconazole than with other antifungals. Reports of ketoconazole-induced liver injury were independent of dose, duration or indication.

Since there is minimal systemic absorption, the use of topical ketoconazole products is not affected by the new label changes. Ketoconazole tablets are used off-label for treatment of Cushing’s syndrome. In these cases, the benefit of the drug may outweigh the risks and treatment should be continued as medically necessary with appropriate supervision. Health care professionals and patients are encouraged to report adverse events or side effects related to the use of these products to the FDA’s **MedWatch** Safety Information and Adverse Event Reporting Program available online, by telephone at 1-800-FDA-1088 or by fax at 1-800-FDA-0178.

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Feedback

## We're changing our prior authorization phone process to better serve you

We've heard your feedback loud and clear that we could make our Pharmacy Clinical Help Desk prior authorization phone system easier to use.

Soon, we will be changing our system so that you no longer have to authenticate your NPI and the member contract number in order to reach a pharmacy representative. We hope that this change will save you time and make it simpler for you to get the help you need. As always, please listen to the prompts carefully. Choosing an incorrect prompt can increase your wait time. You will still need to have the physician and member information readily available so that we can access account information.

Thank you for sharing your comments with us.

## BCN Advantage announces formulary changes for 2014

The BCN Advantage<sup>SM</sup> HMO-POS plan formulary for individual and group members will change for 2014. The **new formulary** is posted on our website.

See **Page 19** for details.

## BCBSM and BCN Custom Drug List 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 Drug List 2013 and the BCN Advantage<sup>SM</sup> HMO-POS Comprehensive Formulary*. Note that most members with a commercial drug benefit do not have coverage for Tier 3 drugs.



[BCBSM / BCN Custom, and BCN Advantage Comprehensive Formulary Updates – Third quarter 2013 PDF](#)

## RationalMED safety program is under way

In July, we told you about **RationalMed**, a new program to identify medication-related safety issues. Prescribers may receive notifications from RationalMed suggesting interventions to enhance member safety and decrease overall medical and pharmacy expense.

If you have questions about a RationalMed notice you have received, please contact Express Scripts at 1-800-717-6630 between 9 a.m. and 5:30 p.m., Monday through Friday.

## Reminder: Prior authorization in place for Vicodin/Xodol (g)

In our Sept. – Oct. issue, we told you that prior authorization criteria are in place for Xodol<sup>®</sup> and its generic equivalents, including the newly reformulated Vicodin<sup>®</sup> containing 300mg of acetaminophen. This new prior authorization requirement is based on the cost of the new formulation and applies to both new and refill prescriptions.

When a member requires a hydrocodone/acetaminophen product, please consider prescribing the generic version of Norco<sup>®</sup> (hydrocodone/acetaminophen 325mg). For more information, see Page 45 in the **Sept.-Oct. issue**.

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## Blues stop mailing paper remittance advices Dec. 6

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Dec. 6, 2013 is the date when Blue Cross Blue Shield of Michigan and Blue Care Network will stop printing and mailing paper remittance advices (also known as vouchers) for Michigan providers. There is one exception. BCBSM Local facility remittance advices will continue to be mailed.

Out-of-state providers – BCBSM will stop mailing remittance advices to participating out-of-state providers on Dec. 6. Out-of-state providers that are paid through the Medicare crossover process will continue to receive paper remittance advices. BCN will continue to mail paper remittance advices to out-of-state providers until mid-2014.

The move to online remittance advices enables our alignment with the federally mandated electronic funds transfer and electronic remittance advice requirements. These rules are a component of the Administrative Simplification provisions specified in the Patient Protection and Affordable Care Act. This part of health care reform is designed to:

- Reduce administrative costs
- Enhance the ease of doing business between insurers and providers
- Promote the growth of online recordkeeping

For more information, refer to the Sept. 30, 2013 **BCN Alert article**, *Blues to discontinue paper remittance advices*.

### Action steps for paper remittance advice users

All providers in the state of Michigan and those outside of the state that have a contract with BCBSM or BCN should follow these steps:

1. If you do not have access to Provider Secured Services at **bcbsm.com**, **sign up today**. You must register every national provider identifier and the associated BCBSM PINs for which you submit claims. **You will not be able to receive electronic payments or view online remittance advices for claims billed with an NPI that is not registered or for claims associated with a BCBSM PIN that is not linked to your NPI.**
2. If you are already registered for Provider Secured Services, but need to add some NPIs or need to link some BCBSM PINs to current NPIs, you need to complete one of these forms:
  - a. Providers complete **Authorization to Modify Provider Codes (PDF)**.
  - b. Billing services complete **Addendum "B" Authorization for Representative Access (PDF)**.
3. Follow these **Steps for locating a remittance advice** online to find up to three years of remittance advice history and the ability to search by check number, EFT trace number, period of time, or for a specific patient.

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### Paper remittance, continued from Page 43

4. If you still receive paper checks, **sign up for electronic funds transfer**. Not all BCBSM hospitals and facilities have access to EFT today, but will be able to register for EFT starting on Dec. 6, 2013. When you complete the EFT registration process, make sure to register every NPI you use and the BCBSM PINs associated with each NPI. If you have some NPIs or BCBSM PINs that are not registered for EFT, you will need to register these NPIs. To register for the first time – or to add additional NPIs – follow these steps:
- Go to **bcbsm.com**. Click on the dropdown next to *LOGIN* and log in as a provider to Provider Secured Services.
  - Scroll down to *Electronic Funds Transfer* and click on *Register Provider*.
  - Complete the information and click *Submit*.

Please allow three to five weeks for processing. Once the registration process is complete all funds for the registered NPI (or PIN) will be sent electronically.

Professional providers or hospitals and facilities that currently do not access Provider Secured Services are encouraged to enroll for access as soon as possible. This will ensure that your staff has the access needed when paper remittance advice vouchers are no longer provided or to enroll for EFT on or after Dec. 6, 2013.

### Where to go for help

If you need help accessing online remittance advices or signing up for Provider Secured Services or electronic funds transfer, contact your BCBSM provider consultant or BCN provider representative. For technical assistance, you can also call the BCBSM Web Support Help Desk at 1-877-258-3932, Monday through Friday from 8 a.m. to 8 p.m.

*The information in this document is based on preliminary review of the national health care reform legislation and is not intended to impart legal advice. The federal government continues to issue guidance on how the provisions of national health reform should be interpreted and applied. The impact of these reforms on individual situations may vary. This overview is intended as an educational tool only and does not replace a more rigorous review of the law's applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice.*

## Reminder: Electronic BCN claims need alpha prefix

As we notified you in September on web-DENIS, EDDI and through letters to software vendors, effective Oct. 1, 2013, all BCN electronic claims now need the entire member contract number, including alpha prefix. Electronic claims submitted without the alpha prefix receive a front-end edit indicating that the “contract alpha prefix is required”. Claims must then be corrected and resubmitted. Please call the EDI helpdesk at 1-800-542-0945 if you have any questions.

## Changes to Electronic Remittance Advice and Electronic Funds Transfer effective January 2014

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You may be aware of the Affordable Care Act and the changes relating to patients and businesses, but it also affects the electronic Health Information Portability and Accountability Act Standard Transactions. The ACA has defined mandated Operating Rules through the Council for Affordable Quality Healthcare and the Committee on Operating Rules for Information Exchange (CAQH/CORE) that will sit on top of, or build on, the current HIPAA Standard Transaction guidelines. For more information on these guidelines, click on the [CAQH/CORE website](#).

Two of the Operating Rules that specifically relate to the HIPAA mandated 835/ERA standard transaction are CORE 382 ERA Enrollment Data Rule and CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes 835 Rule with a mandated effective date of Jan. 1, 2014.

1. CORE 382 ERA Enrollment Data Rule mandates that health plans are required to offer electronic enrollment for 835/ERA at a minimum and must use standardized templates to collect data for these enrollments.

If you've already enrolled to receive the electronic 835/ERA, you **do not** have to enroll again. However, if you wish to make an update or cancel your current enrollment, or if you are enrolling for the first time, you need to be aware of these changes.

To complete the new ERA Enrollment, log in to the Trading Partner Agreement and Provider Authorization tool using your assigned Provider Trading Partner Agreement ID and password.

ERA Enrollment Instructions will display as an option on the *Trading Partner Agreement Provider Menu* screen. If you choose to receive an electronic 835/ERA, complete the appropriate Provider Authorization to be directed to the 835 Enrollment Form.

2. CORE 360 standardizes the use of adjustment reason and remark codes in the 835/ERA transaction into four different business scenarios:
- Business Scenario #1: Additional Information Required —Missing/Invalid/Incomplete Documentation
  - Business Scenario #2: Additional Information Required —Missing/Invalid/Incomplete Data from Submitted Claim
  - Business Scenario #3: Billed Service Not Covered by Health Plan
  - Business Scenario #4: Benefit for Billed Service Not Separately Payable

These changes will allow for a more consistent use of the reason and remark codes by payers for auto-posting of the 835 electronic remittance information. The new listing of codes, by business scenarios, is available on the [CAQH/CORE website](#).

### Another operating rule that relates to both EFT and 835/ERA

3. CORE 370 EFT and ERA Reassociation (CCD+/835) Rule mandates delivery of an ERA and EFT to be within three business days of each other if you're setup for both.

Blue Cross Blue Shield of Michigan is required to advise health care providers to notify their financial institution or bank that they have enrolled to use EFT. Further, providers should request that their financial institution or bank return a health plan payment reassociation number to them in CCD+ format. The reassociation number, located in the Addenda record of the banking EFT CCD+ data elements, is necessary for reassociation or tracing of the EFT to ERA in a provider's accounts receivable or practice management system. When addressing this with your financial institution, it is recommended that you speak with the branch manager about obtaining the reassociation number.

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#### Final operating rule that relates to Electronic Funds Transfer only

CORE 382 ERA Enrollment Data Rule mandates that health plans are required to offer EFT to all providers and must use standardized templates to collect data for these enrollments.

BCBSM and BCN require all professional providers to use electronic funds transfer. If you don't use EFT, please follow these **online instructions** to begin receiving electronic payments from the Blues. All BCBSM PINs associated with the NPIs for which you submit claims must be registered for EFT. EFT offers you faster access to your payments and there's no cost to participate.

BCBSM hospital and facilities have access to vouchers today but will be able to register for Electronic Funds Transfer as of December 6, 2013.

To register please follow the steps below:

- Log in to Provider Secured Services
- Scroll down to *Electronic Funds Transfer* located on the left side of the screen
- Click on *Register Provider*
- Simply complete the information and submit

Please allow three to five weeks for processing. Once the registration process is complete all funds for the registered NPI will be sent electronically.

**Note for Blue Care Network providers:** If you enrolled for EFT directly with BCN, you will need to enroll with BCBSM through **Provider Secured Services**.

Professional providers or hospitals and facilities who currently do not access the Provider Portal are encouraged to enroll for access as soon as possible. This will ensure that your staff has the access needed on or after Dec. 6, 2013, to enroll for EFT or to be able to view the remittance advice vouchers online when they're no longer provided on paper.

#### Need help?

- If you need help accessing online remittance advices, signing up for Provider Secured Services or electronic funds transfer, contact your BCBSM provider consultant or BCN provider representative.
- For technical assistance, you also can call the BCBSM Web Support Help Desk at 1-877-258-3932, Monday through Friday from 8 a.m. to 8 p.m.
- For questions or help with 835/ERA, contact the BCBSM EDI Help Desk at 1-800-542-0945, Monday through Friday from 8 a.m. to 4:30 p.m.

Additional information is available in the Sept. 30 **BCN Alert**.

*The information in this document is based on preliminary review of the national health care reform legislation and is not intended to impart legal advice. The federal government continues to issue guidance on how the provisions of national health reform should be interpreted and applied. The impact of these reforms on individual situations may vary. This overview is intended as an educational tool only and does not replace a more rigorous review of the law's applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice.*

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## The Blues offer inpatient documentation, coding accuracy training for hospitals

Blue Cross Blue Shield of Michigan is offering a training guide to assist with inpatient documentation and coding accuracy. We want to help our hospitals by aligning their documentation with reportable diagnoses in accordance with the Centers for Medicare & Medicaid Services requirements.

These improvements in documentation and coding accuracy will ensure better quality peer comparisons, population management, risk scores, reimbursement and incentive distribution.

The training guide is available on web-DENIS:

- Log in to web-DENIS.
- Click on *BCN Provider Publications and Resources*.
- Click on *Learning Opportunities*.

For your convenience, the presentation is also available for viewing on your smart phone or tablet.

If you have any questions, please contact your provider representative.

## Multiple radiology payment reduction clarified

In January 2011, Blue Care Network adopted a multiple imaging reduction procedure discount, following the lead of the Centers for Medicare & Medicaid Services. The main scope of the program is that the reimbursement for the technical component of the services is subject to a reduction. There is no reduction on the professional component (indicated by modifier 26).

For imaging procedures subject to the multiple procedure reduction, the technical component is reduced on the procedures with the lower relative value units (RVUs), when multiple procedures are reported on the same day by the same provider (or providers within the same group).

The chart below shows three procedure codes for imaging services which are subject to the multiple procedure reduction and the reimbursement of the technical component on each code.

	Procedure Code	Units	Revenue Code	Subject to MPR	Reimbursement
1	70470	1	351	Yes	Half
2	71260	1	352	Yes	Half
3	74177	1	352	Yes	Full

The complete listing of codes subject to the MPR can be located on the [CMS website](#).

This reduction applies to professional claims submitted for both commercial and BCN Advantage<sup>SM</sup> lines of business and for facility claims for the commercial line of business. BCN Advantage facility claims are processed in accordance with the CMS reduction methodology.

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## Send claims for outpatient diabetic supplies to Blue Care Network

Blue Care Network is changing the way claims for outpatient diabetic supplies are processed. Claims for those supplies submitted on or after Jan. 1, 2014, should be sent to BCN rather than to J&B Medical Supply, Inc. This applies to services for members with BCN HMO<sup>SM</sup>, BCN Advantage<sup>SM</sup> HMO-POS and BCN Advantage<sup>SM</sup> HMO products and applies whether the BCN coverage is primary or secondary. Claims submitted before Jan. 1 should be sent to J&B.

This process is changing because BCN needs to keep track of members' health care expenses, including pharmacy and diabetic supplies. Under health reform, all medical expenses paid by a member will accumulate and be counted toward out-of-pocket maximums.

Paper claims for outpatient diabetic supplies should be sent to one of the following addresses, as appropriate:

- Blue Care Network Claims  
P.O. Box 68710, Grand Rapids MI 49516-8710
- BCN Advantage Claims  
P.O. Box 68753, Grand Rapids MI 49516-8753

For claims billed electronically, please follow the normal billing process.

## Reminder: Correct claims that BCN denied BI2 or B15 claim lines with TOB7

Blue Care Network wants to remind hospitals to follow instructions published in the "Claims" chapter of the *BCN Provider Manual* to correct claims that are rejected due to coding issues.

The TOB7 procedures allow you to correct claims that are rejected for missing codes or invalid revenue and code combinations (denial reason codes BI2 or B15).

For more information about this procedure, contact your provider representative.

### 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 the tips, click on Clinical editing billing tips below.

- Submitting clinical editing appeals
- Appealing BCZ denials for CPT code \*90670



[Clinical editing billing tips PDF](#)

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## Billing Q&A

### Question:

**I submitted a claim and one of the lines came back split with an explanation code of N54. I don't understand why Blue Care Network is splitting my claims. If Medicare has an issue with the amount I report, the entire line is denied. Why is there a difference?**

### Answer:

The Center for Medicare & Medicaid Services uses limits referred to as "medically unlikely" edits for many but not all CPT and HCPCS codes. When CMS establishes a medically unlikely edit for a code and the reported amount exceeds the maximum allowed, typically the entire line or amount is denied.

It is Blue Care Network's intent to process up to the allowed amount. Therefore, if the reported amount exceeds the maximum, the line is split. This allows us to pay up to the allowed units, and only the units that exceed the limit receives an edit. The provider still has full appeal rights for the denied amounts via the clinical editing appeal process.

### Question:

**I received a clinical editing denial on a claim I submitted to Blue Care Network. I would like to bill the member for this since the plan did not reimburse me. Can I do that?**

### Answer:

No. Clinical edits are related to correct coding guidelines and processes. For these edits, members are held harmless. While they are considered provider liability, there are mechanisms in place for providers to seek recourse from the plan.

Depending on the edit received, the provider may just need to submit a corrected or status claim. The other option for providers is to submit a clinical editing appeal, with clinical documentation supporting their position. The clinical editing process is noted in the *BCN Provider Manual*.

### Question:

**I am confused on reporting nerve conduction studies (NCS) with electromyography. It seems either the EMG or the NCS codes are changing every year. If both diagnostic tests are done at the same visit, how do I report them?**

### Answer:

In 2013, the NCS codes were updated. The focus was taken away from the type of test (for example, motor or sensory) and placed on quantity. When the same nerve is tested at multiple sites for one NCS, it is counted as only one test. You can get the total number of tests by adding the NCS done on the different nerves. Additionally, the bilateral modifier is not applicable with the new nerve conduction study codes, as it is strictly quantity based.

If the NCS is performed along with an EMG, the appropriate code needs to be reported. In 2012, add-on codes were developed for reporting an EMG done at the same visit as an NCS. The codes are \*95885 – \*95887, and need to be selected based on level of care (for example, limited or complete) and site (for example, extremity or non-extremity). As these are add-on codes, they should be reported with a valid primary code (for example, \*95907 – \*95913).

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## Have a billing question?



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

## Use these tips to transition PT, OT, ST cases continuing into 2014

Blue Care Network has implemented a year-end transition plan for the physical, speech and occupational therapy authorization process. This process worked well for therapy providers and members in 2013; therefore, the same strategy applies for 2014.

### Care that starts in November or December

All 2013 treatment authorizations for physical therapy, occupational therapy and speech therapy will end December 2013 for members whose coverage follows a calendar-year plan. If an episode of care begins in 2013 and is expected to continue into 2014, the following apply:

- An initial evaluation or reevaluation for therapy is not necessary to continue an active episode of care into 2014.
- You must enter a new referral either through e-referral or by calling BCN Care Management **before** the first treatment in 2014.
- A member does **not** need a new referral from the member's primary care physician to complete the active episode of care.

### Care that continues into 2014

Physical, occupational and speech therapy providers should enter their own referrals for therapy services for all patients receiving therapy services in December that will carry over into January 2014. The referral begin date should be the date of the first appointment in 2014. You may enter the 2014 referral into e-referral in December 2013. If you are unable to use e-referral, you may contact Care Management at 1-800-392-2512. For more information or instructions on using e-referral, please contact your BCN provider representative.

Approvals for 2014 must meet these requirements:

- The member is an eligible BCN member on the date services are rendered.
- Services received must be a benefit covered under the member's contract.
- Benefits must be available or remaining as defined by the member's contract.

## For members with plan year benefits

Most BCN plans apply benefits on a calendar-year basis, but some groups administer benefits on a plan year with renewal dates other than Jan. 1. Health care providers can verify this information when checking eligibility on web-DENIS or CAREN. If you identify a member with a plan year, adjustments to the start and end date of an authorization is subject to the benefit year renewal date. BCN and Landmark work together to administer benefits accordingly.

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## Tips, continued from Page 50

Therapists should enter the 2014 referral on e-referral with the following information:

### Physical Therapy

Procedure code	Submit applicable procedure code
Start date	Enter date of the first visit for 2014
Count	1
Date span	60 days

- Category A and B therapy referrals are processed according to their tier level and therapists receive a determination letter.
- Category C providers who have patients currently under care or new patients who begin treatment in January will receive a letter approving three therapy visits. The three-visit approval will be granted through Jan. 31, 2014. Be sure to submit a treatment plan prior to the third visit to avoid the risk of lapse in treatment due to lack of authorization. Beginning Feb. 1, 2014, new referrals revert to the established policy of one evaluation and one visit for all new patients seen by Category C providers.

### Occupational Therapy

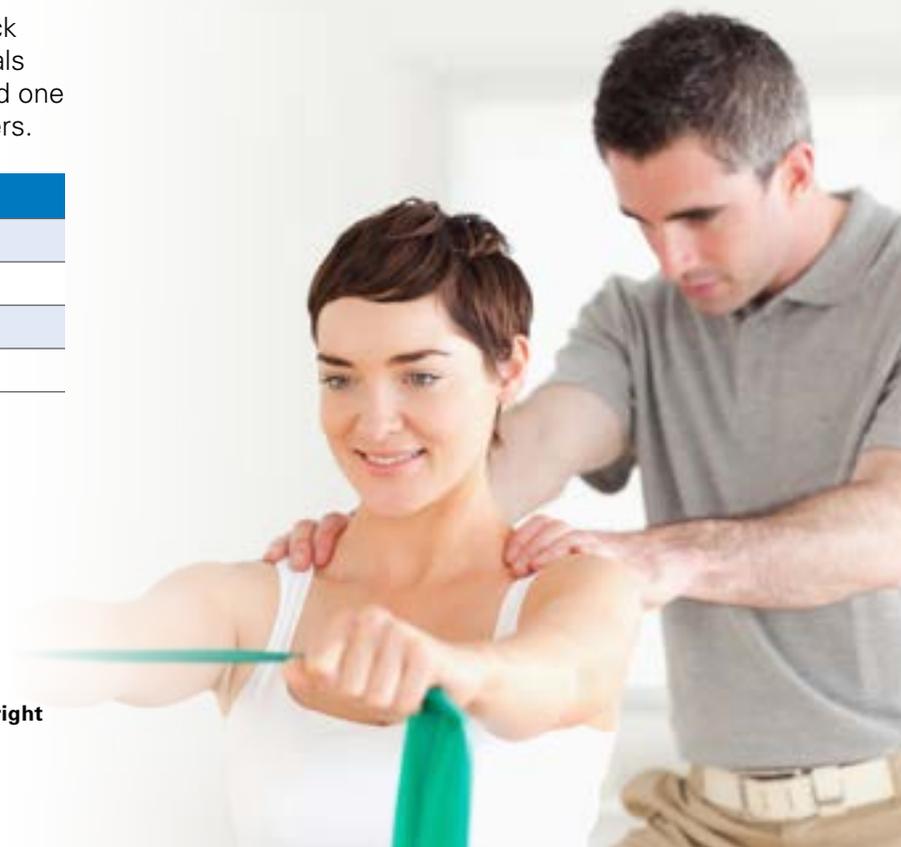
Procedure code	Submit applicable procedure code
Start date	Enter date of the first visit for 2014
Count	1
Date span	60 days

- Landmark processes occupational therapy referrals according to the established process and therapy providers receive a determination letter.

### Speech Therapy

Procedure code	*92506
Start date	Enter date of the first visit for 2014
Count	1
Date span	60 days

- Requests automatically pend for speech therapy. Landmark processes speech provider referrals according to the established process and therapy providers receive a determination letter.
- Speech therapy providers should submit a treatment plan as soon as they determine that care is required for 2014. Landmark reviews for medical necessity and sends a determination letter. BCN Care Management accepts requests for transition cases by phone or by e-referral. Please call Care Management at 1-800-392-2512.



## New benefit/clinical review requirements to take effect

Benefit/clinical review requirements for the following procedures are changing in 2014:

Procedure	Requires benefit/clinical review	Effective date
Breast biopsy (excisional)	Yes	Jan. 1, 2014
Percutaneous ventricular assist devices (pVAD)	Yes	Jan. 1, 2014
Contrast-enhanced computed tomography/angiography (CCTA)	Yes	Feb. 1, 2014

These changes apply to all members with BCN HMO<sup>SM</sup> (commercial), BCN Advantage<sup>SM</sup> HMO-POS and BCN Advantage<sup>SM</sup> HMO coverage.

These new requirements are reflected in the 2014 *BCN Referral and Clinical Review Program*, which will be available on the Web by Jan. 1, 2014. You can open a copy of this document by clicking on the PDF in this article.

BCN's referral and clinical review document is updated as needed throughout the year. The most current program is always available on the Web.

To access the referral and clinical review document, which includes a list of procedure codes that require clinical review, go to **ereferrals.bcbsm.com** and click on *Clinical Review & Criteria Charts*.



[2014 Referral and Clinical Review Program PDF](#)

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## Percutaneous insertion of ventricular assistive device requires clinical review effective January 1, 2014

Effective January 1, 2014, clinical review is required for insertion of a percutaneous ventricular assistive device for Blue Care Network adult members.

Percutaneous ventricular assist devices have been developed for short-term use in patients who require acute circulatory support. These devices are placed through the femoral artery.

Insertion of a pVAD is covered when used as a bridge to recovery in patients with cardiogenic shock who aren't responding to medication and concurrent intra-aortic balloon pump therapy. It is not covered when used as an alternative to IABP in patients with cardiogenic shock or when used as ancillary support in high-risk patients undergoing invasive cardiovascular procedures.

This program applies to Blue Care Network commercial (including self-funded groups,) BCN Advantage<sup>SM</sup> HMO-POS and BCN Advantage<sup>SM</sup> HMO members.

The CPT codes that apply are \*33990, \*33991, \*33992 and \*33993.

Providers should submit requests for clinical review for these procedures to BCN electronically via e-referral. For urgent requests, health care providers may contact BCN's Care Management department at 1-800-392-2512 to request clinical review.

For more information, view the medical policy posted on Web-DENIS for *Total Artificial Hearts and Implantable Ventricular Assist Devices*.

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# Excisional breast biopsy requires clinical review effective Jan. 1, 2014

Clinical review is required for excisional breast biopsy, effective Jan. 1, 2014. Blue Care Network covers excisional biopsy in certain situations in which there is a need for an open surgical procedure.

As an alternative, BCN covers the minimally invasive diagnostic procedure of needle core biopsy for suspected breast abnormalities. Needle core biopsy does not require clinical review.

Needle core biopsy is preferred over excisional biopsy for the diagnosis of breast cancer because the procedure:

- Equals surgical biopsy in accuracy
- Eliminates the need for members with image-detected breast abnormalities to undergo an open surgical procedure
- Improves the cosmetic outcome for the member
- Increases opportunities for multidisciplinary treatment planning
- Lowers morbidity
- Costs less, overall, for diagnosis

Clinical review of excisional breast biopsy is required for members of BCN commercial (including self-funded groups), BCN Advantage<sup>SM</sup> HMO-POS and BCN Advantage<sup>SM</sup> HMO plans. The CPT codes involved are \*19101, \*19120, \*19125 and \*19126.

Providers may submit requests electronically for clinical review for these procedures. Users are prompted to complete an appropriateness questionnaire for clinical review consideration. If the criteria are met, the request is automatically approved. If the criteria are not met, the request requires further clinical review. For urgent requests, health care providers may contact BCN's Care Management department at 1-800-392-2512 to request clinical review.

A sample questionnaire will be made available at a later date on the BCN e-referral Web pages at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Visit the *Clinical Review and Criteria Charts* page and look under the "Medical necessity criteria / benefit review requirements" heading.

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## Contrast-enhanced computed tomography angiography of the heart and coronary arteries requires clinical review effective February 1, 2014

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Contrast-enhanced computed tomography angiography is a noninvasive imaging test that requires the use of intravenously administered contrast material and high-resolution, high-speed CT machinery to obtain detailed volumetric images of blood vessels. It is a potential alternative to current diagnostic tests for cardiac ischemia, for example, non-invasive stress testing or coronary angiography.

Effective February 1, 2014, clinical review will be required for contrast-enhanced coronary CT angiography for Blue Care Network members. This program applies to Blue Care Network commercial (including self-funded groups,) BCN Advantage<sup>SM</sup> HMO-POS and BCN Advantage<sup>SM</sup> HMO members.

The following patients are considered appropriate candidates for CT angiography by the American College of Cardiology:

- Those with stress test results that are equivocal or discordant with other clinical evidence, in lieu of invasive coronary angiography
- Those with low-intermediate risk acute chest pain in order to exclude coronary artery disease in the emergency department or inpatient setting
- Those with new onset chest pain in low-intermediate risk patients in the outpatient setting
- Symptomatic patients for the evaluation of coronary bypass graft or coronary stent patency, in order to facilitate decision making for invasive angiography
- Those with suspected coronary anomalies
- Patients scheduled for cardiac or major thoracic surgery, such as aortic valve replacement or aortic aneurysm repair, in order to exclude coronary artery disease, as an alternative to invasive coronary angiography
- Patients with incomplete invasive catheterization results as an alternative to repeat invasive catheterization

- Patients anticipating cardiac surgery who require an assessment of coronary or pulmonary venous anatomy
- For the assessment of complex congenital heart disease including anomalies of coronary circulation, great vessels, and cardiac chambers and valves
- Evaluation of cardiac mass (suspected tumor or thrombus) and patients with technically limited images from echocardiogram, MRI or TEE
- Evaluation of pericardial conditions (pericardial mass, constrictive pericarditis, or complications of cardiac surgery) and patients with technically limited images from echocardiogram, MRI or TEE
- Evaluation of pulmonary vein anatomy prior to invasive radiofrequency ablation for atrial fibrillation (for example, pulmonary vein isolation)
- Noninvasive coronary arterial mapping, including internal mammary artery prior to repeat cardiac surgical revascularization
- Evaluation of suspected aortic dissection or thoracic aortic aneurysm
- Evaluation of suspected pulmonary embolism.

CCTA is excluded from coverage for the following:

- Individuals who do not meet the criteria stated above
- For screening purposes
- Multidetector CT scanners that have fewer than 64 detectors
- Computed tomography of the heart, without contrast material, with quantitative evaluation of coronary calcium. Calcium scoring reported in isolation is considered a screening service. See JUMP policy "Computed Tomography to Detect Coronary Artery Calcification."

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Providers may submit requests for clinical review for these procedures to BCN electronically via e-referral. Users are prompted to complete an appropriateness questionnaire for clinical review consideration. If the criteria are met, the request will be automatically approved. If the criteria are not met, the request will require further clinical review. For urgent requests, health care providers may contact BCN's Care Management department at 1-800-392-2512 to request clinical review.

CPT codes that are applicable under the policy and may be considered established when criteria is met include \*75572, \*75573 and \*75574; CPT code \*75571 is considered experimental.

A sample of the appropriateness questionnaires will be made available on [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) at a later date. Please refer to the *Clinical Review & Criteria Charts* page under the "Medical necessity criteria/benefit review requirements" heading.

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## New Q&A available on outpatient rehabilitation services

Do you have some unanswered questions about outpatient rehabilitation services? If so, you should refer to a new Q&A document that addresses some questions often asked by outpatient rehabilitation providers.

To find this new document, *Outpatient rehabilitation services: Frequently asked questions for rehab providers*, visit [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Click *Outpatient PT, OT, ST* to open the Outpatient Physical, Occupational and Speech Therapy Management Program page. The Q&A is located under the "Therapy management resources" heading at **Outpatient rehabilitation services: Frequently asked questions**.

The topics addressed in the Q&A include:

- The difference between benefit limits and the number of visits approved
- The difference between the evaluation date and the start date of treatment
- Entering the case into e-referral: reporting the evaluation and the treatment visits
- Reporting some but not all outpatient rehabilitation visits to Blue Care Network
- How providers can protect themselves from financial liability
- Functional limitation data collection reporting

You can also find the Q&A on the web-DENIS Billing page. It's located immediately under the facility billing instructions for physical, occupational and speech therapy.



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