

# BCN Provider News



## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

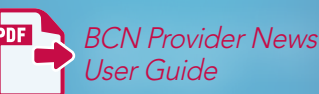
## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



### We made some changes in response to our provider survey

We've identified areas for improvement and made some changes in 2019 related to our utilization review processes in response to recent survey results.

We conducted an online provider satisfaction survey in 2018 to obtain provider feedback related to utilization review. The survey consisted of a series of questions designed to provide information about physician and office staff knowledge, experience, use and satisfaction with utilization management processes. This information assisted us in determining necessary service improvements.

To gather insight into awareness and perception of the programs relating to provider satisfaction, the health plan analyzed the data and, while the results were favorable, the findings identified opportunities in some areas.

Please see [Provider survey](#), continued on Page 3

### We're making some changes to increase security on our Provider Secured Services, effective Sept. 12

Your online security is important to us. So we're making changes to our Provider Secured Services to help make your information and transactions more secure.

Here are some changes effective Sept. 12.

- Your user ID will be deactivated after 90 days of inactivity.
- We'll maintain a password history of six passwords. When you change your password, it must be different from your previous six passwords.
- Password length is changing to a minimum of eight characters.

Please see [Provider Secured Services](#), continued on Page 2

### Inside this issue...

**4** We're changing the categorization process for physical therapy

**10** Oncology management program effective for Medicare Advantage plans in January

**21** From the medical director: Primary care physicians can help prevent suicide

## Feedback | [Subscribe](#)

# Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Provider Secured Services, *continued from Page 1*

- New passwords must contain at least one:
  - » Number
  - » Upper case letter
  - » Lower case letter
  - » Special character
- Your password cannot be the same as your user ID.
- You'll need to change your password every 60 days. The system will prompt you when it's time to do so.

### Signing in after Sept. 12

Users will be able to sign on with their current passwords after we make our security changes.

### How to restore access if your user ID has been disabled

Your user ID will be disabled if you enter your password incorrectly three times. To re-enable your ID, you must answer your security questions accurately. If you answer them wrong three times, the account will be locked and you'll need to call the Web Support Help Desk to unlock your ID.

You can reach the Web Support Help Desk at 1-877-258-3932, Monday-Friday between 8 a.m. and 8 p.m. Eastern time.

### If your account has been deactivated

We'll have a new process for restoring access to an account that's been deactivated.

Complete and fax the **Provider Secured Services ID Reassignment** form to us. Directions for faxing are on the form.

### Questions?

If you have questions or have trouble logging in, call the Web Support Help Desk at the above number.

#### Editor

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

#### Provider Communications

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

#### Market Communications Publications

Colleen McIver

#### Contributors

William Beecroft, M.D.; Camillya Christian-Smith; Laura Cornish; Pharm. D; Amy Frady; Jody Gembarski; Clare Horvath; Joshua McCullough; Jacquelyn Redding

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

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

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

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

# Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Providers: List top locations when updating your information with CAQH

Blue Cross Blue Shield of Michigan and Blue Care Network have updated our systems in collaboration with CAQH that allows providers to list the active locations where you see members.

Follow these guidelines when updating your information in CAQH:

- Make sure you list accurate locations where you're seeing members on a regular basis.
- Indicate the frequency of your practice servicing location to show how many days you practice at each location (for example, weekly, if you practice there at least once a week.)

Limiting your addresses to three active locations for directory publications purposes won't affect claims processing since Blue Cross and BCN services aren't address-specific. Doing so will help direct members to the appropriate locations when seeking services.

As your location patterns change you'll still be able to change the initial addresses.

If you have any questions about this change, contact Provider Enrollment Customer Service at 1-800-822-2761.

### Provider survey, *continued from Page 1*

Of the overall satisfaction results, there were four top scores:

- Satisfaction with BCN's online e-referral process
- Finding BCN medical policies online
- BCN's medical director explained remaining appeal options following a denied peer-to-peer discussion
- Timeliness of inpatient admission decisions according to the physician

The bottom two scores were:

- Timeliness of admission review decisions
- Ease of understanding the appeal instructions in the denial notification letter and in BCN's provider manual for inpatient admission appeals

To improve the identified opportunities, we performed the following activities in 2019:

- Conducted on-site training with various facilities on how to use e-referral and manage authorizations efficiently

- Decreased turnaround times for more clinical reviews and explored opportunities to auto-approve certain diagnosis codes for acute admissions
- Educated providers on how to attach clinical information on e-referral submissions. We are now looking at ways to create more questionnaires to obtain clinical information during the submission process
- Reviewed terms associated with authorizations and referrals
- Reviewed the peer-to-peer process for opportunities to improve the experience
- Explored options with the system vendor for better indicators to show notifications to providers when the plan communicates to them through e-referral

Your feedback has provided valuable information about your experience with us and guides us in our efforts to improve our services.

### About the survey

The Physician Satisfaction survey was available electronically on our website from September through December 2018. A total of 750 providers responded to the online survey. Two participants were selected from the total participants to receive \$250 gift cards. Your responses help us evaluate our efforts and determine other improvements to enhance our care management processes. The survey questions were designed to gather information about how you use care management services and to measure your satisfaction with each of the functional units within Care Management.

# Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## We're changing the categorization process for physical therapy

We're changing the categorization process for physical therapy. Beginning January 2020, we'll use the same categories for Blue Care Network and BCN Advantage<sup>SM</sup> as we do for Blue Cross Blue Shield of Michigan and Medicare Plus Blue<sup>SM</sup>.

Physical therapists will continue to be assigned to one of three tiers, or categories: A, B or C. The categories are based on physical therapy claims for all four networks. We hope that having one assigned category covering all Blue Cross and BCN networks will make it easier for you to manage therapy requests.

eviCore healthcare, an independent company that manages authorizations for us, will complete the analysis of the categorization process. They'll also generate the Provider Performance Summaries, or profile reports, based on paid claims.

Due to the upcoming changes in the categorization process, you won't receive profile reports that were originally scheduled for July 2019 for Blue Cross and for November 2019 for BCN. You'll maintain your current provider categories and current program requirements until you receive the new combined categories.

eviCore plans to send the new combined categorizations to providers in February 2020. You'll still have 15 days from receipt of your categorization report to request reconsideration. Going forward, the combined profile reports will be available in February and August, with notifications from eviCore going out to providers in late January and July.

We'll include additional information about the categorization merger in the upcoming months.

## How can we improve our online tools?

Blue Cross Blue Shield of Michigan and Blue Care Network want to know what we can do to improve our online tools to make them easier and more useful for you – our partner providers. We specifically want to know about your experience using online provider tools and services, including the tools available when you log in to our secure provider website at [bcbsm.com](http://bcbsm.com). Can you spare eight minutes to share your thoughts? Your input will help us focus future improvements where they can be most helpful to you.

**Take survey now.**

This survey will be available through the end of September 2019. Thank you for sharing your opinions. Your responses will be confidential.

## Sign up for additional training webinars

Provider Experience is continuing its series of training webinars for health care providers and staff. The webinars are designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

Here's how to register for upcoming training webinars:

Webinar name	Date and time	Registration
Blues 201 – AIM Specialty Health®	Tuesday, Sept. 24, 10 to 11 a.m.	<a href="#">Click here</a> to register
Blues 201 – AIM Specialty Health®	Thursday, Sept. 26, 1:30 to 2:30 p.m.	<a href="#">Click here</a> to register

The October sessions focus on the claims and appeals process for Blue Cross Blue Shield of Michigan, Blue Care Network, Medicare Plus Blue and BCN Advantage facility and professional claims.

Webinar name	Date and time	Registration
Blues 201 – Claims Appeal Overview	Tuesday, October 15, 9:30 to 11:30 a.m.	<a href="#">Click here</a> to register
Blues 201 – Claims Appeal Overview	Tuesday, October 15, 1:30 to 3:30 p.m.	<a href="#">Click here</a> to register
Blues 201 – Claims Appeal Overview	Tuesday, October 22, 9:30 to 11:30 a.m.	<a href="#">Click here</a> to register
Blues 201 – Claims Appeal Overview	Tuesday, October 22, 1 to 2 p.m.	<a href="#">Click here</a> to register

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

# Network Operations

**Cover Story**

**Network Operations**

**BCN Advantage**

**Patient Care**

**Behavioral Health**

**Quality Counts**

**Pharmacy News**

**Billing Bulletin**

**Referral Roundup**

**Index**



## Reminder: Update your *Provider Authorization* form when you have changes

Blue Cross Blue Shield of Michigan is dedicated to safeguarding the protected health information of our members. These safeguards include the completion of a *Trading Partner Agreement and Provider Authorization* form as part of the electronic data interchange setup process. All EDI trading partners must complete a *TPA and Provider Authorization* form before exchanging any PHI with Blue Cross.

Terms of the TPA require you to notify Blue Cross of any changes in your trading partner information. If you switch service bureaus (clearinghouses), software vendors, billing services or the recipient for your 835 files, you must update your Provider Authorization form. Updating the form ensures information is routed to the appropriate destination. No update is needed when your submitter and trading partner IDs don't change.

You should review your provider authorization information if you've:

- Joined a new group practice
- Left a group practice and now bill using your own NPI
- Hired a new billing service
- Started submitting claims through a clearinghouse or you've changed clearinghouses
- Decided you no longer want to receive 835 remittance files
- Selected a new destination for your 835s

You must update your *Provider Authorization* form if you'll be sending claims using a different submitter ID or routing your 835s to a different unique receiver or trading partner ID. To make changes to your EDI setup, visit [bcbsm.com/providers](http://bcbsm.com/providers) and follow these steps:

- Click on *Quick Links*.
- Click on *Electronic Connectivity (EDI)*.
- Click on *How to use EDI to exchange information with us electronically*.
- Click on *Update your Provider Authorization Form* under EDI Agreements.

If you have any questions about EDI enrollment, contact the EDI Help Desk at 1-800-542-0945. For assistance with *TPA and Provider Authorization* form, select the *TPA* option.

## How to submit authorization request for transgender services for University of Michigan employees

In the last issue of *BCN Provider News* we told you we've expanded BCN medical coverage for transgender employees of the University of Michigan, effective July 1. This applies to members covered by U-M Premier Care and GradCare plans.

You can identify BCN members who are eligible for these services by their group number, which is 00124316. The number is on the front of their University of Michigan-branded ID cards. As always, be sure to check web-DENIS for benefits and eligibility.

### Submitting authorization requests

These new services require authorization. Use the e-referral system to submit authorization requests.

One of the following questionnaires will open in the e-referral system when you submit these authorization requests:

- Face and neck hair removal
- Facial feminization surgery/chondrolaryngoplasty

Preview questionnaires are available on the [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website, on BCN's **Authorization Requirements & Criteria** page. We encourage you to use these preview questionnaires to prepare your answers in advance.

For more details, see the University of Michigan **fact sheet on health plan coverage for gender-affirming services**.

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



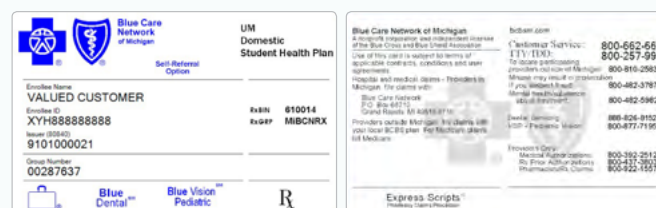
## Blue Care Network offers new University of Michigan student health plan

Blue Care Network is offering two new plans for University of Michigan students and their eligible dependents. The U-M Student Health Plan for domestic students was effective Aug. 24. The plan for international students is effective Sept. 1. Both use the self-referral option where members can seek care in or out of network without a referral.

We assign a University Health Service primary care physician to domestic students on the Ann Arbor campus. We assign all other students to a primary care physician based on proximity to their ZIP code. Any medical care received using an out-of-network provider will result in a higher cost share for the student.

These plans also include a unique pharmacy benefit that has minimal authorization requirements for most covered drugs (international plan only), adult dental coverage and vision-exam-only coverage. Vision exam coverage is administered through the medical benefit and not a stand-alone vision product.

Students with this plan will receive a BCN member ID card shown here. You can check the member's eligibility on web-DENIS, by calling Provider Inquiry or through an electronic 270/271 transaction.



## Order Blue Cross mobile app supplies for your office

Our Blue Cross mobile app kit helps you spread the word to patients about the conveniences of using the Blue Cross mobile app.

### What's in the kit

The kit includes postcards you can hand out to patients, an acrylic stand for the postcards and a poster to display in your lobby or exam rooms. If you already have a kit and need to reorder posters or postcards separately, you can do that, too.

### What's great about the app

The app easily connects Blue Cross Blue Shield of Michigan and Blue Care Network members securely to their personal online account. Right there in your office, they can:

- Access their virtual ID card and share it with you
- Check copayment amounts
- Help your medical assistants or nursing staff verify current prescriptions (if they have pharmacy coverage)

The app also gives patients the tools they need — instead of calling you — when they need to:

- Find network doctors or specialists
- Verify the status of referrals and authorizations
- Check what's covered
- Review their claims before paying your bill

### Order your supplies today and start spreading the word.

See related article, "Help members share their Blue Cross ID cards through our mobile app," about the mobile app in the **July-August issue**, Page 7.



*Mobile app supplies*



## We're waiving cost share for certain drugs for BCN Advantage Prestige members

BCN Advantage<sup>SM</sup> is waiving the member cost share for certain drugs classes for BCN Advantage HMO-POS Prestige members diagnosed with coronary artery disease and congestive heart failure. This will be effective Jan. 1, 2020.

This initiative is a continuation of a pilot with the Centers for Medicare & Medicaid Services that we began in 2019 as part of the CMS' value-based insurance design efforts. The waiver of cost share for drugs associated with congestive heart failure is a new initiative.

We'll identify members for the program based on diagnosis and mail a letter informing members that we've enrolled them in a care management program. Members can opt out of care management, but they'll still receive their eligible prescriptions with no cost share.

For coronary artery disease, we're waiving the cost share for four drug classes: antiplatelet drugs, statins, ACE/ARBs and beta-blockers for members diagnosed under one of 59 ICD-10 codes.

For congestive heart failure, we're waiving the cost share for these drug classes: ACE/ARBs, beta-blockers, diuretics, vasodilators and some other drugs for members diagnosed under one of 24 ICD-10 codes.

### About the VBID program

Through the Value-Based Insurance Design model, CMS is testing a broad array of complementary Medicare Advantage health plan innovations designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, and improve the coordination and efficiency of health care service delivery.

### We're offering incentives to BCN Advantage Prestige members to participate in advance care planning

We're also piloting a program to promote advance care planning through the VBID program.

As part of the medical record documentation, physicians must document whether a member has an advance directive. BCN Advantage<sup>SM</sup> Prestige members who have an advance directive and complete an online program about end of life choices will receive a \$25 gift card.

We're working with Welvie<sup>SM</sup>, a vendor involved with some of our other health and wellness programs, to administer this program.

## New advanced illness and frailty exclusions for HEDIS star measures

The National Committee for Quality Assurance now allows patients to be excluded from select HEDIS<sup>®</sup> star quality measures due to advanced illness and frailty. They acknowledge that measured services most likely would not benefit patients who are in declining health.

You can now submit claims with advanced illness and frailty codes to exclude patients who meet the criteria from select measures. Using these codes also reduces medical record requests for HEDIS data collection purposes.

For a description of the criteria and a convenient list with some of the appropriate HEDIS-approved billing codes, see the PDF below to view the *2019 HEDIS<sup>®</sup> Advanced Illness and Frailty Exclusions Guide*.

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



*Advanced illness and frailty exclusions*

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



## Process changes for the NOMNC and DENC forms affect skilled nursing facilities

We have changed the processes for completing the Notice of Medicare Non-Coverage form, known as the NOMNC, and the Detailed Explanation of Non-Coverage form, known as the DENC. Both forms are required by the Centers for Medicare & Medicaid Services for Medicare Advantage members.

### Here's what's changing:

- naviHealth will now complete the NOMNC form and provide it to the skilled nursing facility prior to each member's termination of services. The skilled nursing facility will continue to be responsible for delivering the form to the member.
- When the member appeals the termination of services decision, naviHealth will complete the DENC form and provide it to the skilled nursing facility. The facility will continue to be responsible for delivering the form to the member. naviHealth will also obtain the medical records and the valid signed NOMNC from the skilled nursing facility and send these documents, along with the DENC to the Quality Improvement Organization.

We hope these changes will help you comply with these government regulations.

### Additional information you need to know

It is crucial for skilled nursing facilities to deliver the NOMNC and DENC forms in a timely manner. Failure of the facility to deliver the NOMNC to the member may result in the provider being held financially liable for the continued services until two days after the member receives a valid notice, or until the effective date of the valid notice, whichever is later, per **CMS 100-04 Chapter 30 §260.3.6**. Providers may not balance bill the member for these services.

### Background information

Skilled nursing facilities must notify Medicare beneficiaries about their right to appeal a termination of services decision by complying with the requirements for providing the NOMNC form, including the time frames for delivery.

A valid DENC must be provided to the Quality Improvement Organization when the QIO notifies the facility about an appeal of a termination of the skilled nursing facility services. The DENC must be issued to the member and returned to the QIO, along with the requested supporting documentation, within the established time frame set forth by the QIO in the notification to the provider of the appeal.

Copies of the NOMNC and DENC forms and instructions are available at the **CMS website**.

We're adding medications to the BCN Advantage and Medicare Plus Blue PPO Part B specialty prior authorization drug list

See article on **Page 29**.

## We're discontinuing the Provider Distinction Awards program

Blue Cross Blue Shield of Michigan and BCN have administered the Provider Distinction Awards program since 2014. This program recognized providers for their contributions to our Medicare Advantage star quality ratings by placing plaques in provider practices honoring those practices achieving 80% or above on the Centers for Medicare & Medicaid Services' star quality measures.

Senior Health Services has decided to discontinue the Provider Distinction Awards program. This difficult decision was based on the amount of effort and costs associated with administering the program, particularly in light of the continuing growth in the number of program recipients and increasing complexity of data analysis.

Although we'll no longer distribute plaques to high-performing offices, we remain appreciative of the high-quality care that our physician practices deliver to our members, helping us achieve our annual star ratings.



# Livanta LLC Replaces KEPRO as BFCC-QIO For Medicare regions 2, 3, 5, 7 and 9

Livanta LLC replaced KEPRO as BFCC-QIO (Beneficiary and Family Centered Care-Quality Improvement Organization) serving Medicare Regions 2, 3, 5, 7 and 9, effective June 8, 2019. Livanta’s contact information is listed below.

Note: All related Medicare Beneficiary Notices should be updated to include the phone number and the address listed below:

Livanta LLC  
 9000 Junction Drive, Suite 10                      1-888-524-9900  
 Annapolis Junction, MD 20701                      Fax: 1-833-868-4059

Please note that although Livanta now services the regions listed above, some regions will continue to be serviced by KEPRO. KEPRO will continue to retain beneficiary appeals and quality-of-care reviews on a regional basis for Medicare Regions 1, 4, 6,8 and 10. Information for Medicare regions is listed below.

Region	Address	Contact
<b>1</b> (CT, ME, MA, NH, RI, VT)	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	1-888-319-8452 1-833-868-4055 (fax)
<b>2</b> (NJ, NY, PR, VI)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	1-866-815-5440 1-833-868-4056 (fax)
<b>3</b> (DE, DC, MD, PA, VA, WV)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	1-888-396-4646 1-833-868-4057 (fax)
<b>4</b> (AL, FL, GA, KY, MS, NC, SC, TN)	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	1-888-317-0751 1-833-868-4058 (fax)
<b>5</b> (IL, IN, MI, MN, OH, WI)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	1-888-524-9900 1-833-868-4059 (fax)
<b>6</b> (AR, LA, NM, OK, TX)	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	1-888-315-0636 1-833-868-4060 (fax)
<b>7</b> (IA, KS, MO, NE)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	1-888-755-5580 1-833-868-4061 (fax)
<b>8</b> (CO, MT, ND, SD, UT, WY)	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	1-888-317-0891 1-833-868-4062 (fax)
<b>9</b> (AZ, CA, HI, NV, Pacific Islands)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	1-877-588-1123 1-833-868-4063 (fax)
<b>10</b> (AK, ID, OR, WA)	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	1-888-305-6759 1-833-868-4064 (fax)

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





# Oncology management program effective for Medicare Advantage plans in January

A new utilization management program for medical oncology drugs for Medicare Plus Blue<sup>SM</sup> PPO and BCN Advantage<sup>SM</sup> members will begin in January 2020. Providers will need to obtain authorizations from AIM Specialty Health<sup>®</sup> for some medical oncology and supportive care medications.

This program became effective for BCN HMO<sup>SM</sup> (commercial) members in August 2019. It includes the following benefits:

- Synchronization with Blue Cross Blue Shield of Michigan and Blue Care Network’s medical policies
- 24/7 access to the AIM *ProviderPortal*<sup>SM</sup> for automated clinical appropriateness review and access to the AIM contact center personnel, including oncology nurses and oncologists, during business hours
- Actionable information — Includes a comprehensive set of current, evidence-based AIM Cancer Treatment Pathways for more than 80 clinical scenarios
- Enhanced reimbursement — Receive enhanced reimbursement by choosing an AIM Cancer Treatment Pathway regimen, when clinically appropriate (to be billed using designated S-codes)

Providers can view a list of medications managed by AIM on our [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website.

## Join a webinar to learn more

Learn about the new medical oncology program and how to use the AIM *ProviderPortal*<sup>SM</sup> by attending a webinar (intended for non-clinical provider staff).

To attend a webinar, click on your preferred date and time below and then click *Add to my calendar*. (The times below are all Eastern time. If the link opens for you in Pacific time, just save it to your calendar and it should automatically change to Eastern time.)

- |                                          |                                           |                                                 |
|------------------------------------------|-------------------------------------------|-------------------------------------------------|
| <b>Thursday, Oct. 24, 9 to 10 a.m.</b>   | <b>Thursday, Dec. 12, 9 to 10 a.m.</b>    | <b>Thursday, Jan. 9, 2020, 9 to 10 a.m.</b>     |
| <b>Wednesday, Nov. 6, noon to 1 p.m.</b> | <b>Wednesday, Dec. 18, noon to 1 p.m.</b> | <b>Wednesday, Jan. 22, 2020, noon to 1 p.m.</b> |
| <b>Thursday, Nov. 21, 9 to 10 a.m.</b>   |                                           |                                                 |

Clinicians are encouraged to learn more at [aimspecialtyhealth.com/oncology](http://aimspecialtyhealth.com/oncology) and to view a short video that describes the need for clinical pathways and how these were developed. Click on the link to the video and use AIMONCOLOGY as the password to view the video – **Clinician Overview – Medical Oncology Program video**, running time 11 minutes, 47 seconds.

We’ll be providing additional information as we approach the effective date.

AIM Specialty Health<sup>®</sup> has started managing medical oncology and supportive care drugs for BCN HMO<sup>SM</sup> (commercial) members starting Aug. 1, 2019. If you missed the webinars, there’s one left on Tues., Sept. 10, from 9 to 10 a.m. Click [here](#) to register.



# Important information about Medicare Advantage SNF post-payment audit and recovery process

For skilled nursing facilities, the post-payment audit and recovery process for Medicare Plus Blue<sup>SM</sup> PPO and BCN Advantage<sup>SM</sup> members is changing. Here’s some information you need to know.

- HMS<sup>®</sup> will no longer perform post-payment SNF audits for dates of service on or after June 1, 2019, for Medicare Plus Blue claims.

Note: BCN Advantage SNF claims haven’t been subject to post-payment audits.

- As we communicated on April 5, 2019, naviHealth will authorize Resource Utilization Group, or RUG, levels during the patient’s stay (from preservice through discharge) for SNF admissions with dates of service **through Sept. 30, 2019**, for Medicare Plus Blue and BCN Advantage members. naviHealth will work with SNFs to ensure that the biller submits the appropriate RUG level for reimbursement.
- To align with Centers for Medicare & Medicaid Services payment methodology, naviHealth will authorize Patient-Driven Payment Model, or PDPM, levels during the patient’s stay (from preservice through discharge) for SNF admissions with service dates **on or after Oct. 1, 2019**, for Medicare Plus Blue and BCN Advantage members. naviHealth will work with SNFs to ensure the biller submits the appropriate PDPM level for reimbursement.
- On a quarterly basis, Blue Cross and BCN will review paid SNF claims to ensure that RUG or PDPM levels in the claims match the RUG or PDPM levels on the authorizations. If we find overpayments because RUG or PDPM levels on the claims don’t match RUG or PDPM levels on the authorizations, we will pursue payment recoveries as necessary.
- You won’t need to submit medical records during the quarterly post-payment review process.

## Providers should work closely with naviHealth

To ensure that SNF claims reflect the authorized RUG or PDPM level, you should work closely with naviHealth throughout the patient’s stay.

- Prior to discharge, a naviHealth care coordinator will work with your biller to verify that the authorized RUG or PDPM levels are submitted for reimbursement.
- If you have questions about the RUG or PDPM level that naviHealth authorized, contact naviHealth during the patient’s stay.
- When you submit SNF Medicare Advantage claims, make sure the RUG or PDPM levels on the claims match the RUG or PDPM levels on the authorization connected to the stay.

## Additional information

As a reminder, naviHealth started managing authorization requests for Medicare Plus Blue and BCN Advantage members admitted to post-acute care on or after June 1, 2019.

For details, see the **Post-acute care services: Frequently asked questions by providers** document.

# BCN Advantage

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## We're offering in home bone density testing for BCN Advantage members

We're offering in-home bone density testing for BCN Advantage<sup>SM</sup> members who meet certain criteria. This initiative is intended to help meet the Healthcare Effectiveness Data and Information Set, or HEDIS<sup>®</sup>, measure, "Osteoporosis Management in Women Who Had a Fracture." Our member outreach does not include those within the MPSERS or URMBS groups.

We're using a vendor, MedXM, to attempt to schedule eligible members for an in-home bone mineral density test. If the member doesn't schedule the test through the vendor, we contact the primary care physician to complete the test. If the member or physician doesn't respond to MedXM's attempts to contact them, we reach out directly to the member to encourage them to complete the testing in their home with a Blue Cross Blue Shield of Michigan nurse or technician. (There are geographic limitations with in-home testing.)

If a MedXM technician or a Blue Cross nurse completes the bone mineral density screening, we'll send a copy of the results to both the member and her primary care physician.

Members who are covered under the HEDIS measure are women ages 67 to 85 who have recently had a fracture and have not had an osteoporosis medication prescribed or a bone mineral density screening within six months of the fracture date.

The 2019 Quality Rewards Program includes the Osteoporosis Management in Women Who Had a Fracture measure. The payout includes \$100 per service completed for each eligible member after the provider reaches an overall 78% quality score in this measure. The provider will earn the payout regardless of who completes the bone mineral density test, or if the member fills an approved osteoporosis prescription from her doctor.

For more information on osteoporosis, see the article titled, "Talk with your patients about osteoporosis," on **Page 13** of this issue.

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

## We're calling select Medicare Part D members to discuss their medications

Blue Cross Blue Shield of Michigan pharmacists have been calling select Medicare Part D members through August to educate members about the importance of taking their medications as prescribed.

We've been contacting members who aren't taking their medications, based on claims data that shows their prescriptions haven't been filled.

Pharmacists will review medications related to the following star measures:

- Statin Therapy for Patients with Cardiovascular Disease
- Diabetes Care — Kidney Disease Monitoring
- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension (RAS antagonists)
- Medication Adherence for Cholesterol (Statins)
- Statin Use in Persons with Diabetes

This campaign is being conducted to support our pharmacy measures within the Centers for Medicare & Medicaid Services' star ratings system.

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



## Talk with your patients about osteoporosis

Many people don't know they have osteoporosis until they suffer a fracture. That's why it's important to maintain ongoing conversations with your older patients about the risks of falls and the benefits of osteoporosis screening.

### Starting the conversation

- Proactively evaluate the risk of falls with older patients at each office visit:
  - Ask your patients if they've fallen or had issues with balance and walking.
  - As appropriate, suggest:
    - » A cane or walker
    - » An exercise program
    - » Vision testing
  - Assess the potential causes such as medications.
  - Consider the need for vitamin D supplementation.
- For women age 65 and older, reinforce the importance of screening for osteoporosis with bone mineral density testing. This test is the only one that can diagnose osteoporosis.
- For women age 67 and over who've already incurred a fracture, order a bone mineral density test and prescribe an osteoporosis medication within six months of the fracture. Do this unless BMD testing was done within two years of the fracture or osteoporosis treatment has occurred 12 months before the fracture.

### Checking on osteoporosis care

HEDIS® star measures, including the Health Outcomes Survey, evaluate osteoporosis care and the risk of falls.

- HEDIS measures:
  - The Osteoporosis Management in Women Who Had a Fracture Measure. This measure assesses the percentage of women age 67 and older who had a bone mineral density test or treatment for osteoporosis within six months of a fracture.

- » Patients who had bone mineral density testing two years prior to a fracture or osteoporosis treatment 12 months before the fracture are excluded.
- The Risk of Falls measure assesses the percentage of members 65 and older who:
  - » Were seen by a practitioner in the past 12 months
  - » Discussed falls or problems with balance or walking with their current provider
- The Health Outcomes Survey asks patients:
  - Have you ever had a bone mineral density test to check for osteoporosis?
  - Has your doctor discussed the risk of falls, how to prevent falls or how to treat problems with balance or walking?

### For more information

The U.S. Preventive Services Task Force [webpage on osteoporosis](#) indicates that doctors should screen all women age 65 and older for osteoporosis.

The American College of Physicians published evidence-based [osteoporosis treatment guidelines](#) in the Annals of Internal Medicine on May 9, 2017. The group recommends that doctors offer pharmacologic therapy to reduce the risk for hip and vertebral fractures in women with known osteoporosis.

You can also check out the Centers for Disease Control and Prevention's [Older Adult Falls](#) webpage.

See the article titled "We're offering in-home bone density testing for BCN Advantage members," on [Page 12](#).

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



## Physicians should recommend physical activity to older patients

One in three older adults falls every year and these falls threaten the lives, independence and health of these adults. Twenty to 30% of those adults who suffer moderate to severe injuries after experiencing a fall will find it harder to get around or live independently. Falls also increase the risk of an early death.

One out of every five falls causes a serious injury such as a broken bone or head injury. The most common cause of traumatic brain injury is a fall.

People who fall but don't experience an injury may develop a fear of falling which may cause many to limit their activities. This can lead to reduced mobility and loss of physical fitness which increases their actual risk of falling.

One of the most important things providers can recommend to their older patients is physical activity.

There are four types of exercise that encompasses all the benefits of physical activity: endurance, strength, balance and flexibility. It's important to remind patients to start out slowly and build up to more activity and increase the intensity of activity. Exercising shouldn't cause pain or cause someone to become tired. Many local fitness centers, hospitals, churches, religious groups, senior/civic centers, parks, recreation associations, YMCAs, YWCAs or even shopping malls have exercise, wellness or walking programs.

The following list includes some groups you can recommend to older patients looking for information about physical activity:

- American College of Sports Medicine  
1-317-637-9200  
[www.acsm.org](http://www.acsm.org)
- Centers for Disease Control and Prevention  
1-800-232-4636 (toll-free)  
1-888-232-6348 (TTY/toll free)  
[www.cdc.gov](http://www.cdc.gov)
- National Library of Medicine  
Medline Plus  
*Exercise for Seniors*  
*Exercise and Physical Fitness*  
[www.medlineplus.gov](http://www.medlineplus.gov)
- President's Council on Fitness, Sports and Nutrition  
1-240-276-9567  
[www.fitness.gov](http://www.fitness.gov)

**For more information contact:**

National Institute on Aging Information Center  
1-800-222-2225 (toll-free)  
1-800-222-4225 (TTY/toll-free)

[www.nia.nih.gov](http://www.nia.nih.gov)  
[www.nia.nih.gov/Go4Life](http://www.nia.nih.gov/Go4Life)





## Save the date: You're invited to a Stars Premiere event near you

This year, Blue Cross Blue Shield of Michigan's Quality and Provider Education team and the Customer Experience team are inviting you to a special production called the Stars Premiere.

Don't miss this opportunity to join us to hear about and experience the latest and greatest ideas for providing exceptional patient experiences. The event will include information about the Medicare Star Rating System, HEDIS® measures, the Health Outcomes Survey and much more.

The Stars Premiere will be held in theaters around the state. When you attend, you can earn Continuing Education Unit credits and participate in a highly engaging 90 minutes of conversation and activities. We'll also include important information about closing gaps in care immediately following the event. Plus, you'll be able to take away tools and tips designed to help your office improve patient satisfaction.

### What to expect

You'll be able to choose from either the 8 a.m. or 11 a.m. session, depending on your area of interest. There will be morning refreshments and movie popcorn. The schedule of events is:

- **8 a.m. session**
  - 8 to 9:30 a.m.: Patient experience and satisfaction session for physicians, office managers and other patient experience leaders
  - 9:30 to 10:45 a.m.: HEDIS, HOS, CAHPS and Stars update session for physicians, office managers and other staff who work to close gaps in care
  - **Note:** Arrive at 7:45 a.m. for refreshments.
- **11 a.m. session**
  - 11 a.m. to noon: ICD-10 for coders, billers and others interested in coding
  - **Note:** Arrive at 10:45 a.m. for refreshments.

### Locations and registration

Tentative dates and locations (subject to change) are below. To register, click on the links. **Note:** You won't be able to register until Aug. 1. Each person must register.

- Tuesday, Sept. 17: Lansing, Celebration! Cinema Lansing & IMAX ; 200 E Edgewood Blvd
  - **8 a.m. session**
  - **11 a.m. session**
- Wednesday, Sept. 18: Grand Rapids, Celebration! Cinema Grand Rapids North and IMAX; 2121 Celebration Dr NE
  - **8 a.m. session**
  - **11 a.m. session**
- Thursday, Sept. 19: Traverse City, AMC Cherry Blossom 14; 3825 Marketplace Cir
  - **8 a.m. session**
  - **11 a.m. session**
- Tuesday, Sept. 24: Sterling Heights, AMC Forum 30; 44681 Mound Rd.
  - **8 a.m. session**
  - **11 a.m. session**
- Wednesday, Sept. 25: Saginaw (Frankenmuth) Address available upon registration
  - **8 a.m. session**
  - **11 a.m. session**
- Thursday, Sept. 26: Ann Arbor, GQT Quality 16; Quality 16, 3686 Jackson Rd.
  - **8 a.m. session**
  - **11 a.m. session**

# Patient Care

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



## Blue Cross Coordinated Care to launch in 2020

Blue Cross Blue Shield of Michigan and Blue Care Network will launch a new approach to care management next year, called Blue Cross Coordinated Care.

The program takes a holistic, member-centric approach to help ensure the greatest effect on our members' overall health and the cost of care. It will be deployed across all lines of business, including Blue Cross PPO, BCN HMO<sup>SM</sup>, group and individual customers and Medicare Advantage members.

The program's goal is to support health care providers in their efforts to provide the best possible care for patients. It's not intended to replace the doctor-patient relationship in any way. Keep in mind that the **Provider-Delivered Care Management** program, which is part of Value Partnerships, will continue.

Specially designated nurse care managers will lead multidisciplinary teams to:

- Help patients understand their treatment plan and options
- Answer any questions they may have regarding their chronic conditions
- Help coordinate their care with you and other health care providers, including pharmacists, behavioral health clinicians and social workers
- Assist in getting additional resources they may need for their specific health care needs, such as transportation
- Provide co-management assistance for members in provider-delivered care management, if necessary

For more details, see the **column** by Drs. Aaron Friedkin and Duane DiFranco and Ann Baker in the May-June 2019 issue of *Hospital and Physician Update*.

## Opioid refusal form available for members on Blue Cross website

In the **July-August issue**, we told you about a form that patients can sign if they don't want their doctors to prescribe opioids to them.

The law that went into effect in late March allows patients to refuse opioids by placing a letter in their medical file.

There are exceptions in the law, including a provision that a prescriber or a nurse under the order of a prescriber may administer an opioid if it's medically necessary for treatment.

Blue Cross has made the form available on our website so members can print, sign and give to their doctors for their permanent medical records.

- Tell patients to log in to the member portal of **bcbsm.com**. Then click on *Forms*.
- The nonopioid directive form is under Managing My Account.







# CMS to approve grants for substance use disorder treatment funding

The Centers for Medicare & Medicaid Services recently released a notice of funding opportunity for state agencies to apply for planning grants that will aid treatment and substance use disorders. At least 10 states will be approved for this grant; awards totaling \$55 million will be used over the span of the 18-month program. After the completion of the initial program, five states will be selected to carry out the program further to a 36-month demonstration.

Planning grants will focus on:

- Increasing the capacity of Medicaid providers
- Improving reimbursements and expanding the number or treatment capacity of Medicaid providers
- Recruitment, training, and technical assistance for recovery services

The grant builds upon CMS’s approach to combat the opioid crisis (see the **CMS Roadmap**) which includes:

1. Prevention
  - a. Identify and stop the over-prescribing of opioids.
  - b. Enhance the diagnosis of opioid use disorder to get support for people who need it.
  - c. Promote effective, non-opioid pain treatments.
2. Treatment
  - a. Ensure access to treatment across CMS programs and geography.
  - b. Give patients options for a broader range of treatments.
  - c. Support innovation through new models and best practices.
3. Data
  - a. Understand opioid use patterns across populations.
  - b. Promote sharing of actionable data.
  - c. Monitor trends to assess impact of prevention and treatment efforts.





## Battling the opioid epidemic: A roundup of recent news and information

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

### Statewide partners commit \$5 million for programs to treat opioid addiction

Gov. Gretchen Whitmer and the Michigan Opioid Partnership announced in June that a combination of public and private funds totaling \$5 million in grants will support programs for people with opioid use disorder. Grants will fund the planning, training and coordination of treatment for opioid use disorder, including the use of medication-assisted treatment.

Two hospital systems across the state will receive grants to pilot projects designed to help change the culture in hospitals to better combat the opioid epidemic: Beaumont Hospital and Munson Medical Center. The hospitals will receive grants of more than \$1.3 million for projects that utilize medication-assisted treatment in partnership with outpatient treatment providers. Additional hospital grants are expected to be announced in the coming months.

For complete details, see the [MI Blues Perspectives blog](#).

### 2019 Opioid Progress Report released

The American Medical Association has released its **2019 Opioid Progress Report** — the third year that the AMA has reported on actions that physicians have taken to help end the nation's opioid epidemic. The report shows significant decreases in opioid prescribing as well as increases in the use of prescription drug monitoring programs and naloxone prescriptions. Here are some key findings:

- Opioid prescriptions decreased 33% between 2013 through 2018 from 251.8 million to 168.8 million.
- Health care professionals made more than 462 million prescription drug monitoring programs queries in 2018, up from 61.4 million in 2014.
- More than 66,000 physicians and other health care professionals have a federal waiver to prescribe buprenorphine in the office for the treatment of opioid use disorder — an increase of more than 28,000 since 2016.

In addition to the national data, the AMA also released state-level data for opioid prescribing and **PDMP use**.

### Follow MQIC blood lead testing guidelines

Michigan Quality Improvement Consortium guidelines recommend blood lead level testing at ages 9 months and 18 months. The **guidelines** are at the Michigan Quality Improvement Consortium website.

The Michigan Department of Health and Human Services has a Lead Poisoning Prevention Program that provides education and outreach regarding lead hazards and the effects of lead poisoning. Prevention strategies are included in a state work plan for preventing childhood lead poisoning. It also offers information on the number of children with elevated blood lead levels and the percentage of children tested. The program includes training on in-office lead level testing, and a questionnaire on lead exposure.

For more information on this program, visit the [Michigan Department of Health and Human Services](#) website.

The Centers for Disease Control and prevention offers a **fact sheet** for parents and information on their **website** for providers.

# Patient Care

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Medical policy updates

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

### Noncovered services

- Radiofrequency ablation of peripheral nerves to treat pain including Coolief™ Cooled radiofrequency
- Genetic testing for FMR1 and FMR2 Variants (Including Fragile X and Fragile XE Syndromes)
- Genotype-guided warfarin dosing

### Covered services

- Artificial pancreas device systems
- Genetic testing — Assays of genetic expression in tumor tissue as a technique to determine prognosis in patients with breast cancer
- Drug testing of urine, oral fluids and hair
- Genetic testing — Expanded molecular panel testing of cancers to identify targeted therapies
- Genetic testing for hereditary hemochromatosis
- Reconstructive breast surgery / management of implants
- Reduction mammoplasty
- Genetic testing for FLT3, NPM1, CEBPA, IDH1 and IDH2 variants in acute myeloid leukemia
- Genetic testing — Molecular markers in fine needle aspirates (FNA) of the thyroid



Medical Policy Updates

## Criteria corner

*Blue Care Network uses Change Healthcare’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 Change Healthcare on various topics.*

### Question:

**For the General Medical – Respiratory criteria on episode day one in the Acute level of care, would a pigtail catheter satisfy the criteria requirement of a chest tube?**

### Answer:

Chest tube criteria can be applied for a pigtail drain when it is used to treat an acute issue and all rules and requirements for a criteria point can be met. Chest tube criteria should not be applied for a chest tube or fluid drainage system that is not being used for an acute issue. Chest tubes placed for long term use would not meet the intent of this criteria.

### Question:

**Within multiple subsets of the Acute Adult InterQual criteria, interventions or treatments require the administration of a volume expander. Would the administration of blood products with the intention of supporting the circulatory system meet this requirement?**

### Answer:

The note attached to the Volume Expander criteria helps to clarify its intent:

*“Volume expanders are fluids administered intravenously to increase circulatory volume. Studies have demonstrated that a balanced crystalloid solution (for example, lactated ringers) is preferable to colloid in restoration of intravascular volume. However, the type of fluid selected for administration should be based on patient specific factors. In order to apply criteria for volume expanders, there should be documentation of a volume deficit supported by clinical findings. The volume of infusion is patient specific and varies based on the cause of volume depletion, comorbid condition, and patient response. Criteria for volume expander should not be applied for maintenance intravenous fluids or electrolyte replacement.”*

When applying criteria for volume expanders, the documentation must support that the fluids are being given for the purpose of volume expansion.

Please see [Criteria corner](#), continued on Page 20

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

# Patient Care

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



**Criteria corner**, continued from Page 19

**Question:**

For criteria point 'Adult and Geriatric Psychiatry' - Inpatient - Ep. Day 2-13 and 14-X - ... - Acute Onset of Disorientation: Is the acuity of onset only after the member has been admitted, or could it be for the treatment episode?

For example, let's say that a member has been admitted to an inpatient psychiatric unit for a psychotic episode, and the symptoms include delusional thought content, auditory hallucinations and general disorientation to person/place/time. The member's baseline is absent disorientation and hallucinations. If we were to review the case on day four, would the acute onset of disorientation count as this is an acute episode, or would it not apply because the disorientation occurred before the 24 hours preceding the review?

**Answer:**

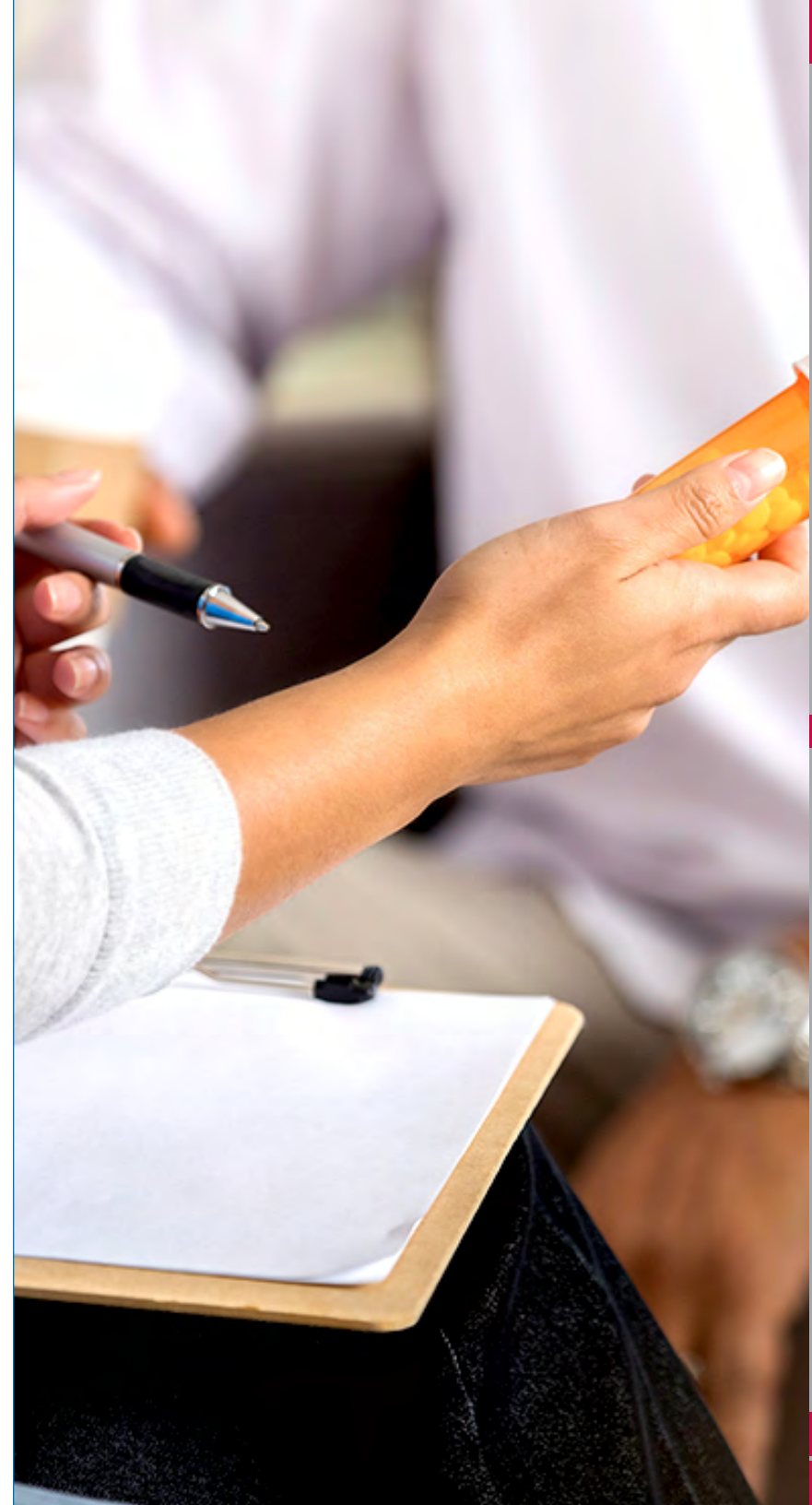
The patient's disorientation must be present within the last 24 hours, requiring continued stay.

**Question:**

If a medication is ordered by an attending psychiatrist, but the patient refuses to take it, would you say that it does or does not count for any of the 'Adult/Geriatric' or 'Child/Adolescent Psychiatry' - Inpatient - Ep. Day 2-13 or 14- ....Psychiatric Medication Evaluation criteria, either 'Medication Adjustment' or 'Medication Initiated'?

**Answer:**

The patient must receive the ordered interventions to meet criteria.



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

Behavioral Health

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



## Primary care physicians can help prevent suicide

By Kristyn Stewart, M.D.



Suicide rates have steadily risen since 2000, making suicide the tenth leading cause of death in the United States, claiming more than double the lives each year as homicides. Suicide was the second leading cause of death among individuals between the ages of 10 and 34, and the fourth leading cause of death among individuals between the ages of 35 and 54 in 2017, according to the National

Institute of Mental Health.

In addition to the emotional loss associated with suicide, there is also an economic loss as the burden falls most heavily on adults of working age. This leads to lost income, lost productivity and increased medical costs in the workforce. According to the Suicide Prevention Resource Center, the average cost of one suicide is \$1,329,553, and 97% of this cost is due to lost productivity.

The rates of suicide were highest for American Indian and Alaska Native males and females, followed by white males and females. While males are four times more likely to die by suicide, females are three times more likely to attempt suicide. The risk is further elevated in those with substance use disorders; they are six times more likely to complete suicide than those without substance use disorders.

In 2017, firearms were the most common method of death by suicide, accounting for a little more than half (50.57%) of all suicide deaths followed by suffocation (including hangings) at 27.72% and poisoning at 13.89%, according to the American Foundation for Suicide Prevention. Additional risk factors include mood disorders, past history of attempts and family history of suicide.

Suicide prevention in the primary care setting is essential given that up to 45% of individuals who die by suicide have seen their primary care physician within a month of their death and up to 67% of those who attempt suicide receive medical attention after an attempt, according to Substance Abuse and Mental Health Services Administration.

Primary care physicians have the potential to prevent suicides as well as connect patients to specialty care through collaboration or in partnership with behavioral health providers. Primary care physicians are increasingly asked to screen for a variety of health conditions, but often lack the capacity to take these screenings on.

However, there are brief screening tools for suicide risk and other mental health issues, such as depression, that can be completed by patients while in waiting areas. Providers can then review these self-reports to identify in advance those who may be at risk and need additional time at their office visit.

# Behavioral Health

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## From the medical director, *continued from Page 21*

These screening tools are easily implemented in an office setting. The burden needn't fall directly on the shoulders of physicians, as other health professionals can take on the task of screening individuals for depression, suicide and mental and substance use disorders.

Education regarding risk factors and warning signs can assist prevention. The following list of warning signs can help identify a person who may be at acute risk of taking his or her own life.

- Threatening to hurt or kill oneself, or talking of wanting to hurt or kill oneself
- Seeking access to firearms, available pills or other means
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary

The best way to prevent suicide is to use a comprehensive approach that includes these key components<sup>1</sup>:

- Establish protocols for screening, assessment, intervention and referral.
- Train all staff in suicide care practices and protocols, including safety planning and lethal means counseling.
- Create agreements with specific behavioral health practices that will take referrals.
- Ensure continuity of care by transmitting patient health information to emergency and behavioral health care providers to create seamless care transitions.
- Follow up with at-risk patients by phone between visits and provide information about the National Suicide Prevention Lifeline crisis line and services.

### Resources

There are multiple free toolkits available to primary care physicians to assist in this implementation and they contain educational materials, screens such as the PHQ-9 and additional resources. Several are listed below:

#### **Suicide Prevention Resource Center toolkit:**

<http://www.sprc.org/settings/primary-care/toolkit>

#### **Zero Suicide**

<http://zerosuicide.sprc.org/>

#### **Each Mind Matters Resource Center**

<https://emmresourcecenter.org/resources/training-resource-guide-suicide-prevention-primary-care-settings>

#### **National Suicide Prevention Lifeline**

<http://www.suicidepreventionlifeline.org>

1-800-273-TALK (8255), available 24 hours a day, seven days a week. The service is available to anyone. Calls are confidential.

<sup>1</sup>Suicide Prevention Resource Center: <https://www.sprc.org/settings/primary-care>

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

# Behavioral Health

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Blue Care Network offers office posters and tip sheets about depression

Depression is associated with high societal costs and greater functional impairment than some chronic diseases, including diabetes, according to the Centers for Disease Control and Prevention.

Primary care physicians treat 85% of patients with depression and are usually in the best position to screen and diagnose patients during annual exams. MQIC guidelines recommend that doctors screen adults 18 and older for depression annually.

Blue Care Network has a toolkit about depression for providers that includes an office poster and tip sheet about treating depression with step therapy. You can order the complete toolkit (which includes two posters, a tip sheet and 12 brochures for members) using the order form below.

You can order up to 50 brochures for members for your office waiting area. There's a separate line on the form to order only brochures.



*Depression tools order form*

## Michigan board-certified behavior analysts must be licensed starting Jan. 7, 2020, to be reimbursed by BCN and Blue Cross

Starting Jan. 7, 2020, board-certified behavior analysts practicing in Michigan must have a current license from the State of Michigan to be eligible for reimbursement from Blue Cross and Blue Care Network. BCBA's who are not licensed are not eligible for reimbursement for services provided on or after Jan. 1, 2020.

For information on the licensing process, refer to the **Behavior Analysts webpage** of the Michigan Department of Licensing and Regulatory Affairs website.



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



# Providers should discuss childhood immunizations with parents

Approximately 300 children in the United States die each year from vaccine-preventable diseases, according to the National Committee for Quality Assurance.

Childhood vaccines are crucial to help protect children from serious and potentially life-threatening diseases. It’s important for providers to continue to have conversations with parents about the importance of vaccines.

Below are the HEDIS® specifications for childhood immunizations.

- One Tdap (tetanus, diphtheria toxoids and acellular pertussis) vaccination between 10 and 13 years of age
- One meningococcal (serogroup A, C, W, or Y) vaccination between 11 and 13 years of age
- Two or three human papillomavirus (HPV) vaccinations between 9 and 13 years of age ; Either
  - Two HPV vaccinations (must be 146 days apart)
  - Three HPV vaccinations
- Four DTaP (diphtheria, tetanus, and acellular pertussis) vaccinations between 42 days old and 2 years of age
- Three IPV (inactivated polio vaccine) vaccinations between 42 days old and 2 years of age
- One MMR (measles, mumps, and rubella) vaccination between 1 and 2 years of age
- Three HiB (haemophilus influenza type B) vaccinations between 42 days old and 2 years of age
- Three hepatitis B vaccinations by 2 years of age.
- One VZV (varicella zoster) vaccination between 1 and 2 years of age
- Four pneumococcal conjugate vaccinations between 42 days old and 2 years of age
- One hepatitis A vaccination between 1 and 2 years of age
- Two or three rotavirus vaccinations between 42 days old and 2 years of age
  - Two doses of the two-dose rotavirus vaccine or
  - Three doses of the three-dose rotavirus vaccine
- Two Influenza vaccinations between 6 months and 2 years of age

## References

<https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases?topicid=23>

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

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



# Quality Counts

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Preventive cancer screenings

The National Committee for Quality Assurance HEDIS® measures include several cancer screening guidelines. They're listed below.

- Cervical cancer screening — Every three years for women age 21 to 64 or a cervical cancer screening and human papillomavirus (HPV) co-test every five years for women age 30 to 64
- Breast cancer screening — Every two years for women 50 to 74
- Colorectal cancer screening — Men and women 50 to 75  
All the following qualify:
  - Fecal occult blood test — Annually
  - Colonoscopy — Every 10 years
  - Flexible sigmoidoscopy — Every five years
  - CT colonography — Every five years
  - FIT (fecal immunochemical test) DNA — Every three years

For information on HEDIS measures and technical resources go to the [NCQA website](#).

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

## We're sending letters to members to remind them about preventive screenings and immunizations

Blue Care Network is sending gaps in care letters to members in October to encourage them to get recommended screenings and immunizations. The letters also include recommended immunizations for children and adolescents. This mailing doesn't include BCN Advantage<sup>SM</sup> members.

Members will receive one of the following screening letters based on their status. We send letters regardless of whether the member has a primary care physician on file with us.

- Screenings for adult members
- Immunizations for adolescents
- Immunizations for 0-to 2-year-olds

These gaps in care letters encourage members to be proactive about their health. They also help fulfill our responsibility to improve quality scores and encourage members to stay healthy and visit their doctors.





## We've added more vaccines to the pharmacy benefit

Eligible Blue Care Network and Blue Cross Blue Shield of Michigan commercial (non-Medicare) members now have coverage for additional vaccines under their pharmacy benefits, effective Aug. 1. This allows participating pharmacies to bill through the pharmacy claims processing system.

We've added the following vaccines to the pharmacy benefit:

- Tetanus, diphtheria
- Polio
- Measles, mumps, rubella
- Meningococcal B
- Varicella (chickenpox)

The program covers the same vaccines that are offered under the Vaccine Affiliation program, which are currently billed under the medical benefit. Listed here are the vaccines and age requirements covered under the pharmacy benefit.



Vaccine	Common name	Age requirements
Influenza virus	Flu	None
Havrix®	Hepatitis A	None
Vaqta®	Hepatitis A	None
Twinrix®	Hepatitis A & B	None
Gardasil®9	HPV	9 to 27 years old
Cervarix®	HPV	9 to 27 years old
Gardasil®	HPV	9 to 27 years old
M-M-R® II	Measles, mumps, rubella	None
Menveo®	Meningitis	None
Menactra®	Meningitis	None
Menomune®	Meningitis	None
Trumenba®	Meningococcal B	None
Bexsero®	Meningococcal B	None
Ipol®	Polio	None
Pneumovax 23	Pneumonia	None
Pneumococcal (PCV7)	Pneumonia	None
Prevnar 13®	Pneumonia	65 and older
Shingrix®	Shingles	50 and older
Zostavax®	Shingles	60 and older
Boostrix®	Tetanus, diphtheria and whooping cough	None
Adacel®	Tetanus, diphtheria and whooping cough	None
Tenivac®	Tetanus, Diphtheria	None
Varivax®	Varicella (chickenpox)	None

BCN and Blue Cross members' vaccines can be processed under both pharmacy benefits and medical plans but only one plan can be billed per claim. Both plans require a qualified administrator at a Blue Cross-participating pharmacy or medical office to give the vaccine.

- Qualified pharmacists giving the vaccine can bill one of the following:
  - The member's pharmacy plan
  - The member's medical plan when the pharmacy participates in the medical Vaccine Affiliation program
- Participating medical offices giving the vaccine should bill the member's medical plan.

Most BCN and Blue Cross commercial (non-Medicare) members with prescription drug coverage are eligible. Most of the vaccines will be covered with no out-of-pocket cost to members if their benefits meet the coverage criteria.

# Pharmacy News

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



## Vaccines, *continued from Page 26*

Grandfathered and retiree opt-out groups won't be part of this program. These groups will maintain their current vaccine coverage under their medical benefit.

Most Blue Care Network and Blue Cross members can search for a participating retail pharmacy by logging in to their member account at [bcbsm.com](http://bcbsm.com).

Here's what members need to do:

- After logging in, hover the mouse over *My Coverage* in the blue bar at the top of the page.
- Select *Prescription Drugs* from the drop-down menu.
- Scroll down to *Where to go for care*; then click on *Locate a retail pharmacy*. The link will take the member directly to Express Scripts®. They won't have to log in again.

Members can also **look up pharmacies** in our network. But they'll get the most up-to-date information by searching online through Express Scripts.

## Additional medical benefit specialty drugs have authorization and site-of-care requirements for BCN HMO members, effective Oct. 1

Effective Oct. 1, 2019, additional medical benefit specialty drugs have authorization and site-of-care requirements for BCN HMO<sup>SM</sup> (commercial) members. These changes **don't** apply to BCN Advantage<sup>SM</sup> members.

### Prior authorization requirements

For members initiating therapy on or after Oct. 1, 2019, you must request authorization for these drugs:

- Lemtrada® (alemtuzumab, HCPCS code J0202)
- Ocrevus® (ocrelizumab, HCPCS code J2350)
- Tysabri® (natalizumab, HCPCS code J2323)

Members who currently receive these drugs in one of the following locations are authorized to continue treatment through Sept. 30, 2020:

- Doctor's or other health care provider's office
- The member's home, from a home infusion therapy provider
- Ambulatory infusion center
- Hospital outpatient facility (Lemtrada and Tysabri **only**)

However, you'll need to request authorization for these members for therapy that begins on or after Oct. 1, 2020, for these services to be eligible for reimbursement.

### Site of care requirement for Ocrevus

Ocrevus will also be added to the Site of Care program, effective Oct. 1, 2019. If your patient currently receives Ocrevus infusions at an outpatient hospital facility, you may need to discuss other infusion options.

As part of our shared commitment to keeping health care affordable, we hope you'll join us in supporting our members as they move to new therapy locations.

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Specialty drugs, *continued from Page 27*

### List of requirements

For a list of requirements related to drugs covered under the medical benefit, see the **Requirements for drugs covered under the medical benefit – BCN HMO and Blue Cross PPO** document located on our [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website.

We'll update the requirements list to reflect the changes for these drugs.

Blue Care Network and Blue Cross Blue Shield of Michigan reserve the right to review for medical necessity prior to the effective dates. A prior authorization approval isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.

As a reminder, you can always find information about authorization requirements for these drugs on the **Medical Benefit Drugs — Pharmacy** page in the BCN section of the [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website.

## Quarterly update: Medical drug authorization and site-of-care requirements for BCN HMO and Blue Cross' PPO members

Blue Care Network and Blue Cross Blue Shield of Michigan encourage proper utilization of high-cost medications that are covered under the medical benefit. As part of this effort, we maintain a comprehensive list of requirements for drugs that are covered under the medical benefit for Blue Cross' PPO and BCN HMO<sup>SM</sup> (commercial) members.

Please see below for medical drugs that had authorization or site-of-care updates or both during April, May and June of 2019:

HCPSC code	Brand name	Generic name
J1599	Asceniv™	immune globulin
J0584	Crysvita®	burosumab-twza
J1599	Cutaquig®	immune globulin
J3590	Evenity®	romosozumab-aqqp
J0517	Fasenra™	benralizumab
J3245	Ilumya™	tildrakizumab-asmn
Q5103	Inflectra®	infliximab-dyyb
J3397	Mepsevii™	vestronidase alfa-vjvk
J1301	Radicava®	edaravone
J1745	Remicade®	infliximab
Q5104	Renflexis®	infliximab-abda
J3490*	Spravato™	Esketamine
J1746	Trogarzo™	ibalizumab-uiyk
J3590	Ultomiris™	Ravulizumab
J3590*	Zolgensma®	onasemnogene abeparvovec-xioi

\* This code will change to a unique code.

For a more detailed list of requirements related to drugs covered under the medical benefit, please visit the appropriate page on our [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website.

- BCN's **Medical Benefit Drugs — Pharmacy** page
- Blue Cross's **Medical Benefit Drugs — Pharmacy** page

The authorization requirements apply only to groups that are currently participating in the standard commercial Medical Drug Prior Authorization program for drugs administered under the medical benefit. These changes don't apply to BCN Advantage<sup>SM</sup> members, Medicare Plus Blue<sup>SM</sup> PPO or Federal Employee Program<sup>®</sup> members.

An authorization approval isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.

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



## We're adding medications to the BCN Advantage and Medicare Plus Blue PPO Part B specialty prior authorization drug list

For dates of service on or after Oct. 1, 2019, the following medications will require prior authorization for BCN Advantage<sup>SM</sup> and Medicare Plus Blue<sup>SM</sup> PPO:

- J1599 Asceniv<sup>TM</sup>
- J0584 Crysvisa<sup>®</sup>
- J1301 Radicava<sup>®</sup>
- J0565 Zinplava<sup>TM</sup>

### BCN Advantage

For BCN Advantage, we require prior authorization for these medications for the following sites of care when you bill the medications as a professional service or as an outpatient-facility service and you bill electronically through an 837P transaction or on a professional CMS-1500 claim form:

- Physician office (place of service code 11)
- Outpatient facility (place of service code 19, 22 or 24)
- Home (place of service code 12)

We also require prior authorization when you bill electronically through an 837I transaction or using a UB04 claim form for a hospital outpatient type of bill 013x.

### Medicare Plus Blue PPO

For Medicare Plus Blue, we require prior authorization for these medications for the following sites of care when you bill the medications electronically through an 837P transaction or on a professional CMS-1500 claim form:

- Physician office (place of service code 11)
- Outpatient facility (place of service code 19, 22 or 24)

### Important reminder

You must obtain authorization prior to administering these medications. Use the NovoLogix<sup>®</sup> online tool to quickly submit your authorization requests. It offers real-time status checks and immediate approvals for certain medications. Also note:

- For BCN Advantage, if you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix.
- For Medicare Plus Blue, you can fax an **Addendum P form** to gain access to the NovoLogix online tool.

## NovoLogix user interface enhancements coming soon

If you use NovoLogix<sup>®</sup> to submit prior authorizations for certain Part B medical specialty drugs, you'll soon see an enhanced user interface when you log in to the online tool. The enhancements will streamline the process of creating authorization requests.

The interface changes are minimal and easy to navigate, and you'll be able to switch between the current and enhanced interfaces while you adjust to the changes. We'll provide more information, such as user guides and training videos, as we get closer to the release date.

As a reminder, you can always find information about authorization requirements for these drugs on the [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website:

- Blue Care Network page: **Medical Benefit Drugs — Pharmacy page**
- Blue Cross page: **Medical Benefit Pharmacy Drugs — Pharmacy page**

# Pharmacy News

**Cover Story**

**Network Operations**

**BCN Advantage**

**Patient Care**

**Behavioral Health**

**Quality Counts**

**Pharmacy News**

**Billing Bulletin**

**Referral Roundup**

**Index**



## 2019 IVIG dosing strategy is changing, starting Oct. 1

Blue Care Network and Blue Cross Blue Shield of Michigan currently include immune globulin products in the prior authorization program under pharmacy and medical benefits for BCN HMO commercial and Blue Cross' PPO members. IVIG/SCIG products available for the medical benefit are also included in the Site of Care program.

Immune globulin replacement therapy is indicated for many labeled and off-label indications and traditionally is dosed using a patient's actual body weight. IVIG/SCIG (see list below) has been shown to have very little distribution into fat tissue and is only present in the intravascular space and extracellular fluids. Clinical literature supports alternative dosing strategies that provide comparable drug exposure without altering the clinical outcomes of treatment.

Drug name	HCPCS code
Asceniv™	J1599
Bivigam™	J1556
Carimune® NF	J1566
Cutaquig®	J1599
Cuvitru™	J1555
Flebogamma®	J1572
Gammagard® Liquid	J1569
Gammagard® S/D	J1566
Gammaplex®	J1557
Gamunex®-C	J1561
Hizentra®	J1559
Hyqvia®	J1575
Octagam®	J1568
Panzyga®	J1599
Privigen®	J1459

To minimize drug waste, reduce unnecessary drug exposure and decrease the risk of adverse events, we will update our dosing strategy for intravenous and subcutaneous immune globulin therapy.

Effective Oct. 1, 2019, we'll calculate doses using adjusted body weight for members who meet one of the following criteria:

- Body mass index is 30 kg/m<sup>2</sup> or greater
- Actual body weight is 20% to 30% higher than their ideal body weight

This applies to all members starting therapy on or after Oct. 1, 2019. Members currently receiving immune globulin will continue to receive their current dose until their prior authorizations expire.

This change does **not** apply to:

- Blue Cross' pediatric members 15 years old or younger
- Blue Cross' pediatric members 18 years old or younger weighing 50 kg or less
- Any member covered by Medicare Plus Blue<sup>SM</sup> PPO, BCN Advantage<sup>SM</sup> or the Federal Employee Program®

We're contacting members currently on IVIG/SCIG therapy to let them know about this change.





# Blue Cross and BCN launch new Preferred Drug List for group employees

Blue Cross Blue Shield of Michigan and Blue Care Network now offer the Preferred Drug List, a lower-cost drug formulary for self-funded and large group employees.

The Preferred Drug List offers therapeutically effective medications that have the greatest clinical value at the lowest net cost. Our Pharmacy and Therapeutics Committee of physicians and pharmacists reviews and approves medications based on clinical efficacy and safety. In addition, Blue Cross and BCN pharmacists review and update the drug list regularly to keep pace with the ever-changing prescription drug market.

Features of the **Preferred Drug List** include the following:

- Medications that have been selected for their clinical effectiveness, safety and maximized savings.
- Certain medications that do not provide greater clinical value than comparable or lower net-cost alternatives are excluded. Some examples include:
  - Medications with lower-cost generic equivalents
  - Medications with lower net-cost brand or lower-cost generic alternatives with the same therapeutic outcomes



# Pharmacy News

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



## All BCN commercial members are moving to the exclusive specialty pharmacy network effective Jan. 1

Effective Jan. 1, 2020, Blue Care Network commercial members are moving to the Exclusive Specialty Pharmacy network for specialty pharmacy medications and must fill specialty drugs through AllianceRx Walgreens Prime or their local Walgreens retail store. This program does not apply to specialty medications administered under the medical benefit and certain members may be exempted from this program.

You may be aware that some Blue Cross Blue Shield of Michigan and BCN commercial members have already transitioned to this exclusive specialty network in 2019; this change is now applicable to all BCN commercial members beginning in 2020. This change does not apply to Medicare Advantage members.

Starting in October, AllianceRx Walgreens Prime will contact your patients who are affected by this change and advise them to speak to you about getting new prescriptions. If your patients don't already use a local retail Walgreens store or AllianceRx Walgreens Prime home delivery for specialty medications, we'll send you a letter about this change and you'll need to give your patients new prescriptions before Jan. 1, 2020. Members with this Exclusive Specialty program may be responsible for the full cost of their drugs **if they do not use our exclusive provider.**

To set up your patient with AllianceRx Walgreens Prime home delivery, send the specialty medication prescription along with all pertinent patient demographic information such as full name, date of birth, allergy information, phone and insurance number, to AllianceRx Walgreens Prime by one of the following methods:

- Fax: **1-866-515-1356**
- Electronically: E-prescribing name is AllianceRx WALGREENS PRIME-SPEC-**MI**
- Phone: **1-866-515-1355**
- For more information, visit [alliancerxwp.com/hcp](http://alliancerxwp.com/hcp).

After AllianceRx Walgreens Prime receives the prescription, the pharmacy will need to contact your patient based on the information you provided and have the patient enroll with them before delivery can be arranged.

For a current list of specialty drugs in this program, go to [bcbsm.com/specialtydrug](http://bcbsm.com/specialtydrug). This list is updated monthly.





### What is a seizure and how does it differ from epilepsy?

A **seizure** occurs from an episode of a sudden, uncontrolled electrical disturbance in the brain. It can cause abnormal movements and changes in awareness and behavior lasting anywhere from a few seconds to several minutes. **Epilepsy** is a condition characterized by recurrent seizures with no clear underlying cause. **Status epilepticus** describes a seizure that lasts longer than five minutes, or when seizures occur close together and the patient doesn't recover consciousness in between.

Depending on the type of seizure, signs and symptoms may include the following:

- A staring spell
- Uncontrollable jerking movements of the arms and legs
- Loss of consciousness or awareness
- Cognitive or emotional symptoms, such as fear, anxiety or déjà vu
- Temporary confusion following a seizure (postictal state)

Seizures can be caused by many underlying conditions:

- Congenital abnormalities
- Head injuries
- Poisoning
- Stroke
- Brain tumor

### Documentation and coding tips

If known, provider documentation should specify the underlying cause of the seizure, such as:

- Low blood sugar
- Traumatic brain injury
- Alcohol or drug use, abuse, dependence or withdrawal

To assign a code properly, documentation of the seizure type is required. The following are a few common types of seizures:

- Tonic-clonic (grand mal)
- Myoclonic
- Atonic
- Tonic
- Clonic
- Absence (petit mal)

For greater specificity, providers should also document the status of the seizure:

- Intractable or not intractable
- Presence or absence of status epilepticus

Provider documentation must also include the treatment plan, if known, or plans to refer the patient to a neurologist or other specialist for treatment:

- Use of anti-convulsion medications such as carbamazepine, phenytoin, lamotrigine or levetiracetam
- Surgery
- Vagus nerve stimulation
- Responsive neurostimulation
- Deep brain stimulation

According to ICD-10-CM, a single seizure episode is classified to code R56.9, **unspecified convulsions**.

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

**Coding corner**, continued from Page 33

Epilepsy, or recurrent seizures, is classified to category G40. The ICD-10-CM coding system subcategorizes epilepsy even further:

- Generalized versus localized epilepsy
- Localized epilepsy with localized onset versus simple partial seizures

In addition, separate codes identify idiopathic versus symptomatic epilepsy with a fifth character to specify whether the seizures are intractable and a sixth character to identify the presence or absence of status epilepticus.

Some examples of seizure disorder codes appear in the chart below:

Condition	ICD-10 code
Unspecified convulsions (seizures)	R56.9
Post traumatic seizures	R56.1
Epilepsy, unspecified, not intractable, without status epilepticus (seizure disorder)	G40.909
Generalized idiopathic epilepsy and epileptic syndromes, not intractable with status epilepticus	G40.301
Localization-related (focal or partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus	G40.109
Absence epileptic syndrome, intractable, with status epilepticus	G40.A11
Absence epileptic syndrome, not intractable, without status epilepticus	G40.A09
Epileptic seizures related to external causes, not intractable, without status epilepticus	G40.509

**Sources:**

[www.mayoclinic.org](http://www.mayoclinic.org)

2019 ICD-10-CM Professional for Physicians

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

## Clinical editing billing tips

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

This issue's tip includes:

- Reporting and coding debridement codes
- Diagnosis code reporting



# Billing Bulletin

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



## Billing Q&A

**Question:**  
 I received an edit reducing the payment amount due to multiple procedure reduction. I attempted to submit a clinical edit appeal and it was returned. Can I appeal this edit?

**Answer:**  
 A multiple procedure reduction is not an appealable explanation code. The multiple procedure reduction is applied in accordance with Chapter 1 of the *National Correct Coding Initiative Policy Manual*. The claim line has been processed with the reduced payment due to several possible reasons. Some of these reasons may include: multiple surgeries, co-surgeons, surgical teams, assistant surgeons or multiple radiology or cardiac procedures. These services are often indicated by a modifier on the claim line. Because the modifier or claim information indicates a need for payment reduction following the NCCI policy manual, they are not subject to appeal.

**Question:**  
 I had a clinical edit appeals returned to me for invalid explanation codes. When I called Provider Inquiry, I was told to send a clinical edit appeal. What explanation code should I be using?

**Answer:**  
 Remittance advice notices contain different columns; some are related to claim information and others are payment information. The area on a remittance advice to review for a clinical edit is under the explanation column and BCN Code. This is the code to submit on the clinical edit appeal. A complete list of appealable codes can be found here:

- Log in to Provider Secured Services
- Go to *BCN Provider Publications and Resources*
- Click on Billing/Claims.
- Scroll down to Clinical Editing Resources.

Explanation		
BCN Code	Reason Code	Remark Code



**Question:**  
 I received a clinical denial that the units exceed the daily limit but there is a payment on the line stating the line was paid at 100%. Why was a clinical edit received that the units were exceeded?

**Answer:**  
 BCN has daily limits set for certain procedure or HCPCS codes. If the claim line exceeds that limit, the allowed units will pay; the additional units receive an “exceeds daily limit” edit. Payment for the additional units can be made through appeal.

Our old claims processing system split these denials into two lines: one paid and a second denied. This made it clear as to how many units were denied. This split was not available with the new system and therefore the line pays, but also receives the clinical edit exceeds daily limit.

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



## Proper taxonomy required for certain BCN claims

Blue Care Network requires that providers include the proper taxonomy on claims for certain services to BCN HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members, to facilitate correct reimbursement. This was effective Aug. 1.

This applies to the following types of claims:

- For home infusion therapy claims, use taxonomy 251F00000X.
- For ambulatory infusion center claims, use taxonomy 261QI0500X.
- For limited distribution pharmacy claims, use taxonomy 3336S0011X.

Your claims may be denied if you don't use proper taxonomy when submitting these claims to BCN.

Providers are already required to include proper taxonomy when submitting claims for these services when they are provided to Blue Cross' PPO (commercial) members.



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

# Referral Roundup

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



## Reminder: We made some changes to the e-referral home page

We made an update to the e-referral system home page earlier this year to improve its performance for Blue Cross Blue Shield of Michigan and Blue Care Network cases, including commercial and Medicare Advantage. The e-referral system home-page dashboard displays only new or updated cases from the previous 60 days.

### Important to know

*Your cases will display faster on the home page.* This is especially helpful if you typically have a lot of cases.

*We don't delete cases that are past the 60-day display frame.* You can access all your cases by searching for them with the reference number or the member's contract number.

Blue Cross and BCN will continue to make enhancements to the e-referral system to make it easier to use. Watch for future web-DENIS message and news items on the [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website.

## Contact eviCore for help in using the new eviCore provider portal for BCN PT, OT and ST authorizations

Need help submitting authorization requests or finding cases in the eviCore healthcare provider portal? Contact eviCore's Client & Provider Services department.

### How to contact eviCore's Client & Provider Services department

Email [clientservices@eviCore.com](mailto:clientservices@eviCore.com) to get eviCore's assistance with authorization requests for outpatient physical, occupational and speech therapy and physical medicine services by chiropractors for BCN HMO<sup>SM</sup> or BCN Advantage<sup>SM</sup> members. For urgent cases, call eviCore at 1-800-646-6418; select option 4.

When you send an email, you'll get a response that includes a ticket number. An eviCore representative will research your request and contact you.

### Additional information

As a reminder, on May 27, 2019, eviCore healthcare started managing all authorization requests for outpatient PT, OT and ST by therapists and physical medicine services by chiropractors for BCN HMO and BCN Advantage members. This includes requests for both initial and follow-up services.

You can get additional information in the **Outpatient rehabilitation services: Frequently asked questions** document, which we've posted on [the PT, OT, ST webpage](#) in the BCN section of our [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website.

## Enter BCN retrospective authorization requests for cardiology and radiology services in e-referral

Effective immediately, enter retrospective authorization requests for cardiology and radiology services with dates of service prior to Oct. 1, 2018, in the e-referral system for BCN HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members. eviCore healthcare no longer handles these requests.

Until recently, the e-referral system was programmed to block these requests. We've updated the e-referral system to accept these requests, so you no longer need to call BCN Utilization Management.

As a reminder, AIM Specialty Health® manages cardiology and radiology authorizations for BCN HMO (commercial) and BCN Advantage members with dates of service on or after Oct. 1, 2018.

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

# Referral Roundup

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## Updates to BCN referral and authorization requirements documents

We recently updated the **BCN Referral and Authorization Requirements** document.

The document now includes links to the preview questionnaires for all services for which questionnaires open in the e-referral system. This includes questionnaires that began opening on June 23, 2019.

We also moved the list of codes for services that require authorization to a separate **Procedure codes that require authorization** document. It lists each code — not code ranges — which means you can search for individual codes in the document or within the **ereferrals.bcbsm.com** website. In the BCN Referral and Authorization Requirements document, the page that previously listed the codes now includes a link to this new, separate document.

You can find this document in the BCN section of the **ereferrals.bcbsm.com** website. Click **Authorization Requirements & Criteria** on the left, and then scroll down and look under the “Referral and authorization information” heading.



## How to submit authorization request for transgender services for University of Michigan employees

In the last issue of **BCN Provider News** we told you we’ve expanded BCN medical coverage for transgender employees of the University of Michigan, effective July 1. This applies to members covered by U-M Premier Care and GradCare plans.

You can identify BCN members who are eligible for these services by their group number, which is 00124316. The number is on the front of their University of Michigan-branded ID cards. As always, be sure to check web-DENIS for benefits and eligibility.

See the full article on **Page 5**.

# INDEX: September–October 2019

## Index

### Cover Story

### Network Operations

### BCN Advantage

### Patient Care

### Behavioral Health

### Quality Counts

### Pharmacy News

### Billing Bulletin

### Referral Roundup

### Index



### Network Operations

We made some changes in response to our provider survey . . . **Page 1**

We're making some changes to increase security on our Provider Secured Services, effective Sept. 12 . . . **Page 1**

Providers: List top locations when updating your information with CAQH . . . **Page 3**

We're changing the categorization process for physical therapy . . . **Page 4**

How can we improve our online tools? . . . **Page 4**

Sign up for additional training webinars . . . **Page 4**

Reminder: Update your *Provider Authorization* form when you have changes . . . **Page 5**

How to submit authorization request for transgender services for University of Michigan employees . . . **Page 5**

Blue Care Network offers new University of Michigan student health plan . . . **Page 6**

Order Blue Cross mobile app supplies for your office . . . **Page 6**

### BCN Advantage

We're waiving cost share for certain drugs for BCN Advantage Prestige members . . . **Page 7**

New advanced illness and frailty exclusions for HEDIS star measures. . . **Page 7**

Process changes for the NOMNC and DENC forms affect skilled nursing facilities . . . **Page 8**

We're discontinuing the Provider Distinction Awards program. . . **Page 8**

Livanta LLC Replaces KEPRO as BFCC-QIO For Medicare regions 2, 3, 5, 7 and 9 . . . **Page 9**

Oncology management program effective for Medicare Advantage plans in January. . . **Page 10**

Important information about Medicare Advantage SNF post-payment audit and recovery process. . . **Page 11**

We're offering in home bone density testing for BCN Advantage members . . . **Page 12**

We're calling select Medicare Part D members to discuss their medications . . . **Page 12**

Talk with your patients about osteoporosis . . . **Page 13**

Physicians should recommend physical activity to older patients . . **Page 14**

Save the date: You're invited to a Stars Premiere event near you . . **Page 15**

### Patient Care

Blue Cross Coordinated Care to launch in 2020 . . . **Page 16**

Opioid refusal form available for members on Blue Cross website . . **Page 16**

CMS to approve grants for substance use disorder treatment funding . . . **Page 17**

Battling the opioid epidemic:  
A roundup of recent news and information . . . **Page 18**

Follow MQIC blood lead testing guidelines . . . **Page 18**

Medical policy updates. . . **Page 19**

Criteria corner. . . **Page 19**

### Behavioral Health

From the medical director: Primary care physicians can help prevent suicide. . . **Page 21**

Blue Care Network offers office posters and tip sheets about depression . . . **Page 23**

Michigan board-certified behavior analysts must be licensed starting Jan. 1, 2020, to be reimbursed by BCN and Blue Cross . . . **Page 23**

### Quality Counts

Providers should discuss childhood immunizations with parents . . **Page 24**

Preventive cancer screenings . . . **Page 25**

We're sending letters to members to remind them about preventive screenings and immunizations . . . **Page 25**

### Pharmacy News

We've added more vaccines to the pharmacy benefit . . . **Page 26**

Additional medical benefit specialty drugs have authorization and site-of-care requirements for BCN HMO members, effective Oct. 1 . . . **Page 27**

Quarterly update: Medical drug authorization and site-of-care requirements for BCN HMO and Blue Cross' PPO members . . **Page 28**

We're adding medications to the BCN Advantage and Medicare Plus Blue PPO Part B specialty prior authorization drug list. . . **Page 29**

NovoLogix user interface enhancements coming soon . . . **Page 29**

2019 IVIG dosing strategy is changing, starting Oct. 1 . . . **Page 30**

Blue Cross and BCN launch new Preferred Drug List for group employees . . . **Page 31**

All BCN commercial members are moving to the exclusive specialty pharmacy network effective Jan. 1 . . . **Page 32**

### Billing Bulletin

Coding corner: Treating patients with seizure disorder. . . **Page 33**

Clinical editing billing tips . . . **Page 34**

Billing Q&A . . . **Page 35**

Proper taxonomy required for certain BCN claims . . . **Page 36**

### Referral Roundup

Reminder: We made some changes to the e-referral home page . . **Page 37**

Contact eviCore for help in using the new eviCore provider portal for BCN PT, OT an ST authorizations. . . **Page 37**

Enter BCN retrospective authorization requests for cardiology and radiology services in e-referral . . . **Page 37**

Updates to BCN referral and authorization requirements documents . . . **Page 38**

How to submit authorization request for transgender services for University of Michigan employees . . . **Page 38**