Blue Cross Blue Shield of Michigan and Blue Care Network partner with WebMD Health Services to offer integrated wellness solutions

Starting this fall, Blue Cross Blue Shield of Michigan and Blue Care Network members will have access to a new set of health and wellness programs. Through a partnership with WebMD Health Services, Blue Cross will offer a new online wellness platform – including a health assessment, digital health assistant and health information – along with other wellness programs to its group and individual members. The new partnership gives our customers, including employer groups looking to keep costs down, the opportunity to incorporate wellness programs into their benefit structure.

“We’re excited to offer our members these new wellness programs from a well-known and trusted company like WebMD Health Services,” said Ann Baker, vice president, Wellness and Care Management at Blue Cross. “It is partnerships like these that will enable us to continue meeting the increased demands of our customers now and in the future.”

Research shows employee health and productivity have a direct correlation. An estimated 40 percent of U.S. workers experience fatigue, which costs employers more than $136 billion per year in lost productivity. A 2012 study in USA Today stated employers who invest in wellness programs see increased employee retention, attendance and productivity. Absenteeism costs improved by an average of $2.73 for every dollar spent on wellness, a return on investment of over 150 percent.

The partnership with WebMD Health Services adds the latest technology to Blue Cross Blue Shield of Michigan’s wellness platform. The innovative tools are accessible on mobile devices allowing members to take the health assessment or access the digital health assistant on a tablet or mobile phone. Additionally, members will have the opportunity to access the digital wellness programs through the bcbsm.com member site anywhere, anytime. Blue Cross members will have on-demand access to check their coverage, monitor claims activity and shop for doctors and health care services.

Please see WebMD, continued on Page 2
Don’t forget to retest with CAQH every 120 days

Did you know that if you don’t retest with CAQH® every 120 days, you won’t be included in our provider directories, including our “Find a Doctor” search tool?

That’s one of the main reasons it’s so important to take the time to perform this task.

Here are some other reasons to retest with CAQH, a nonprofit alliance of health plans and trade associations focused on simplifying health care administration:

- To ensure that your affiliation with the Blues isn’t interrupted
- To update your CAQH information if you change your practice location
- To ensure that claims payment isn’t interrupted

Blue Cross Blue Shield of Michigan uses CAQH to gather and coordinate our practitioner credentialing information.

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

If you have any questions about CAQH, call the CAQH help desk at 1-888-599-1771 or email the support desk at caqh.updhelp@acgs.com For information about the credentialing process, contact your provider consultant.

Note: Practitioners applying for affiliation must be board certified or board eligible and meet the established timelines for board certification in either the primary or secondary specialty listed on their CAQH application. Please remember to complete these questions on your enrollment form.
Will changing your PO affiliation affect relationships with patients or incentive rewards?

David Share, M.D., M.P.H., Blue Cross Blue Shield of Michigan senior vice president, Value Partnerships, and Alison Pollard, Blue Care Network vice president, Provider Affairs, sent a letter on Feb. 20 to physician organizations participating in the Physician Group Incentive Program to answer a question that was on the minds of some physicians.

They wondered whether changing their physician organization affiliation would affect their relationships with patients or disrupt any potential rewards they may receive through Blue Cross Blue Shield of Michigan incentive programs. The short answer is “no.”

The following information is an excerpt from the letter.

For all products and pay-for-performance programs, BCBSM and BCN allow patients to continue their medical care with their physician of choice even if their physician decides to change physician organizations.

Patients (members) attributed to or assigned to physicians in a physician organization are not bound to that PO. Physicians within POs may exercise their right to change POs, without concern about disruption in their relationships with their patients. Physicians’ patients may elect to continue to seek care with the same physician when the physician joins a new PO, or may choose to seek care with a new physician. The decision regarding whether patients remain with a physician is not at the discretion of the physician organization.

Physicians will not be negatively affected in regard to potential rewards in BCBSM incentive programs if they change physician organization affiliation. Physician-specific incentives are not linked to the physician organization and should a physician change POs during an incentive program year, BCBSM will apportion earned incentives based on the performance of each PO and the proportion of the year the physician was in each PO. The performance recognition payments made by BCN, BCN Advantage and Blue Cross Medicare Advantage plans are based on the performance of the individual physician and will be paid to the physician (or physician’s employer) at their relationship at the time of the incentive is paid.

If you have any questions, contact your Provider Consultant.
Enhanced process helps get new providers credentialed sooner

Blue Care Network’s enhanced credentialing process allows providers entering Michigan and residents completing their training to start the credentialing process before their malpractice insurance is effective or training is completed.

We begin processing credentialing applications 30 days prior to the malpractice insurance effective activation date. Practitioners should submit their application to Blue Care Network no more than 30 days before the effective date of their malpractice insurance. We are not able to efficiently process applications submitted more than 30 days prior to the effective date.

Practitioners in the process of completing their residency training can submit their application 60 days prior to their training completion date.

Once BCN receives an application and all credentialing requirements are confirmed (training, malpractice insurance, hospital affiliation), we will note the completion date in our credentialing system. This will become the provider’s active credentialing date. The provider will then be added to our network directories and can start billing for claims.

Blue Care Network announces new tobacco incentive winners

Blue Care Network has chosen the winners of the tobacco office staff contest for November and January.

Congratulations to the office staffs at Karu Medical Associates in Saginaw and Ryan Medical Associates in Warren.

Both offices won $500 in gift cards in our monthly drawings as part of Blue Care Network’s tobacco cessation initiative.

Office staffs are still eligible for our ongoing incentive. Please continue to distribute our Quit Guides and encourage patients to complete our tobacco cessation survey. Paper surveys are available from your provider consultant. You can also ask your BCN members to complete the survey online at bcbsm.com/bcnsmokingsurvey.

Congratulations also to Dr. Jessica Lutz who practices at Sparrow Medical Group West in Lansing. She won a $3,000 check as part of our CPT II code incentive for physicians. Providers who bill at least five CPT II codes in a specified quarter related to smoking cessation and counseling are entered into a quarterly drawing.

Reminder: Please note that while we encourage you to provide counseling about tobacco use to all members, only BCN commercial members are eligible for incentives as part of the tobacco cessation campaign.
BCN offices closed for holiday

Blue Care Network offices will be closed on May 25 for Memorial Day.

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

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

Note: Precertifications for admissions to skilled nursing facilities and other types of transitional care services should be called in during normal business hours unless there are extenuating circumstances that require emergency admission.

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

Do not use this number to notify BCN of an admission for commercial or BCN AdvantageSM HMO‑POS members. Admission notification for these members can be done by e‑referral, fax or phone the next business day.

When an admission occurs through the emergency room, contact the primary care physician to discuss the member’s medical condition and coordinate care before admitting the member.

BCN professional fee schedules updated July 1

The Blue Care Network professional fee schedules are being updated effective July 1. BCN continually reviews the need for fee schedule adjustments. This ongoing process looks at market competitiveness, considers equitable differences between primary care and specialty care, and attempts to set fair rates for providers without raising the costs for our employers and members.

If you have questions or would like a copy of the new fee schedule, please contact your provider consultant.
Blues retain Mobile Medical Examination Services Inc, Inovalon for home health reviews

Blue Cross Blue Shield of Michigan and Blue Care Network have once again retained two independent companies to conduct home health reviews, formerly known as in-home assessments, for eligible BCN AdvantageSM and Blue Cross Medicare Advantage members.

The health reviews are part of our members’ coverage and are completely voluntary.

Licensed health care professionals from Mobile Medical Examination Services™ Inc., or MedXM, and Inovalon™ will provide the personalized home health reviews. These reviews will include a medical history review, brief physical exams and documentation of any existing medical conditions. They won’t replace any care members receive from their physicians. Also, the MedXM and Inovalon health professional can’t access a member’s medical history or write prescriptions.

This type of outreach helps support our members’ health and your ongoing care. It also provides documentation of any current medical conditions, helping to guide our care management programs.

We’ll provide information obtained from these reviews to the Centers for Medicare & Medicaid Services as part of our risk-adjustment initiatives. We’ll also share it with you to support your patient care efforts.

Please place a copy of these reviews in your patients’ medical records. You may also want to encourage patients to schedule an office visit following a home health review to discuss the review with them.

If you have any questions, please contact your provider consultant.
Aspirin use prevents heart attacks and strokes in women

Our Chronic Care Improvement program, designed to prevent cardiovascular disease in BCN Advantage members is well into its fourth year. If we achieve our goal to prevent cardiovascular disease, we’ll also meet our other important goals to decrease heart attacks, strokes and related deaths in BCN Advantage members. You may remember from previous articles that we’re using the clinical interventions championed by Million Hearts™, a public initiative led by the Centers for Disease Control and the Centers for Medicare & Medicaid Services to prevent 1 million heart attacks and strokes in the United States by 2017. The Million Hearts clinical interventions focus on improved management of the “ABCs” – Aspirin for high-risk patients, Blood pressure control, Cholesterol management and Smoking cessation.

Aspirin for high-risk patients
This article will focus on heart attacks and stroke in women. Many people continue to believe that heart attacks represent a problem targeting older men, yet heart disease is the number one killer of both women and men in the United States. Each year, about 795,000 Americans have a stroke and about 610,000 are first or new strokes.1 According to the American Heart Association/American Stroke Association, women have more strokes than men do and strokes kill more women than men. Stroke is the third leading cause of death in women and the fourth leading cause of death in men. About 55,000 more women than men have a stroke each year.2 The risk of having a stroke also varies with race and ethnicity. Risk of having a first stroke is nearly twice as high for blacks than for whites, and blacks are more likely to die following a stroke than are whites.3 Hispanics’ risk for stroke falls between that of whites and blacks.3 American Indians, Alaska Natives, and blacks are more likely to have had a stroke than are other groups.4

A study of nearly 40,000 initially healthy women 45 years of age or older found that aspirin (100 milligrams every other day) reduced the risk of a first stroke by nearly 25 percent, and in women over 65 years of age, it decreased the likelihood of both heart attack and stroke.5 We know that daily aspirin use isn’t for everyone. However, we’re committed to the Million Hearts goal of increasing aspirin use when appropriate, from the baseline measurement of 47 percent to 65 percent by 2017. You can join us by talking to your patients about aspirin use, and prescribing it when indicated.

Documenting these discussions in the patient’s medical record will help us measure improvements in aspirin use rates. Our 2015 BCN Advantage Million Hearts Incentive Program rewards you for having and documenting this discussion. If your BCN Advantage patient is prescribed or currently taking aspirin or antiplatelet therapy, report CPT II code 4086F for all patients meeting the criteria.

Preventing 1 million heart attacks and strokes by 2017 will require the work and commitment to change from all of us. More information about this initiative is available on the Million Hearts website.

Reminder: 2015 Blue Advantage Rewards program expands reward opportunities

We know that being healthy takes commitment. That’s why the Blue Advantage Rewards program this year goes even further to support efforts by BCN Advantage℠ HMO-POS and BCN Advantage℠ HMO members to be their healthiest.

Members who get any of the five preventive services in the 2015 program, appropriate for them, will get a custom Entertainment® coupon booklet or coupon set.

Five different rewards are available. Not all members are eligible for all rewards. As in 2014, offers are for items members prefer, and coupons are redeemable closer to home.

In 2015, members are encouraged to get the following services:

- Member health evaluation
- Retinal eye exam
- Mammogram
- Flu vaccine
- Diabetes testing

Rewards will go to members who complete and return the form provided for each procedure. Members must get evaluations or screenings between Jan. 1 and Dec. 31, 2015 to qualify for rewards.

The member health evaluation, introduced to the program a couple of years ago, encourages members to visit their primary care physician at least annually for the following wellness services:

- Creation of a personal prevention or treatment plan, including any needed tests, vaccines or screenings
- Blood pressure check
- Body mass index assessment
- Review of medications, including over-the-counter medicines, vitamins and supplements
- Discussion of safety concerns, such as preventing falls

In January 2015, we sent a program launch book to BCN Advantage members. It outlines the program and includes easy-to-understand educational information about the five procedures. Only services that take place between Jan. 1 and Dec. 31, 2015 will qualify for rewards. The attestation for the member health evaluation and the other test and exam reward forms must be postmarked or faxed to BCN by Jan. 12, 2016.
Health Risk Assessment reminders

Under the Healthy Michigan Plan, primary care physicians must complete a health risk form at the time of the appointment. Blue Cross Complete members receive a copy of the HRA form in their welcome packet and should bring it to their appointment. The form is also available on mibluecrosscomplete.com/providers and on NaviNet.

Please follow these guidelines:

- Complete the HRA form legibly and in its entirety. Please Note: When completing Section 4 Member Results, be sure to include all required information if a diagnosis is checked ‘yes’ (for example, blood sugar test results for diabetes). Incomplete HRAs will not be eligible for the incentive payment.

- A member of the clinical team can complete the HRA form, but the PCP will need to sign it.

- Fax the entire form to 1-855-287-7886 within five business days of the appointment.

- Submit a claim with CPT code *99420 with modifier 25 to indicate that an HRA was completed.

- Direct any questions about the status of the HRA to 1-888-312-5713. Blue Cross Complete will pay a $15 incentive upon receipt of the claim.

* CPT codes, descriptions and two-digit modifiers only are copyright 2014 American Medical Association. All rights reserved.
Emdeon enrollment for EFT

Blue Cross Complete uses Emdeon® for electronic payments. If you are already enrolled with Emdeon through another health plan, you can access Emdeon and select Blue Cross Complete using BCC Payer ID 32002. For providers not already enrolled with Emdeon, visit emdeon.com/epayment.

Member rights and responsibilities

Members can review their rights and responsibilities, information on benefits and coverage, how to obtain services, and how to voice a complaint or appeal at any time by reading the Blue Cross Complete member handbook on mibluecrosscomplete.com.

To get a printed copy, call Blue Cross Complete Customer Service at 1-800-228-8554.

Blue Cross Complete encourages primary care physicians to extend office hours

Primary care physicians can increase their availability to members by extending appointment times into the evening and weekends. Extended office hours can help members overcome barriers related to scheduling and ensure they can be seen in a timely manner.

Updating your office changes

You must retest with CAQH every 120 days to be included in our provider directories, maintain your affiliation with the Blues and ensure that claims payments aren’t interrupted.

Practice information must also be updated through CAQH. If you have any questions about CAQH, call the CAQH help desk at 1-888-599-1771 or visit the CAQH website.

In addition, you must make these changes with NaviNet. Contact NaviNet at 1-888-482-8057 or send an email to support@navinet.net.
Reminder: In some instances, Blue Cross Complete combines two admissions into one for DRG reimbursement

Blue Cross Complete’s Utilization Management department reviews inpatient readmissions that occur within 15 days of discharge from a facility that is reimbursed by diagnosis related groups, when the member has the same or a similar diagnosis for each admission.

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

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

In some instances, Blue Cross Complete will combine two admissions into one for the purposes of the DRG reimbursement. The facility’s discharge planning process is a key factor in determining whether the two admissions can be reimbursed separately. More information is included in the Blue Cross Complete Provider Manual.

Note: For dual-eligible members (those with Original Medicare, BCN AdvantageSM or BCBSM’s Medicare Plus Blue PPO as their primary plan and Blue Cross Complete as their secondary plan), inpatient readmissions will be reviewed according to the requirements of the member’s primary plan.

The 15-day readmissions policy is a Medicaid policy that is implemented by all Medicaid health plans. We have an appeals process in place for providers who disagree with our determination to combine admissions for payment.

BCN commercial and BCN Advantage have a 14-day policy. Those guidelines can be found in the Claims and Care Management chapters of the BCN Provider Manual.
Physicians can use multiple strategies to provide care to patients with hypertension

By Denice Logan, M.D.

Hypertension is a common diagnosis. Approximately 50 million Americans suffer from hypertension, a major risk factor for myocardial infarction, stroke, and renal disease, according to the National Committee for Quality Assurance.

As you’re probably aware, JNC 8 has proposed new guidelines and treatment recommendations. (See the PDF for the JNC 8 algorithm.) The Healthcare Effectiveness Data and Information Set® measurements for controlling blood pressure are consistent with JNC 8 guidelines.

The goal is to achieve a healthy blood pressure. For ages 18 and up to 59 years old, that’s ≤ 139/89, with or without diabetes mellitus and chronic kidney disease. If the patient is older than 60 to 85 without diabetes mellitus the measure guideline is blood pressure ≤ 149/89. This is the intent, but the guidelines state 140/90 and 150/90. Therefore if at 140/90 for 18 to 59 or 150/90 for age 60 or older, then this is not at goal.

More than 70 percent of individuals require two or more drugs to achieve blood pressure control. Therefore, consideration may be given for a combination drug if the two individual medications are formulated into one pill. This may increase patient compliance. (See related article Page 27.)

Medication compliance is just one barrier to achieving good outcomes for patients. Education is an important aspect of treating patients. To help you with this effort, Blue Cross Blue Shield of Michigan has uploaded several videos for patients about blood pressure on YouTube. Your provider consultant can also offer educational literature for your office.

In addition, The American Medical Group Foundation, a non-profit group, offers a provider toolkit to help physicians manage patients with hypertension. Some of their recommendations are also recommended by Blue Cross and Blue Care Network.

• Use a registry or electronic health record to track patients who need monitoring.
• Check blood pressure at every visit.
• Train office staff in accurate blood pressure measurement.
• Provide patients with self-regulation tips, including advice on nutrition, exercise and stress management. Refer to a nutritionist when appropriate.
• Promote data sharing among the physicians in your practice.

Please see Medical director, continued on Page 13.
Physicians who have been featured in our Best Practices columns agree that patient education and frequent follow-up are critical to helping patients manage their blood pressure. Sometimes you need to see patients more frequently to adjust their medication and monitor their progress. Helping patients to understand and manage side effects also helps increase compliance.

Some physicians have told us they also employ self-management techniques. For example, they find it useful to require patients to take their blood pressure at home and bring logs to their follow-up visits.

The Community Preventive Services Task Force, established by the U.S. Department of Health and Human Services to develop guidance on community-based health promotion interventions, also recommends that physicians consider team-based care. The team includes the patient, the primary care physician and may include nurses, pharmacists and dietitians. Together, they work with the PCP to provide medication management, follow-up and self-management support to the patient. Information about team-based care can be found at the Community Guide website.

We hope you find these tools useful in managing your patients with hypertension. We’re always happy to hear feedback from you on what works with your patients.

### HEDIS measure for controlling blood pressure

<table>
<thead>
<tr>
<th>Age</th>
<th>Controlled Blood Pressure*</th>
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</thead>
<tbody>
<tr>
<td>18 – 59 years old</td>
<td>≤ 139/89, with or without diabetes mellitus and chronic kidney disease</td>
</tr>
<tr>
<td>60 – 85 years old</td>
<td>≤ 149/89 without diabetes mellitus</td>
</tr>
</tbody>
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*Exclusions:
- Patients with end stage renal disease (ESRD)
- Pregnant during the measurement year
- Admission to a non-acute inpatient setting during the measurement year

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
BMI assessment is an important screening tool

Childhood obesity is a significant public health threat. Over the last 30 years, the rate of childhood obesity has tripled and nearly quadrupled, according to the Michigan Department of Community Health.

Nearly $3 billion in annual medical costs statewide are attributable to obesity. Studies have suggested that obesity, poor nutrition and physical inactivity leads to reduced academic performance, diminished self-esteem and quality of life, and lower workforce productivity.

As a result of the Healthy Kids Healthy Michigan project, MDCH recommended that providers add obesity measures to the Michigan Care Improvement Registry to monitor, evaluate and prioritize childhood obesity prevention efforts.

Obese children have a more likely chance of being obese adults, and overweight adults tend to have an increased risk of several health problems, including diabetes, coronary artery disease, hypertension, hyperlipidemia and some cancers.

The Michigan Quality Improvement Consortium guidelines recommend that children age 2 or older be assessed at each periodic health exam by measuring and recording weight and height using the Centers for Disease Control and Prevention BMI-for-age growth chart (for either girls or boys) to obtain a percentile ranking. While there are some sophisticated measures for determining whether a person is overweight or obese, using the BMI is a simple and inexpensive screening tool that takes into account a person’s height and weight.

Although BMI is a good tool to screen for obesity, overweight, healthy weight, or underweight, it’s not a diagnostic tool. Health care providers should perform further assessment which might include skin-fold thickness measurements and evaluation of diet, physical activity, family history and other appropriate health screenings.

The BMI-for-age percentile is used for children and teens because BMI is both age- and sex-specific. The percentile indicates the relative position of the child’s BMI number among children of the same sex and age along with growth patterns of children throughout the United States.

Please see BMI assessment, continued on Page 15
BMI assessment, continued from Page 14

Age and sex are considered for children and teens for two reasons:

- The amount of body fat changes with age.
- The amount of body fat differs between girls and boys.

Healthy weight ranges can’t be provided for children and teens for the following reasons:

- Healthy weight ranges change with each month of age and for each sex.
- Healthy weight ranges change as height increases.

For adults 20 years and older, BMI is interpreted using standard weight status categories that are the same for all ages and for both men and women. Even though the correlation between the BMI number and body fatness is strong, the correlation varies by sex, race, and age. Consider the following examples:

- At the same BMI, women tend to have more body fat than men.
- At the same BMI, older people, on average, tend to have more body fat than younger adults.
- Highly trained athletes may have a high BMI because of increased musculature rather than increased body fatness.

BMI is only one risk factor connected to certain chronic diseases. The National Heart, Lung and Blood Institute guidelines recommends looking at two other predictors: Waist circumference and other risk factors, such as high blood pressure or physical inactivity that along with obesity correlates to chronic diseases or conditions.

There are six other measurements that can be used and discussed with patients to help them understand their optimal body weight.

These measures include:

- Height-to-waist ratio
- The individual’s waist circumference (it’s believed that abdominal fat is a predictor of risk for obesity-related diseases)
- Resting metabolic rate
- Health body weight range
- Daily caloric intake
- Target heart rate

A BMI assessment may be a good way to screen children and adults for being overweight or obese; however it’s not a diagnostic tool. To determine if excess fat is a problem, a health care provider needs to perform further assessments such as skin fold thickness measurements, evaluations of diet, physical activity, family history and other appropriate health screenings.

Blue Care Network offers preventive care care brochure

Blue Care Network has a member brochure that includes all the preventive care guidelines from the Michigan Quality Improvement Consortium. The brochure lets members know about important screenings.

Preventive care is available with little or no cost sharing to the member when members get services in the network.

The brochure is available at bcbsm.com.
Blue Care Network is mailing letters to parents in June to remind them to schedule an annual physical exam for their children.

We remind them of the importance of the following in the annual exam:

- A body mass index assessment
- Counseling for healthy eating habits and regular physical activity
- A complete physical exam
- A medical history assessment including a developmental and behavioral evaluation
- A review of the child’s immunization schedule

This mailing is part of an overall campaign to combat childhood obesity. Primary care physicians are in the best position to counsel children about healthy habits. Recording BMI, nutritional counseling and counseling for physical activity is a HEDIS® measure for health plans.

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

Blue Care Network works to combat childhood obesity

As part of our efforts, BCN is participating in a pilot program with the University of Michigan Medical Center to enroll 200 of our members between 13 and 18 who have a BMI at or higher than the 95th percentile. We are also working with 10 pediatric offices in the West region to counsel members about breastfeeding, nutrition, physical activity and screen time (for example, television and computers) in children from birth to age five.

In addition, BCN has included incentives in our Physician Recognition Program for physicians who provide specific codes that demonstrate that they completed BMI, nutritional counseling and counseling for physical activity.

Blue Care Network promotes coordination of care for members

Blue Cross Blue Shield of Michigan and Blue Care Network have mechanisms to ensure and promote continuity and coordination of care among medical practitioners (for example, primary care and specialty practitioners).

Blue Cross and BCN policies and the National Committee for Quality Assurance standards require evidence of continuity of care. Provider contracts specify that the specialist’s timely communication to the referring physician is essential to effectively manage the member’s care.

BCBSM and BCN collect and analyze data to identify opportunities to improve coordination of care between specialists and primary care physicians. Feedback from coordination of care audits reveal an opportunity for improved documented communication from behavioral health providers to primary care physicians.

Behavioral health providers are permitted by law to share behavioral health information without signed written consent from the member. A signed written consent from the member is required by law before the release of information related to the treatment of substance abuse or HIV treatment.

Continuity and coordination of medical care and specialty services are paramount to ensure that members receive the highest quality and safest care possible.
Blue Care Network provides continuity of care to members when provider terminates from the network

Continuity of care is available for members whose primary care physician, specialist provider or behavioral health provider voluntarily or involuntarily disaffiliates from Blue Care Network, or for members who are new to the plan and require an ongoing course of treatment.

Members can’t see their current physician if that physician was terminated from BCN for quality reasons. In that case, we require that member to seek treatment from an in-network provider. BCN provides notification to members within 15 days after learning of the effective date of the practitioner’s disaffiliation.

BCN permits the member to continue treatment in the situations described below provided that the practitioner:

- Continues to accept as payment in full, reimbursement from BCN at rates applicable prior to the termination
- Adheres to BCN standards for maintaining quality health care and provides the necessary medical information related to the care
- Adheres to BCN policies and procedures regarding referral and clinical review requirements

Primary care physicians may offer continuity of care for a member in the situations described in the table below. Specialty providers may offer continuity of care for a member receiving an ongoing course of treatment in the situations described in this table.

A disaffiliating physician who wants to offer a member continuity of care in accordance with the conditions of payment and BCN policies must notify BCN and the member who wants approval for continuity of care. Providers may contact BCN’s Care Management department at 1-800-392-2512 to arrange for continuity of care services. Members should contact Customer Service by calling the number on the back of their ID card.

A nurse will provide written notification of the decision to the member and practitioners. Newly enrolled members must select a primary care physician before requesting continuity of care services and within the first 90 days of their enrollment.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Length of continuity of care</th>
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<tbody>
<tr>
<td>General care</td>
<td>90 days after the date of the practitioner notification to the member of the practitioner’s disaffiliation</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Through postpartum care directly related to the pregnancy, if the member is in the second or third trimester of pregnancy at the time of the practitioner’s disaffiliation</td>
</tr>
<tr>
<td>Terminal illness</td>
<td>For the remainder of the member’s life for treatment directly related to the terminal illness, if the member was being treated for the terminal illness prior to the practitioner’s disaffiliation</td>
</tr>
</tbody>
</table>
Men’s health week is June 15 – 21

Blue Care Network encourages all men to get the recommended screenings they need to maintain good health.

You can help by offering some tips for your male patients:

- **Eat healthy.** Start by taking small steps like saying no to supersizing and yes to healthy breakfast. Eat many different types of foods to get all the vitamins and minerals needed. Add at least one fruit and vegetable to every meal.

- **Get moving.** Play with the kids or grandkids. Take the stairs instead of the elevator. Do yard work. Play a sport. Keep comfortable walking shoes handy at work and in the car. Most importantly choose activities that you enjoy to stay motivated.

- **Make prevention a priority.** Many health conditions can be prevented or detected early with regular check-ups. Regular screenings may include blood pressure, cholesterol, glucose, prostate health and more.

For more information visit Michigan Quality Improvement Consortium guidelines on MQIC’s website.

### 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:

**Covered services**

- Defecography/proctography
- Extracorporeal membrane oxygenation
Blue Care Network uses McKesson’s InterQual Level of Care when conducting admission and concurrent review activities for acute care hospitals. To ensure that providers and health plans understand the application of the criteria and local rules, BCN provides clarification from McKesson on various topics.

**Question:**
In General Surgical page 663, Partial responder, what is required to meet “Post critical care ≤24H”?

**Answer:**
By InterQual standards a patient is “Post Critical Care” if they met Critical Level of Care criteria on the previous day. “Post Critical Care” refers to the criteria level of care that was met on the previous day, not to the name or type of unit on which the patient was housed.

A patient isn’t considered to be “Post Critical Care” if InterQual Intermediate Level of Care criteria was applied and met the previous day. They are only considered to be “Post Critical Care” if InterQual Critical LOC criteria was applied and met the previous day.

**Question:**
If a patient is admitted through the ER with a compression fracture and there is no trauma involved, such as a fall, would that be reviewed under the Trauma criteria?

**Answer:**
No, these criteria can’t be applied for a compression fracture in the absence of trauma.

Applicable criteria for a patient who presents with a spontaneous compression fracture may be available in the General Medical Observation criteria for Intractable Pain. If the patient has new onset of paresis or paralysis of an extremity due to the compression fracture the reviewer may be able to apply criteria for Neurological deficit which is found in the General Medical subset; Episode Day 1, Acute LOC.

If a primary review can’t be completed at the requested level of care the reviewer should send the compression fracture case for secondary review for a determination regarding the most medically appropriate level of care.

**Additional information:**
Spontaneous injuries which result from pathological causes such as pathologic fracture won’t be considered to be a traumatic injury. An example of a spontaneous injury caused by a pathologic medical condition is a compression fracture (spinal fracture which occurs due to osteoporosis). These fractures are quite often associated with a fall or other physical activity (bending or twisting) but their cause is pathologic rather than traumatic.

It’s up to the individual reviewer to determine if the documentation in the medical record supports a traumatic versus a pathologic cause of an injury and to apply the criteria accordingly. If the reviewer is uncertain as to whether an injury is a traumatic injury versus a pathologic injury the case may be sent for secondary review for a determination.
Referral to BCN not needed for diabetic retinopathy exam

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

BCN providers do not need to submit a referral to BCN for the annual eye exam when the exam is performed by a contracted BCN provider. A referral between the PCP and specialist must be documented in the member records at both offices. If the member exceeds the one exam per year, a referral will need to be on file in your office for reference. If you have questions regarding provider referrals, contact your BCN provider consultant.

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

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

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

**Procedure codes:**

**Diagnosis codes:**
249.5x, 250.xx, 648.0x

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

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Blue Care Network to reimburse psychiatrists for telemedicine services in some areas

Effective July 1, 2015, Blue Care Network will reimburse psychiatrists for telemedicine services in underserved areas in Michigan.

The following points are important to know about providing these services:

• Psychiatrists will need to be credentialed and be contracted to provide the services.
• Psychiatrists will need to have arrangements with adequate staffing and equipment along with software systems to provide safety and privacy protection for BCN members.
• The services will need to comply with the American Telemedicine Association guidelines for the provision of telepsychiatric services.
• Telepsychiatric services will be limited to emergency and management services and not authorized for telepsychotherapy services.
• Contracting will be based on the originating site being within our identified areas of network need. The remote site can be anywhere.

We welcome additional psychiatric providers wanting to add this modality to their practices. Feel free to contact Dr. William Beecroft at wbeecroft@bcbsm.com if you are interested in providing this type of intervention.

BCN to discontinue authorization requirement for add-on psychotherapy codes for psychiatrists and nurse practitioners

Blue Care Network will discontinue the authorization requirement for psychotherapy “add-on” codes (*90833, *90836, and *90838) for psychiatrists and nurse practitioners beginning July 1, 2015. Any psychotherapy add-on procedure being done when another therapist is also treating the member should be coordinated between both treating providers. Include rationale regarding the need for both providers to be treating the member for therapy concurrently. The two components of each visit (an E&M code with an add-on psychotherapy code) should be adequately documented in the medical record in the event of an audit.

As noted in the Medical Director column by Dr. William Beecroft (BCN Provider News, Sept.-Oct. 2013):

If an “add-on” psychotherapy code is used, documentation would need to include a separate description of 1) session start and stop times, 2) modality and frequency of the treatment furnished, 3) results of clinical testing, 4) summary of the following: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. These notes could be woven into the documentation to cover the E&M code but will take some added attention to this detail if the “add-on” psychotherapy code is used.

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MDCH releases standard consent form for behavioral health

The Michigan Department of Community Health released the first standard consent form (DCH-3927) for sharing health information about behavioral health and substance use treatment information. The form complies with Public Act 129 of 2014. Although providers are not required to use this new standard form, they are required to accept it. For additional information, visit michigan.gov/Bhconsent.

Behavioral Health Incentive Program flier explains incentives for providers

Blue Care Network launched the Behavioral Health Incentive Program in January 2014 to compensate behavioral health practitioners for achieving established quality-of-care metrics. Psychiatrists, psychologists and social workers are eligible for these incentive dollars when they provide qualifying outpatient services to BCN members.

We’ve put together a flier about the program to give you an overview of the incentives in the program.

If you have any questions, please contact your provider consultant. You can locate your assigned consultant at bcbsm.com/providers by clicking on Contact Us in the upper right section of the page.

Blue Care Network mails BHIP projected payment summaries to providers

Blue Care Network’s Behavioral Health Incentive Program compensates behavioral health practitioners for achieving established quality-of-care metrics. Psychiatrists, psychologists and social workers are eligible for these incentive dollars when they provide qualifying outpatient services to BCN commercial members.

To highlight how much incentive dollars behavioral health providers or outpatient clinics can potentially earn given perfect performance and full participation, BCN mailed out a Money Left on the Table summary on March 20. If you received a report, please note that all calculations are approximations only and could be overestimated.

We hope that you reviewed the reports and take full advantage of the program. If you have questions about the reports or the program, contact your provider consultant. You can locate your assigned consultant at bcbsm.com/providers by clicking on Contact Us in the upper right section of the page.
Chlamydia screening is a team effort

There are many reasons to screen for chlamydia. It’s the most common bacterial sexually transmitted disease in the United States. Repeat infection is common and increases a woman’s risk of serious reproductive complications, including pelvic inflammatory disease, infertility and ectopic pregnancy. However, screening rates are often low.

Shannon Kusiak, M.D., who practices in the Ypsilanti area with IHA Family Medicine — Arbor Park, says the key to chlamydia screening is a team approach. She and the other five doctors at the practice use medical assistants to help track screenings and all follow the same protocol with patients.

“I first identify who needs to be screened and do it in a nonthreatening way,” says Dr. Kusiak. “I let patients and parents know it’s part of the physical exam.” Dr. Kusiak says it’s important not to seem as though you’re singling out patients by assuming they’re sexually active. That’s why it’s part of the annual physical for her patients between 15 and 25.

Dr. Kusiak says screening rates could be increased if physicians have an open discussion with patients and make the screening part of the physical. “It’s also important to let patients know about sexually transmitted diseases and some of the effects, such as infertility and PID,” she says.

It’s easier to talk to younger patients if you let them know the discussion is protected,” says Dr. Kusiak. “I can act as an ambassador between the patient and parent, but I also keep the conversation private if that’s what the patient prefers.”

One of the challenges to chlamydia screening is the patient’s belief that she has to have a pelvic examination. “It’s easy to allay a patient’s fears because chlamydia screening only requires a urine specimen,” says Dr. Kusiak.

How does the office make sure they screen all eligible patients? “Most adolescents don’t come in for many visits so we do it mostly on the annual visit. But we also capture them if they only come in for an asthma check,” says Dr. Kusiak.

The office also receives registries from insurance companies that list patients who have not been screened. “I have patients who are assigned to me as their primary care physician who never come in for a visit and we have called them,” she adds.

Dr. Kusiak said it’s important to test annually, but also to check back with patients. “If they’ve had a new sexual partner we do the screening then as well. We definitely recommend testing again,” she says.
Reports about health care quality and disparities available from AHRQ

The Agency for Healthcare Research and Quality has released the National Healthcare Quality Report and the National Healthcare Disparities Report. These reports, which have published annually for the last nine years, measure trends in effectiveness of care, patient safety, timeliness of care, patient centeredness, and efficiency of care.

Key findings in the reports include the following:

- In terms of quality, there is large variation among states with West South Central and East South Central states performing more poorly.
- In terms of access, 26 percent of patients have difficulties getting access to care (This finding does not include improved access as a result of the Affordable Care Act.)
- Minorities and poor people experience worse quality and access for a large proportion of the measures in the reports.
- Areas of improvement include hospital care, adolescent immunizations, hospital care and availability of providers by phone.

AHRQ focused on 48 measures, including immunization; counseling about smoking, weight loss, and exercise; treatment of cancer, diabetes, and pneumonia; and care by nursing homes and home health agencies.

The report also includes information about disparities in quality of care broken out by race and economic status. For example, it notes that Blacks and Hispanics receive worse care than White patients for about 40 percent of the quality measures. Poor people receive worse care than high-income patients for about 60 percent of the quality measures.

The report concludes, “It makes a difference in people’s lives when breast cancer is diagnosed early; when a patient having a heart attack gets the correct lifesaving treatment in a timely fashion; when medications are correctly administered; and when health care providers listen to their patients and their families, show them respect, and answer their questions in a culturally and linguistically appropriate manner. All Americans should have access to quality care that helps them achieve the best possible health.”

The full report is available from the Agency for Healthcare Research and Quality website.

Blue Cross Blue Shield of Michigan and Blue Care Network have identified health care disparities among certain ethnic groups. We have a committee to develop actions to address identified health care gaps. We encourage all contracted providers to identify member demographics in Health e-BlueSM website.
Medical record guidelines

Blue Cross Blue Shield of Michigan and Blue Care Network maintain a policy for content of medical records.

- A clinical record must be maintained for each our members.
- The clinical record should be contemporaneous and organized in a manner that facilitates easy access for reviewing and reporting purposes.
- The medical record should be stored or electronically secured to ensure compliance with HIPAA regulations.
- The content of the medical record should include member demographics, health assessment, reason for visit, diagnoses, documentation of discussion about advanced directives, preventive health and health maintenance, patient education, follow-up plan, consultation review, referred services review.

Our medical record keeping policies supports the Centers for Medicare & Medicaid Services and National Committee for Quality Assurance standards and contain elements from the Michigan Quality Improvement Consortium guidelines.

BCN’s Quality Management Department employs quality management coordinators who are nurses and conduct medical record reviews at our contracted provider offices to monitor compliance with our policies. We conduct medical record reviews annually from a random sample of all network practitioner categories. The performance expectation is at least 80 percent for each clinical indicator. The quality management coordinators provide education regarding medical record standards.

Feedback from the 2014 medical record review summary reflects an overall improvement from 2013. Opportunities for improvement include:

- Documentation regarding advanced directives
- Cervical and colorectal cancer screenings

We can provide medical record forms to assist practitioners with medical record guidelines.

For more information please contact BCN’s Quality Management department at 248-455-2708.
Quality Improvement program information available upon request

Blue Care Network provides you with information about our quality improvement programs and Clinical Practice Guidelines through this newsletter. We make available approved Clinical Practice Guidelines to all Blue Care Network primary care physicians, primary care groups and specialists.

You can find copies of the complete guidelines on our secure provider portal. To access the guidelines:

• Log into web-DENIS.
• Click on BCN Provider Publications and Resources.
• Click on Clinical Practice Guidelines in the Resources section.

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

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

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

To ensure accessibility of care to our members, BCN has access and availability standards for the following types of appointments: preventive care, routine primary care, urgent care, emergency care, after-hours access and practitioner waiting room times. Quality management coordinators monitor access throughout the year. We offer noncompliant physicians the opportunity to become compliant with access standards. More information is available in the BCN Provider Manual. Log in to web-DENIS, click on Provider Manual and open the Access to Care chapter.

Members can call our BlueHealthConnection® line at 1-800-637-2972 for health education and chronic condition management information. If you would like additional information about our programs or guidelines, please contact our Quality Management department via email at BCNQIQuestions@bcbsm.com. You may also call us at 248-455-2714.
Hypertension treatments: The single pill option remains

The Eighth Joint National Committee, commonly referred to as JNC 8, recently released updated guidelines for hypertension. The revised guidelines present an opportunity to reemphasize the combination therapy products available on the Blue Care Network drug lists. This may allow for more effective first-line therapy and help your patients and our members achieve their blood pressure goals more conveniently and with initial therapy.

The guidelines contain recommendations for use of preferred agents that may vary by patient demographics, comorbidities and baseline pressures. Each treatment includes the use of the selected agents “alone or in combination.”

This is in contrast to the JNC 7 guidelines that recommended two drugs for those with stage 2 hypertension only. The JNC 7 guidelines for hypertension from 2003 identified two stages of people with hypertension: those with stage 1 (SBP 140–159 or DBP 90–99 mmHg) and stage 2 (SBP ≥160 or DBP ≥100 mmHg).

JNC 8 recognizes three strategies for dosing antihypertensives:

1. Start one drug, titrate to maximum dose, and then add a second drug.
2. Start one drug and then add a second drug before achieving maximum dose of the initial drug.
3. Begin with two drugs at the same time, either as two separate pills or as a single pill combination (emphasis added).

JNC 8 did not recommend a beta-blocker in the initial treatment choices for any specific group. JNC 8 also states that ACEIs and ARBs should not be used in combination.

Calcium channel blockers and thiazide combinations are recommended as first line therapy for African-Americans. If an African-American patient needs both a calcium channel blocker and a diuretic, the patient must take two pills because no suitable single-pill combination is available in the United States.

Calcium channel blockers and thiazide combinations are not recommended as initial treatment for patients with chronic kidney disease.

ACEIs and ARBs are not recommended as first-line therapy for African-Americans. For all other populations, ACEIs and ARBs are recommended as first-line therapy for the treatment of HT.

Combination generic antihypertensive agents that meet JNC 8 first-line criteria

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Drug Name</th>
<th>Drug Category</th>
<th>Drug Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thiazide-type diuretics and combinations</td>
<td>Accuretic(g) Atacand HCT(g) Aivalde(g) Diovan HCT(g) *Edecrin(g) Exforge(g) *Hydrodiuril (g) *Hygroton(g) Hyzaar(g) Lotensin HCT(g) Micardis HCT(g) Monopril HCT(g) Prinzide(g) Zestril(g) Uniretic(g) Vaseretic(g)</td>
<td>ACE combinations</td>
<td>Accuretic(g) Lotensin HCT(g) Lotrel(g) Monopril HCT(g) Prinzide(g) Zestril(g) Uniretic(g) Vaseretic(g)</td>
</tr>
<tr>
<td>Calcium channel blocker and combinations</td>
<td>*AdalatCC(g) *Calan SR(g) *Dynacirc(g) Lotrel(g) Exforge(g) *Norvasc(g) *Sular(g) Twynsta(g) *Verelan PM(g)</td>
<td>ARB combinations</td>
<td>Atacand HCT(g) Aivalde(g) Diovan HCT(g) Exforge(g) Hyzaar(g) Micardis HCT(g) Twynsta(g)</td>
</tr>
</tbody>
</table>

*Recommended as first-line therapy for African-American patients
Michigan Blues make top hepatitis C drugs available, more affordable for members

The approval of Gilead’s hepatitis C drug, Sovaldi® in 2014 resulted in significant cost increases for members and health plans across the country. The recent approval of Gilead’s Harvoni® and AbbVie’s Viekira Pak® promises to drive 2015 costs for treatment of hepatitis C even higher. All three drugs are considered breakthrough drugs for patients with hepatitis C, with cure rates exceeding 90 percent.

Blue Cross Blue Shield of Michigan and Blue Care Network will include Harvoni, Sovaldi and Viekira Pak on the preferred tiers of the health plans’ drug lists for patients who meet clinical guidelines.

Members will pay the lowest brand name or specialty copayment for these drugs. “Having the three drugs on the preferred tier makes all treatment options available and affordable for our members,” said James Grzegorczyk, R.Ph, director of Pharmacy Services at Blue Care Network.

BCBSM and BCN drug lists updated, available online

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 2015, Custom Select Drug List 2015 and the BCN AdvantageSM HMO-POS Formulary. Please help ensure that our members get the care they need by talking with them about their drug copayment or coinsurance. Note that many members with a commercial drug benefit do not have coverage for Tier 3 drugs.

Blue Cross Blue Shield of Michigan and Blue Care Network regularly update their drug lists. For the most recent updates, go to bcbsm.com.rxinfo.
Properly documenting asthma and chronic obstructive pulmonary disease

Asthma and chronic obstructive pulmonary disease are chronic, inflammatory airway obstructions that share similar symptoms such as shortness of breath, coughing and wheezing. These similarities can make it difficult to distinguish one condition from the other without concise documentation.

Complete and accurate documentation, to the greatest specificity possible, can play a crucial role in continuum of care and proper reimbursement. It’s important to be specific when documenting current medical issues and to be clear if a condition still exists. Using the term “history of” can lead to the assumption that the condition no longer exists and is resolved.

When a patient who has asthma or COPD seeks medical attention for an acute condition such as a sore throat or cough, it’s important that the physician document their chronic conditions as well as their current status. This is important from a coding perspective as the documentation has an impact on the ICD-9-CM codes chosen by the coder.

**Asthma**

Asthma is a chronic or long-term lung disease that inflames and narrows the airways. Codes for asthma fall under ICD-9 category 493 and fourth and fifth digits are required for all codes in this category. The table on below provides more detail for the codes in this category. Note that the 5th digit sub classifications don’t apply to 493.8, which have their own 5th digit descriptions: 493.81 – exercise induced asthma and 493.82 – cough variant asthma.

**Category 493 - Asthma**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>493.0</td>
<td>Extrinsic asthma</td>
</tr>
<tr>
<td>493.1</td>
<td>Instinsic asthma</td>
</tr>
<tr>
<td>493.2</td>
<td>Chronic obstructive asthma</td>
</tr>
<tr>
<td>493.8</td>
<td>Other forms of asthma</td>
</tr>
<tr>
<td>493.9</td>
<td>Asthma, unspecified</td>
</tr>
</tbody>
</table>

**5th Digits for Status**

<table>
<thead>
<tr>
<th>Digit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Unspecified status</td>
</tr>
<tr>
<td>1</td>
<td>With status asthmaticus</td>
</tr>
<tr>
<td>2</td>
<td>With (acute) exacerbation</td>
</tr>
</tbody>
</table>

**COPD**

COPD is an umbrella term for a broad classification of disorders characterized by airway obstruction and airflow limitations.

Diseases that fall under COPD include emphysema, chronic bronchitis and bronchiectasis. In COPD, the air sacs are permanently damaged, making it harder to move air in and out of the lungs.

Please see Coding Corner, continued on Page 30
Because of the wide range of ICD-9-CM codes, specific documentation from the physician assists the coder to select a code to the highest specificity.

### COPD ICD-9 codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>491.0</td>
<td>Simple chronic bronchitis</td>
</tr>
<tr>
<td>491.1</td>
<td>Mucopurulent chronic bronchitis</td>
</tr>
<tr>
<td>491.20</td>
<td>Obstructive chronic bronchitis, without exacerbation</td>
</tr>
<tr>
<td>491.21</td>
<td>Obstructive chronic bronchitis, with exacerbation</td>
</tr>
<tr>
<td>491.22</td>
<td>Obstructive chronic bronchitis, with acute bronchitis</td>
</tr>
<tr>
<td>491.8</td>
<td>Other chronic bronchitis</td>
</tr>
<tr>
<td>492.0</td>
<td>Emphysematous bleb</td>
</tr>
<tr>
<td>492.8</td>
<td>Other emphysema</td>
</tr>
<tr>
<td>496</td>
<td>COPD – not elsewhere classified</td>
</tr>
</tbody>
</table>

Physician documentation makes a difference. For example, if documentation states “asthma,” the coder would select 493.90 (asthma, unspecified), while documentation of “intrinsic asthma” would be coded to 493.10 (intrinsic asthma, unspecified).

Documentation of “COPD” uses the code 496 (COPD, unspecified), while documentation of “exacerbation of COPD” uses code 491.21 (obstructive chronic bronchitis, with acute exacerbation). The fifth digit of an ICD-9-CM code is used to capture the specificity of the diagnosis such as “unspecified, with or without exacerbations” and/or “with or without status asthmaticus” when documented accordingly.

Examples to substantiate validations in the medical record for asthma and/or COPD include:

- Medication given for the condition
- Pulmonary function testing
- Documentation of oxygen saturation (normal range 95 to 100 percent)
- Occupational exposure to dusts and chemicals
- Genetics

As you evaluate patients for asthma and COPD, this information is intended to help you understand the importance of documenting the diagnosis to the highest specificity. From a coding perspective, the medical record coder must be able to validate the condition documented by the physician.

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**Blue Care Network to apply code to remittance to indicate special discount arrangements**

Many of Blue Care Network’s local networks, such as Metro Detroit HMO and Blue Cross Partnered, have unique contracted discount arrangements. Effective April 6, 2015, electronic 835 remittances will use CAS code 131 to indicate that a claim has a specific discount that was applied as part of the local network.

Your paper remittance will show a unique explanation code of BQT (BCN Contract Discount and the IPA name) to indicate the specific discount arrangement was applied to the claim line. Your remittance will also indicate the product ID of MDCO for Metro Detroit HMO or TWES for Blue Cross Partnered. However, your front-end registration process should also capture the member’s product.
2015 schedule for ICD-10 educational presentations

Blue Cross Blue Shield of Michigan will continue to offer ICD-10 educational presentations once a month in 2015 from May to September.

These sessions provide:

- An overview of ICD-10
- Differences between the ICD-9-CM and ICD-10-CM code sets
- Review of the top 10 most frequently reported diagnosis codes
- Steps and resources for readiness and testing

All classes will be held at the New Hudson Conference Center, located at 53200 Grand River, New Hudson. The sessions are from 9 to 11 a.m., with registration beginning at 8:30 a.m.

To register, send an email to icd-10providerreadiness@bcbsm.com. Include your name, provider office name, address, phone number, email, PIN and the date of the class you wish to attend.

You’ll receive confirmation within 72 business hours of registering.

Here are the 2015 ICD-10 training dates:

- Tuesday, May 5, in the Midnight Conference Room
- Tuesday, June 9, in the Midnight Conference Room
- Tuesday, July 14, in the Midnight Conference Room
- Tuesday, Aug. 11, in the Midnight Conference Room
- Thursday, Sept. 10, in the Midnight Conference Room

For ICD-10 provider readiness resources, visit cms.gov/icd10 or roadto10.org.

Also, Blue Cross is providing a monthly ICD-10 provider readiness webinar. Registration for these webinars will be provided in web-DENIS the week before the webinar. The webinars are scheduled for the third Monday of the month from 1 to 2 p.m. through September.

A link to the recorded webinar and a copy of the presentation will be provided on web-DENIS after the session. If you’d like to view prior Precyse University presentations and download the presentations, visit the Precyse University website.

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 the Clinical editing billing tips below.

This issue’s billing tips include:

- Clinical editing appeal processing.
- Reporting vial testing with allergy therapy

Clinical editing billing tips PDF
Billing Q&A

Question:
How can I get paid for procedure codes *99050 and *99051? Sometimes I do and other times I don’t.

Answer:
These codes indicate additional services done in the office, other than regularly scheduled office hours or during regularly scheduled evening, weekend and holiday hours.

These codes are only payable to participating BCN primary care physicians and only for the commercial line of business. For BCN Advantage members, these codes will receive an incidental edit as Medicare considers these codes to be inclusive to the primary service and not separately reimbursable.

As noted, these codes are covered for BCN commercial primary care physicians according to their reimbursement arrangements. They must be reported with an appropriate primary code, such as an E&M service (that is, *99201-99215).

Additionally, if there are several services reported on the claim and the E&M service requires the reporting of a modifier 25 to indicate it is a separate and distinct service from the other procedures, either *99050 or 99051 would require that modifier as well. Documentation in the record must support the reporting of the modifier.

Question:
I received a QNT explanation code on a claim denial and it doesn’t make sense to me. I reported the correct code and place of service. Why did I receive a denial?

Answer:
QNT is one of our more general explanation (EX) codes and is found on many clinical edits. The language of the code is “Our clinical editing rules define the procedure code, modifier or place of service as inappropriate for the reported service.” Examples of when you may see the QNT include the following:

• The reporting of a procedure, such as *95886, with only the diagnosis of carpal tunnel syndrome. This procedure is a more comprehensive service and is not typically indicated when the diagnosis is carpal tunnel syndrome.

• A prenatal ultrasound that is repeated within 150 days of an initial ultrasound. We would expect a limited or follow-up ultrasound to be reported to indicate the subsequent service.

• A new patient E&M when the patient has been seen by the provider or a provider of the same specialty in the group within three years prior. An established patient visit should be reported.

Please see Billing Q&A, continued on Page 33

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Billing Q&A, continued from Page 32

**Question:**
What are the appropriate modifiers needed for physical therapy claims?

**Answer:**
The modifiers that should be reported on therapy claims are GN, GO and GP. The modifiers are specific to the therapy disciplines. BCN requires these modifiers to process speech, occupational and physical therapy claims.

For example, if a patient sees a physical therapist in your office and receives mechanical traction as part of his therapy, the claim would document procedure code *97012 with the modifier GP. This would indicate the traction was done by a physical therapist. If the traction was done by an occupational therapist, the procedure code would remain unchanged, but the modifier would be GO.

**Question:**
We now have a practitioner making home visits. Are vital signs required when billing an E&M code?

**Answer:**
It depends on the patient’s condition. Some of the most recognizable components of an E&M visit are the history, examination and medical decision making. Other components include counseling, care coordination and the presenting problem.

The condition of the patient and the purpose of the E&M service will determine whether vital signs are required when billing an E&M. If an examination is part of the E&M and vital signs are integral to the examination, they should be documented in the patient’s record. If the vital signs or an examination are not integral to the visit, an E&M may still be able to be reported, as long as other components are met.

**Question:**
What are the guidelines for billing preventive visits?

**Answer:**
The procedure codes that are considered preventive and covered without cost sharing are listed in web-DENIS. Click *BCN Provider Publications & Resources* and then click *Health Reform* under Resources. It is important to note that some of the codes have diagnostic restrictions to engage the preventive benefit. Other services may have limits as recommended by the appropriate professional organization, society or regulatory agency. It is important to make sure services are provided in accordance with established and recommended guidelines.

**Question:**
Where can I get BCN screening colonoscopy guidelines?

**Answer:**
BCN provides a listing of health care guidelines, including for colorectal cancer screening in the *Provider Manual*, in the section titled “Clinical Practice and Preventive Care Guidelines”

The guidelines are also on the MQIC website.

**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. You may want to direct urgent questions to your provider consultant. Please do not include any personal health information, such as patient names or contract numbers, in your question to us.
Transplants subject to standard BCN clinical review process effective April 1, 2015

Effective with requests submitted on or after April 1, 2015, transplants that require clinical review are subject to the standard clinical review process managed by BCN Care Management staff. Prior to April 1, clinical review was completed by a BCN case manager. This change applies to solid organ and bone marrow evaluations and harvesting (except kidney, skin and cornea) for all members. This also applies to requests to renew or extend an authorization period if the transplant procedure does not occur within the time frame allowed by the authorization.

Submit requests for review through e-referral

The preferred method for requesting clinical review is to submit the request through BCN's e-referral system. You can also call in the request to Care Management at 1-800-392-2512. Clinical documentation should be faxed to 1-800-675-7278.

Utilization review after admission

Once the member is admitted for the transplant procedure, the facility should initiate a utilization review by faxing the clinical documentation to BCN at 1-866-313-8433. This should occur within one business day of the member’s admission.

Timely notification helps ensure that BCN is involved in the evaluation of discharge readiness and the coordination of discharge planning services. BCN also ensures that members are referred for case management if these services are appropriate.

What the transplant authorization includes

The services authorized typically include all transplant-related procedures rendered by both the professional and the facility members of the transplant team, along with transplant follow-up visits. The authorization period typically begins one day prior to the transplant and extends through the period that is standard for that transplant type or until the member is discharged from the care of the transplant facility, whichever occurs first.

The authorization period is calculated once the member is admitted. That period is referred to as a global period and all transplant-related services are bundled into that global period. The length of the global period is determined by the type of transplant performed. It begins the day prior to the transplant, for solid organ transplants, and the day prior to the ablative chemotherapy, for bone marrow transplants. The time frame extends to the end of the global period that was calculated for the member. Generally, the global period extends beyond the discharge date and can include readmissions that occur within that time frame.

As a rule, the transplant facility coordinates the member’s care. Services outside of those authorized for the transplant may also be submitted for review. These include services such as home nursing care and home infusion. For these services, standard referral and clinical review guidelines apply. Transplant follow-up visits that were included in the initial authorization do not need to be submitted again for review.

Please see Transplants, continued on Page 35
Referral to BCN not needed for diabetic retinopathy exam

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

BCN providers do not need to submit a referral to BCN for the annual eye exam when the exam is performed by a contracted BCN provider. A referral between the PCP and specialist must be documented in the member records at both offices.

Please see article on Page 20 for details.
Guidelines for observations and inpatient hospital admissions

Contracted facilities must notify Blue Care Network of all admissions and provide clinical information within one business day of the admission. Timely notification helps ensure that BCN members receive care in the most appropriate setting, that BCN is involved in the evaluation and coordination of discharge planning and that there are appropriate referrals to case management for members who need those services, including those managing active disease processes, those demonstrating high use of health resources or those who are at high risk for health complications.

Providers should notify BCN of admissions by telephone or fax as follows:

- Telephone: 1-855-724-4285
- Fax: 1-866-526-1326 or 1-866-313-8433
- E-referral (submitting all pertinent clinical documentation)

Post-service requests can also be initiated by contacting BCN Care Management.

BCN nurses conduct admission and concurrent reviews by telephone or fax by obtaining information from the hospital’s utilization review staff, or onsite nurses review medical records. BCN nurses also speak to attending physicians when necessary to obtain information.

Clinical information includes the following relevant information about the member:

- Health history
- Physical assessment
- Test and laboratory results
- Consultations
- Emergency room treatment and response
- Admitting orders

The following table outlines the timeframes we use to make decisions on admission reviews, as defined by the Employee Retirement Income Security Act, the National Committee for Quality Assurance and the Centers for Medicare & Medicaid Services.

<table>
<thead>
<tr>
<th>If...</th>
<th>Then...</th>
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<tbody>
<tr>
<td>The information provided meets BCN’s criteria without requiring additional information</td>
<td>The case is approved within 72 hours of receipt of the request if the member hasn’t been discharged.</td>
</tr>
<tr>
<td>The admission or continued stay cannot be approved with the information provided</td>
<td>If, upon notification of the admission, the member hasn’t been discharged, the BCN nurse may ask the facility and/or attending physician for more information within 24 hours of receipt of request and makes a determination within 72 hours of receipt of request.</td>
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<tr>
<td>After obtaining all available information, the case still cannot be approved</td>
<td>The BCN nurse discusses the information with BCN’s plan medical director.</td>
</tr>
<tr>
<td>The plan medical director cannot approve the case based on the information available</td>
<td>The plan medical director may contact the attending physician for additional information related to any review, as deemed necessary. The BCN nurse notifies the practitioner, primary care physician, member and facility of the determination within 72 hours of receipt of the request.</td>
</tr>
<tr>
<td>Notification of the admission is received after the member is discharged</td>
<td>BCN has up to 30 days after receipt of the request to make a determination.</td>
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Please see Admissions, continued on Page 37
Administrative denials
Administrative denials are determinations made by BCN in accordance with administrative policies and procedures or contract language. These determinations aren’t based on medical necessity or appropriateness. Administrative denials can be issued by BCN with or without review by a plan medical director. Examples of situations likely to result in administrative denials include but aren’t limited to:

- Provider noncompliance with clinical review requirements for elective procedures requiring BCN approval
- Provider noncompliance with providing clinical information needed to render a decision for inpatient admissions within 48 hours of BCN’s request

The administrative determination appeal process affords providers and practitioners one level of appeal for Care Management determinations related to administrative denials.

Administrative appeal requests must be submitted to BCN within 45 calendar days of the provider’s receipt of the denial decision. Documentation submitted must include a written appeal request along with the rationale and supporting documentation, if applicable, related to the denial and any other information pertinent to the request. BCN notifies the provider of the decision within 30 calendar days of receiving all necessary information.

Providers should mail appeal requests to:
Care Management — Provider Appeals, Mail Code C336
Blue Care Network
P.O. Box 5043
Southfield, MI 48086-5043

The decision regarding the administrative determination appeal process is final. If the administrative denial is overturned but a denial determination is subsequently rendered in accordance with BCN criteria, the provider is eligible to appeal through the clinical determination appeal process described above.

For additional information on the inpatient admission guidelines, and the administrative denials and appeal process refer to the BCN Provider Manual.
Which services require clinical review?

Blue Care Network has a process for determining which services require clinical review by its Care Management and Behavioral Health departments. BCN’s clinical review process has been established:

- To ensure uniformity in the provision of medical and behavioral health care
- To ensure the medical appropriateness and cost effectiveness of certain services
- To improve the overall quality of care our members receive
- To lower the cost of coverage for our members

BCN determines which services are subject to clinical review by analyzing the plan’s utilization data and comparing it with the following:

- Internal goals
- External benchmarks, such as HEDIS®
- Medical policies

Other factors are also taken into consideration, such as:

- Procedures high in cost or volume
- Trends toward increasing use of a procedure or service
- Evidence of or reason to suspect actual or potential misuse
- Variations in practice patterns
- Services rendered without direct physician oversight
- Services rendered without any method of cost or quality control — for example, services not subject to capitation or physician referral processes

In deciding which services require clinical review, BCN also looks carefully at:

- The negative impact the proposed review program might have on providers
- The acceptability of any existing criteria, such as InterQual® criteria, Medicare guidelines or information from the medical literature
- Administrative impacts to the health plan and providers
- Market analysis or benchmarking, to determine whether the procedure is within the range of reasonable or accepted practice
- Net cost savings, considering any possible administrative cost offset

Prior to implementation, each proposed review program is vetted internally and is also vetted with actively practicing BCN-contracted providers.

The BCN Referral and Clinical Review Program is the document that captures the decisions about whether to require clinical review. That document is updated on an as-needed basis, but at least twice a year. BCN also communicates clinical review requirements through:

- Articles in BCN Provider News
- News items posted on the ereferrals.bcbsm.com website
- Web-DENIS messages

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Finding home sleep studies providers

You can find the names of home sleep study providers contracted with Blue Care Network at bcbsm.com/find-a-doctor by typing “home sleep testing” in the What are you looking for? field.

For more specific instructions for finding BCN-contracted home sleep study providers, refer to the document Finding home sleep study providers.

Only providers who are board certified in sleep medicine, are specifically contracted with BCN and have a specific Home Sleep Study Agreement and are allowed to bill these services on a professional (CMS) 1500 claim form can bill for this service.

Blue Care Network policies typically cover home sleep studies for adult patients with symptoms of obstructive sleep apnea without other comorbid conditions. A nondiagnostic home sleep study is required for adult members to be considered for approval of a sleep study in an outpatient facility or clinic.

Sleep study candidates include habitual snorers with daytime sleepiness or observed apnea (cessation of breathing lasting 10 seconds or more). Daytime sleepiness can be determined by using a common assessment tool available to health care providers.

Home sleep studies are covered to diagnose obstructive sleep apnea for patients who fit the following description:
- Are 18 years of age or older
- Have a high pretest probability of moderate to severe obstructive sleep apnea
- Have no comorbid conditions

Home sleep studies allow for testing in the comfort of the patient’s own bed and are particularly useful in rural areas where the nearest sleep center may be hours away.

BCN also covers outpatient facility or clinic-based sleep studies for the following members:
- Pediatric members (17 years of age or younger) with symptoms of obstructive sleep apnea
- Adult members with symptoms of obstructive sleep apnea who completed a nondiagnostic home sleep study or who have comorbid conditions that preclude them from being a candidate for a home sleep study.

When you submit a clinical review request for a sleep study on BCN’s e-referral system, the system prompts you to complete a questionnaire to determine the appropriateness of the request. The questionnaire that opens is specific to the treatment setting you have selected.

Examples of the different questionnaires are located on the Sleep Management Program page at ereferrals.bcbsm.com. You can use these examples to organize your responses in preparation for completing the questionnaire in the e-referral system.
Changes to Blue Care Network Referral and Clinical Review Program

We’re making changes to the Blue Care Network Referral and Clinical Review Program that you need to know about. Here’s a summary of the changes and the dates they go into effect.

<table>
<thead>
<tr>
<th>Service</th>
<th>Change</th>
<th>Effective date</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants</td>
<td>Requests for review will be handled by BCN Care Management rather than by a case manager.</td>
<td>April 1, 2015</td>
<td>See the article “Transplants subject to standard BCN clinical review process effective April 1, 2015” on Page 34 of this issue.</td>
</tr>
<tr>
<td></td>
<td>Members must be directed to Blue Distinction Centers+ for Transplants.</td>
<td>May 1, 2015</td>
<td>See the article “BCN Updates Transplant Policy for Blue Distinction Centers” in the March-April 2015 BCN Provider News.</td>
</tr>
<tr>
<td>Drugs covered under the medical benefit:</td>
<td><strong>Aralast NP</strong>&lt;br&gt;<strong>Cerezyme™</strong>&lt;br&gt;<strong>Elelyso™</strong>&lt;br&gt;<strong>Elaprase®</strong>&lt;br&gt;<strong>Fabrazyme®</strong>&lt;br&gt;<strong>Glassia</strong></td>
<td>April 1, 2015</td>
<td>See the article “BCN expanding specialty medical drug approval program on April 1” in the March-April 2015 BCN Provider News.</td>
</tr>
<tr>
<td></td>
<td>Ilaris®&lt;br&gt;Prolastin®&lt;br&gt;Soliris®&lt;br&gt;Vpriv®&lt;br&gt;Zemaira®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs covered under the medical benefit associated with provider code J9999</td>
<td>Require prior authorization / clinical review</td>
<td>April 1, 2015</td>
<td>Procedure code J9999 is assigned to not OTHERWISE classified antineoplastic drugs.</td>
</tr>
</tbody>
</table>

In addition, the procedure codes that require clinical review are split into two lists. The drugs covered under the medical benefit are shown in one chart and all other services are shown in another chart.

Remember, requests for clinical review / prior authorization need to be submitted to BCN prior to the service being provided. The best way to submit the requests is through BCN’s e-referral system. When you submit through the e-referral system, you’re able to see the response to the request.

You should always consult the Blue Care Network Referral and Clinical Review Program posted on the Web for the most updated guidelines. Visitereferrals.bcbsm.com and click Clinical Review & Criteria Charts. Then click Blue Care Network Referral and Clinical Review Program. The clinical program is updated as changes occur.
Clarifications on clinical review requirements for long-term continuous ECG rhythm recording and storage services

For BCN Advantage℠ members. For BCN Advantage members, neither referral nor clinical review is required for services involving long-term continuous electrocardiographic rhythm recording and storage devices worn on an adhesive patch when supplied by a contracted provider and used for time periods longer than 48 hours, up to 14 days. This applies to devices such as the Zio® Patch and LifeStar ACT and to procedure codes *0295T through *0298T.

Clinical review is required for all providers not contracted with Blue Care Network. This includes the manufacturers of the ECG monitoring devices. If the manufacturer will be billing BCN directly for procedure code *0297T, clinical review is required.

For BCN HMO℠ members. For BCN HMO (commercial) members, clinical review is still required for continuous ECG monitoring using these rhythm recording and storage devices. You can submit your request for review via the e-referral system or by calling BCN Care Management at 1-800-392-2512. For commercial members, the following two clinical review requests need to be entered:

- One request for codes *0295T, *0296T or *0298T to be submitted by the specialist or facility (or both), to hook up the device and interpret the results
- One request for code *0297T to be submitted by the provider of the device, for the device itself

Date span on the request. The date span on requests for all members should be 45 days, to allow time for the various activities associated with these devices, including device hook-up, member instruction, the days the device is actually in use, the return of the device and interpretation of the results.

*CPT codes, descriptions and two-digit modifiers only are copyright 2014 American Medical Association. All rights reserved.
Reminder: Member compliance required before reauthorizing positive airway pressure devices

Effective with requests for authorization initiated on or after Jan. 1, 2015, BCN HMO℠ and BCN Advantage℠ members who use positive airway pressure devices must show they’re complying with their treatment recommendations in order to use the devices for longer than 90 days. Northwood, Inc., BCN’s durable medical equipment benefit manager, will no longer authorize use of the devices for 12-month periods.

Durable medical equipment suppliers play a key role in coordinating the member’s compliance data. This information will show whether the member is benefiting from the equipment and is complying with treatment recommendations. The DME suppliers will make sure the member’s practitioner knows whether the member is complying.

Here’s how the new arrangements work:

<table>
<thead>
<tr>
<th>Responsible party</th>
<th>When the PAP device is prescribed</th>
<th>Between day 1 and day 90</th>
</tr>
</thead>
</table>
| Practitioner      | Sends the initial request for authorization to a DME supplier that’s part of the Northwood network  
|                   | Note: If you need assistance locating a network provider, contact Northwood at 1-800-393-6432. | Manages the member, as appropriate  
|                   |                                  | Sees the member for a face-to-face evaluation  
|                   |                                  | Documents whether the member’s symptoms have improved  
|                   |                                  | Determines whether the member needs to use the equipment beyond 90 days  
| Northwood         | Processes the request for authorization | —  
| DME supplier      | Delivers the equipment to the member  
|                   | Instructs the member on how to use the equipment  
|                   | Reviews the Northwood PAP compliance acknowledgement letter with the member  
|                   | Has the member sign the letter  
|                   | Places the letter in the member’s file | Receives the member’s compliance updates and place them in the member’s file  
|                   |                                  | Contacts the practitioner for the order to extend the authorization beyond 90 days  
| Member            | Signs the agreement to indicate his or her intention to comply with treatment recommendations and willingness to verify compliance | Documents compliance by bringing the device’s memory card to the DME supplier or uploading compliance data using online software  
|                   |                                  | Sees the practitioner for a face-to-face evaluation within 90 days |

Please see Member compliance, continued on Page 43
Member compliance, continued from Page 42

If the practitioner has determined the PAP device is needed for more than 90 days and the member’s compliance has been verified during the first 90 days, the DME supplier submits the completed *Northwood PAP Therapy Reauthorization Request Form* to Northwood. No additional documentation is required. The DME supplier should keep all compliance documentation and notes in the member’s medical record and make them available for audit as necessary. Benefits will be extended for the remaining rental months of the PAP device.

If the practitioner determines that the PAP device is needed for more than 90 days but the member did not verify his or her compliance during the first 90 days, the DME supplier must submit the following to Northwood:

- The acknowledgment letter the member signed at the initial visit
- The completed *Northwood PAP Therapy Reauthorization Request Form*, including the date of the member’s face-to-face evaluation with the practitioner
- The practitioner’s notes from the member’s face-to-face evaluation
- The compliance data from the first 90 days

Members who do not comply with treatment recommendations if their usage information shows they used their PAP device for less than four hours per night on 70 percent of nights during each consecutive 30-day period of the 90 days following receipt of equipment.

Members who do not comply with treatment recommendations, who have not had the face-to-face evaluation with their practitioner or whose symptoms have not improved may not be approved by the plan for an extension of benefits. Members not approved for an extension must return the PAP device to the supplier or be responsible for paying for the device when the authorized period ends.

Medical policy on positive airway pressure devices

Read the updated medical policy on positive airway pressure devices for more details. The updated policy is dated May 1, 2015, and includes information from the medical literature. The updated policy will eventually be available to providers on Blue Care Network’s web-DENIS *Medical Policy Manual* page.

To access the policy on that page:

1. Log in to Provider Secured Services.
2. Click *web-DENIS*.
3. Click *BCN Provider Publications and Resources*.
5. Click *Policies by Name*.
6. Click the letter *P*.
7. Click *Positive Pressure Airway Devices in the Treatment of Apnea*.
Last fall we asked you to complete an online survey to tell us how satisfied you are with Blue Care Network’s Care Management services. We’re happy to report that we received more than 1,000 responses. Your responses will help us evaluate our efforts and determine other improvements we can make to enhance our Care Management processes.

We included 14 questions on our survey designed to measure your satisfaction with each of the functional units within Care Management. A six-point response scale allowed you to rate your satisfaction as very satisfied, satisfied, neutral, dissatisfied or very dissatisfied. We also allowed an “opt out” response of no opinion/don’t know. We didn’t count the no opinion/don’t know responses in the totals.

When considering a combination of very satisfied and satisfied responses, satisfaction ratings ranged from 55 percent satisfaction with the provider appeal process to 92 percent satisfaction with our chronic condition management programs. Overall satisfaction with our Care Management programs received a 66 percent rating. We offered you the chance to tell us what we can do to improve your satisfaction with our Care Management programs. We received more than 350 suggestions.

Many of you have the implementation of Care Management’s new e-referral system on your mind. More than half of your comments related to the new system, referrals or phone wait times. We also received comments about the clinical review process, communication issues with Blue Care Network and the CareCore National and Landmark review processes.

This survey tells us that there’s room for improvement in many areas. Here are some things we’re doing:

- The new e-referral implementation team continues to work on improving the operation of e-referral as well as the online tools available to providers.
- An e-referral upgrade, scheduled for midyear 2015, contains enhancements that may improve operation.
- We’re planning a series of articles for BCN Provider News to educate providers about our Care Management programs.

We value your opinion and welcome the feedback you give us about our processes and programs.

All respondents were entered in our drawing to win one of two $250 gift cards and two lucky people were identified as winners.
BCN Advantage
Blues retain Mobile Medical Examination Services Inc., Inovalon for home health reviews ................................. Page 6
Aspirin use prevents heart attacks and strokes in women .......... Page 7
Reminder: 2015 Blue Advantage Rewards program expands reward opportunities ............................................ Page 8

Behavioral health
Blue Care Network to reimburse psychiatrists for telemedicine services in some areas ........................................ Page 21
BCN to discontinue authorization requirement for add-on psychotherapy codes for psychiatrists and nurse practitioners . Page 21
MDCH releases standard consent form for behavioral health ... Page 22
Behavioral Health Incentive Program flier explains incentives for providers .......................................................... Page 22
Blue Care Network mails BHIP projected payment summaries to providers ............................................................. Page 22

Billing Bulletin
Coding corner: Properly documenting asthma and chronic obstructive pulmonary disease ...................................... Page 29
Blue Care Network to apply code to remittance to indicate special discount arrangements .................................. Page 30
2015 schedule for ICD-10 educational presentations .......... Page 31
Clinical editing billing tips... 31
Billing Q&A ......................................................... Page 32
Having a billing question ........................................ Page 33

Blue Cross Complete
Health Risk Assessment reminders ........................................ Page 9
Appointment assistance available for Healthy Michigan Plan members ................................................................. Page 9
Emdeon enrollment for EFT ........................................ Page 10
Member rights and responsibilities ........................................ Page 10
Blue Cross Complete encourages PCPs to offer extended hours. Page 10
Updating your office changes ........................................ Page 10
Reminder: In some instances, Blue Cross Complete combines two admissions into one for DRG reimbursement .......... Page 11

Network operations
Blue Cross Blue Shield of Michigan and Blue Care Network partner with WebMD Health Services to offer integrated wellness solutions ................................................................. Page 1
Don’t forget to reattest with CAQH every 120 days .......... Page 2
Will changing your PO affiliation affect relationships with patients or incentive awards? .................................. Page 3
Enhanced process helps get new providers credentialed sooner . . Page 4
Blue Care Network announces new tobacco incentive winners . Page 4
BCN offices closed for holiday ........................................ Page 5
BCN professional fee schedules updated July 1 .................. Page 5

Patient care
From the medical director: Physicians can use multiple strategies to provide care to patients with hypertension .......... Page 12
BMI assessment is an important screening tool ....................... Page 14
Blue Care Network offers preventive care brochure .............. Page 15
Blue Care Network works to combat childhood obesity ........ Page 16
Blue Care Network promotes coordination of care for members . Page 16
Blue Care Network provides continuity of care to members when provider terminates from the network ................. Page 17
Men’s health week is June 15-21 ..................................... Page 18
Medical policy updates ................................................... Page 18
Criteria corner .............................................................. Page 19
Referral to BCN not needed for diabetic retinopathy exam .... Page 20

Pharmacy news
Hypertension treatments: The single pill option remains .......... Page 27
Michigan Blues make top hepatitis C drugs available, more affordable for members .................................................. Page 28
BCBSM and BCN drug lists updated, available online .......... Page 28

Quality Counts
Best Practices: Chlamydia screening is a team effort ............ Page 23
Reports about health care quality and disparities available from AHRQ ................................................................. Page 24
Medical record guidelines ............................................. Page 25
Quality Improvement program information available upon request ................................................................. Page 26

Referral Roundup
Transplants subject to standard BCN clinical review process effective April 1, 2015 ........................................ Page 34
Referral to BCN not needed for diabetic retinopathy exam .... Page 35
Guidelines for observations and inpatient hospital admissions . Page 36
Which services require clinical review? ..................... Page 38
Finding home sleep studies providers ................................ Page 39
Changes to Blue Care Network Referral and Clinical Review Program ................................................................. Page 40
Clarifications on clinical review requirements for long-term continuous ECG rhythm recording and storage services .... Page 41
Reminder: Member compliances required before reauthorizing positive airway pressure devices .......... Page 42
Medical policy on positive airway pressure devices .......... Page 43
2014 Provider Satisfaction Survey highlights areas for improvement for new e-referral system .................. Page 44