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Blue Care Network offers 19 individual products for 2020

On October 1, consumers will be able to view health plans on the marketplace that are offered in their specific ZIP codes or counties. Enrollment takes place Nov. 1 through Dec. 15.

We're offering*:

- Three products in 15 Upper Peninsula counties
- Six products in 48 rural lower peninsula counties
- Thirteen products in 17 urban counties
- Nineteen products in three southeast Michigan counties

*Total number exceeds 19 because some plans are offered in multiple areas.

Please see [Individual products for 2020](#), continued on Page 2

Lower costs are at the heart of BCN Advantage plan features for 2020

Premiums decreased significantly for the 2020 BCN AdvantageSM Elements and Prestige plans. However, MyChoice Wellness, ConnectedCare and HealthySaver provider-specific plan premiums increased by a dollar. We'll also continue our two \$0 premium plans, Basic HMO-POS and HealthyValue.

- Our Prestige plan members will enjoy a \$400 lower out-of-pocket maximum for 2020, as well as see their specialist copayment drop from \$30 to \$20.
- Elements, HealthyValue and Basic members will spend less on primary care physician visits. Copayments decrease in the following plans: Elements from \$20 to \$10; HealthyValue from \$5 to \$3; Basic decreases to a \$0 primary care physician visit copay in most areas.
- In-network medical deductibles will drop \$10 for Basic, and Classic deductible will decrease from \$125 to \$0. These decreases are offset by \$500 out-of-network deductibles.

Please see [Lower costs](#), continued on Page 7



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User Guide*

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

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Individual products for 2020, continued from Page 1

Prescription drug copayment change for individual plans

For silver and gold plans, we're changing the nonpreferred brand-name drug copay maximum from \$100 to \$150 after deductible. The Silver Extra plan will have copayment of \$150 **before** the deductible. This should lessen consumer confusion between preferred brand-name copayments and nonpreferred brandname copayments.

We're also changing the service area for Preferred HMO Silver Extra, Silver and Silver off-marketplace plans to be available for purchase in the lower peninsula only.

Online visit copays for individual plans

Online visit copayments are changing to \$0 before the deductible on all plans except for Bronze Saver HSA plans, which are changing to \$0 **after** the deductible. The change is for medical visits only. Mental health online visits are still available to individual product members, but the primary care physician copay will apply.

We've also made changes to our small and large group product offerings.

Small group products

We'll have a total of 41 plans for 2020 for the small group market. Our goal is to avoid unnecessary disruption for small groups. Cost-sharing changes have been made to meet 2020 actuarial values to certain plans.

Large group products

We've added a new *Preferred Drug List* (see article in the Sept.-Oct. issue of *BCN Provider News*, **Page 31**) in addition to the *Custom Drug List* and the *Custom Select Drug List*.

The *Preferred Drug List* is available with three- and five-tier prescription drug riders.

We are updating plans with \$1,350 HSA plans and replacing them with \$1,400 HSA plans to accommodate the \$1400/\$2800 minimum deductible IRS requirement. The change will take place on the group's 2020 renewal.

As always, check member eligibility and benefits at every visit before providing services. You can do this through web-DENIS or by calling Provider Inquiry at 1-800-344-8525.

Grievance process changing

The BCN member grievance process is changing to 180 days from date of discovery. It was previously two years.

Ask to see the latest member ID card

January is the time when many patients change health care plans. You should always ask to see the latest member ID card and make sure it matches the coverage listed on web-DENIS.

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Outpatient therapy benefit change for Jan. 1, 2020

Blue Care Network is changing its outpatient therapy visit limit to 60 visits per year for combination of therapies. Currently, the benefit is one period of treatment within 60 consecutive days per year for a combination of therapies. The change is effective Jan. 1, 2020 for large groups of 51 members and greater with the following certificates:

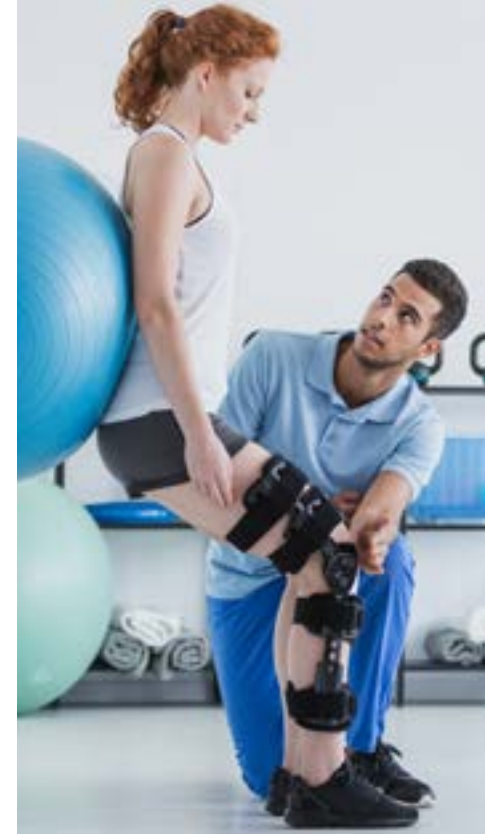
- Classic Large – CLSSLG
- High-Deductible Health Plan Large – HDHPLG
- Blue Elect Plus Large – BEPLG

The benefit enhancement is driven by the large number of member grievances about outpatient therapy limit and change in care management practices. Now, members who start physical therapy to avoid surgery and end up having surgery will be able to seek post-surgery physical therapy without exhausting their benefit.

This change does not affect:

- Employer plans with riders that amend the certificate limit
- Small groups
- Student health plans
- Large groups with the BCN1LG certificate
- Custom self-funded certificates
- Medicare plans

As always, check web-DENIS for eligibility and for outpatient therapy limit confirmation.



Direct reimbursement available to clinical nurse specialists, beginning Jan. 1

Clinical nurse specialists will have the opportunity to participate in Blue Cross Blue Shield of Michigan's Traditional and TRUST PPO networks and Medicare Plus BlueSM, as well as BCN HMOSM and BCN AdvantageSM, starting Jan. 1, 2020.

Participating clinical nurse specialists will receive direct reimbursement for covered services within the scope of their licensure at 85% of the applicable fee schedule, minus any member deductibles and copayments. This change affects Blue Cross and BCN benefit plans that cover services that clinical nurse specialists are licensed to provide. To find out if a patient has coverage, check web-DENIS for member benefits and eligibility or call Provider Inquiry at 1-800-344-8525.

Starting in October, clinical nurse specialists can find enrollment forms and practitioner agreements on bcbsm.com/providers. To find enrollment information, click on *Join Our Network*. Specific qualification requirements are identified within each agreement.

All applicants to the TRUST PPO, Medicare Plus Blue, BCN HMO and BCN Advantage networks must pass a credentialing review before participation. We'll notify applicants in writing of their approval status.

For more information, contact Provider Inquiry.

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We're expanding CAQH ProView 3.0 to include delegated credentialing practitioners

Blue Cross Blue Shield of Michigan and Blue Care Network are expanding the use of the CAQH ProView 3.0 application. The application will include enrollment demographic and credentialing data for delegated credentialing practitioners.

The purpose of this initiative is to:

- Streamline the data exchange process between delegated practitioner groups and Blue Cross
- Allow data to be exchanged consistently and more efficiently
- Improve our provider data quality for our members to view in our directories

We'll be accepting automated data feeds from CAQH ProView 3.0 into our provider data repository. This automated process will make it more efficient for us to maintain provider data and will reduce duplication of data submission for the delegated groups.

We expect to begin beta testing this electronic data exchange with the University of Michigan Medical Group and Genesys PHO for initial enrollment and changes in the first quarter of 2020 and for recredentialing during the summer of 2020.

Note: We still require signature documents for contracting. Continue to send these documents to the Provider Enrollment and Data Management department.

Reminder: Update or review your demographic data twice a year

Our Blue Cross Blue Shield of Michigan and Blue Care Network members rely on the online provider directory for accurate, up-to-date provider information, so it's important that you regularly confirm your demographic data.

Twice a year, our Provider Enrollment and Data Management team mails you your demographic data. When you receive this mailing:

- Review and confirm the accuracy of your demographic information.
- Respond to each mailing.

If you don't respond with information updates or confirm that your current information is correct, your demographic information won't appear in our online directory.

As data changes or updates are needed, send them to us by:

- **Mail**
Provider Enrollment — Attestation
20500 Civic Center Drive
Southfield, MI 48076-4115
H201 — PIAI
- **Fax**
1-844-216-4941
- **Email**
providerdataintegrity@bcbsm.com

If you have questions or need support with updating your data, go to bcbsm.com/providers or call Provider Enrollment at 1-800-822-2761.

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

Blue Cross Blue Shield of Michigan and Blue Care Network corporate offices will be closed on the following dates:

- Nov. 28 and 29 — Thanksgiving
- Dec. 24 and 25 — Christmas
- Dec. 31 and Jan. 1 — New Year's Eve, New Year's Day

During office closures, follow these guidelines when submitting inpatient authorization requests for BCN HMOSM (commercial) and BCN AdvantageSM members.

Acute initial inpatient admissions

Submit these authorization requests as well as concurrent reviews and discharge dates through the e-referral system, which is available 24 hours a day, seven days a week. If the e-referral system is not available, you can fax requests for inpatient admissions and continued stays to BCN HMO (commercial) at 1-866-313-8433 and to BCN Advantage at 1-866-526-1326.

Note: These requests may also be submitted through the X12N 278 *Health Care Services Review — Request for Review and Response* electronic standard transaction.

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

Post-acute initial and concurrent admission reviews

- For BCN HMO (commercial) members, submit these requests by fax at 1-866-534-9994. Refer to the document **Post-acute care admissions: Submitting authorization requests to BCN**
- For BCN Advantage members, naviHealth manages these authorizations. Refer to the document **Post-acute care services: Frequently asked questions for providers**.

Other authorization requests

The types of requests listed below must be submitted by fax. Fax BCN HMO (commercial) requests to 1-866-313-8433. Fax BCN Advantage requests to 1-866-526-1326.

- Authorization requests for sick or ill newborns
- Requests for total parenteral nutrition

Additional information

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

- Determining alternatives to inpatient admissions and triage to alternative care settings
- Arranging for emergency home health care, home infusion services and in-home pain control
- Arranging for durable medical equipment
- Handling emergency discharge planning coordination and authorization
- Handling expedited appeals of utilization management decisions
- Handling of urgent requests that need to be processed within 24 hours

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

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

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Online Training



Sign up for additional training webinars

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

Here's how to register for the upcoming training webinars:

Webinar name	Date and time	Registration
AIM Specialty Health® — Medicare Advantage Medical Oncology	Thursday, Oct. 24, 9 to 10 a.m.	Click here to add to your calendar
AIM Specialty Health® — Medicare Advantage Medical Oncology	Wednesday, Nov. 6, noon to 1 p.m.	Click here to add to your calendar
Blue Cross 101 — Understanding the Basics	Thursday, Nov. 7, 10 to 11:30 a.m.	Click here to register
Blue Cross 101 — Understanding the Basics	Wednesday, Nov. 13, 3 to 4:30 p.m.	Click here to register
AIM Specialty Health® — Medicare Advantage Medical Oncology	Thursday, Nov. 21, 9 to 10 a.m.	Click here to add to your calendar

As additional training webinars become available, we'll communicate about them through web-DENIS, *BCN Provider News* or *The Record*.



Earlier this summer, we hosted webinars about AIM's medical oncology programs for BCN Commercial webinars. A **recording** is available at the **ereferrals.com** website on the provider training page.

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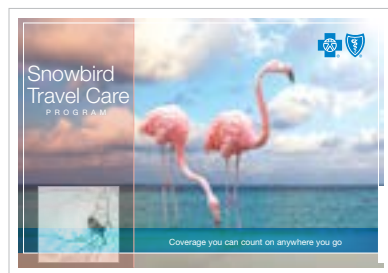
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New Snowbird Travel Care Program for members who travel

Our new Snowbird Travel Care Program for members traveling to Florida and Arizona offers a dedicated customer care line for BCN Advantage HMO-POSSM and Medicare Plus BlueSM PPO members to call for care coordination and assistance while wintering away from home.

Benefits include:

- Securing needed care with a participating (not necessarily in-network) Blue Cross Blue Shield physician
- Helping out-of-state providers collaborate with the member's Michigan primary care doctor
- Identifying local providers who can help manage routine acute conditions as well as specialists, if needed
- Offering expert knowledge in finding and securing community resources that are needed and available, such as adult day care, rehabilitation facilities, medications and durable medical equipment providers
- Finding a local participating pharmacy
- Assisting with care management issues

BCN and Blue Cross care managers will reach out to members to help them continue the treatment plan developed by you and your patients while they are on the road. We may reach out to you about patients participating in this initiative.

Lower costs, continued from Page 1

Enhancements to optional supplemental dental, vision and hearing plans for HMO-POS

HMO-POS members who enroll in the Optional Supplemental Dental, Vision and Hearing plans will see enhancements to the vision and dental segments in 2020. The differences from 2019 are:

Vision

- In-network: Lenses are covered 100% every 24 months
- Out-of-network
 - Elective contacts or frames are reimbursed at 50% coinsurance up to \$300 for Package 1 and \$400 for Package 2
 - Lenses are reimbursed at 50% up to allowed amounts
 - Exams reimbursed at 50% coinsurance up to allowed amounts

Dental

- All out-of-network services are at 50% coinsurance
- In Package 2, all in-network dental services are now available out-of-network at 50% coinsurance

Plans available in 2019

The BCN Advantage plans available are unchanged for 2020. They are:

- BCN AdvantageSM HMO-POS Elements
- BCN AdvantageSM HMO-POS Basic
- BCN AdvantageSM HMO-POS Classic
- BCN AdvantageSM HMO-POS Prestige
- BCN AdvantageSM HMO MyChoice Wellness*
- BCN AdvantageSM HMO ConnectedCare*
- BCN AdvantageSM HMO HealthySaver*
- BCN AdvantageSM HMO HealthyValue*

*Provider-specific, limited area coverage plans.

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BCN Advantage introduces a new over-the-counter benefit for 2020

An over-the-counter quarterly allowance for drugs and health-related products that do not need a prescription is new in 2020 for specific plans.

Items include allergy medications, antacids, cold and flu products, dental and denture care, eye and ear care, first aid, incontinence supplies, pain relievers and fever reducers, skin and sun care, supports and braces.

Elements members can use up to \$15 per quarter for these products. Classic and Prestige members have a \$25 per quarter benefit. The benefit must be used each quarter; there is no carryover. Basic members, who do not have a pharmacy benefit, and those who are in provider-specific plans do not have an over-the-counter allowance.

Important gap coverage news

- Gap Coverage added to the \$0 Select Care formulary Tier 6 — While in the coverage gap, members don't pay the requisite 25% for drugs covered under Tier 6; they continue to pay \$0 at preferred pharmacies and \$5 at standard pharmacies.



Blue Cross and Blue Care Network Medicare Advantage plans achieve four-star ratings from CMS

Our overall 2020 star rating ...

4 out of a possible 5 stars



Blue Cross Blue Shield of Michigan and Blue Care Network both received four-star ratings from the Centers for Medicare & Medicaid Services for 2020 for their Medicare Advantage health plans. The Medicare Star program is a nationally recognized measurement program that provides an overall rating of a health plan's quality and performance for the types of services each plan offers.

Measurements can range from one star (lowest) to five stars (highest). Attaining a four-star or higher level is a moving target because the bar is set higher each year and is harder for all health plans to hit year-after-year.

The BCN AdvantageSM rating reflects just under 20% of our membership in our Medicare Advantage plans.

Together, these results mean 100% of our members across the country are covered by four-star plans, making us one of an elite few that can stake that claim.

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Reminder: Oncology management program effective for Medicare Advantage plans in January

A new utilization management program for medical oncology drugs for Medicare Plus BlueSM PPO and BCN AdvantageSM members will begin in January 2020. Providers will need to obtain authorizations from AIM Specialty Health[®] for some medical oncology and supportive care medications.

This program became effective for BCN HMOSM (commercial) members in August 2019.

See the Sept.-Oct. **BCN Provider News**, Page 10, for details about the program.

Join a webinar to learn more

Non-clinical provider staff can learn about the new medical oncology program and how to use the AIM *ProviderPortal*SM by attending a webinar.

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.)

Thursday, Oct. 24, 9 to 10 a.m.

Wednesday, Nov. 6, 12 to 1 p.m.

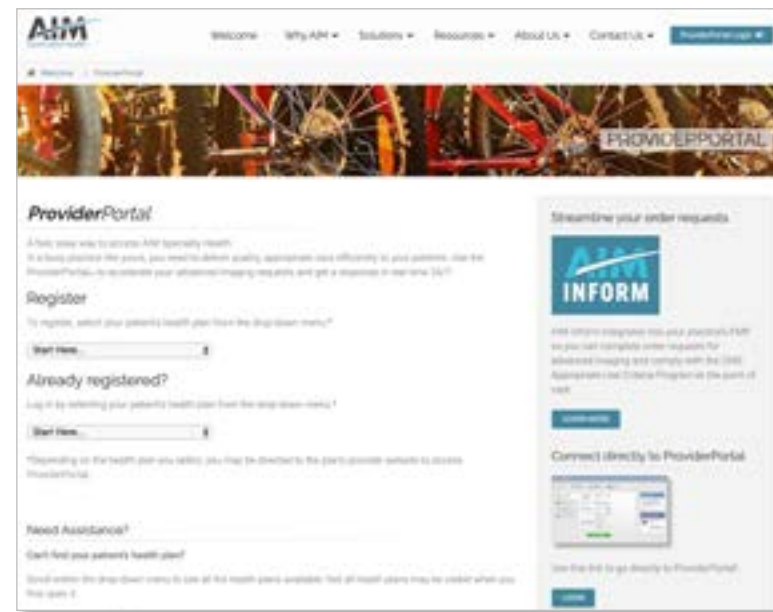
Thursday, Nov. 21, 9 to 10 a.m.

Thursday, Dec. 12, 9 to 10 a.m.

Wednesday, Dec. 18, 12 to 1 pm

Thursday, Jan. 9, 2020, 9 to 10 a.m.,

Wednesday, Jan. 22, 2020, 12 to 1 p.m.



AIM Provider Portal

The AIM *ProviderPortal*SM will be available on Dec. 16. Providers will need to request authorizations from AIM for medical oncology drugs. You can view a list of medications managed by AIM on our **erferrals.bcbsm.com** website. Information about the provider portal is available at the AIM **website**. For information about registering for and accessing AIM *ProviderPortal*, see the Frequently asked questions page on the AIM Specialty Health website.

Clinicians are encouraged to learn more at **aimspecialtyhealth.com/oncology/BCBSM** 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.

Frequently-asked questions

We've posted a frequently asked questions document about the Oncology Management Program on **erferrals.bcbsm.com**. To access it, follow these steps:

- Click on *Blue Cross* or *BCN*.
- Click on *AIM-Managed Procedures*.
- Under Resources, click on **Oncology Management Program: Frequently asked questions for providers**.

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BCN Advantage DRG clinical validation audits began Sept. 1

HMS®, an independent company working for Blue Cross Blue Shield of Michigan, began auditing BCN AdvantageSM-reimbursed diagnosis-related group claims for clinical and coding validation starting Sept. 1, 2019.

In the audits, HMS reviews medical records to ensure that claims are billed in accordance with coding guidelines and that diagnoses are supported by documentation in the medical record.

As part of the auditing process, you should be prepared to share medical records for review. After an audit, HMS will send you the findings and information on how you can request an appeal, if necessary.

The purpose of the DRG clinical audit is to:

- Confirm compliance with national coding guidelines
- Ensure documentation supports the diagnoses and procedures reported
- Detect, prevent and correct waste and abuse
- Facilitate accurate claim payment

HMS will hold webinars for providers with information on the overall DRG clinical validation process and helpful tips.

DRG clinical validation audits are completed in three phases. See the scope of each phase and the data period for each phase in the chart below.

Phase 1: Sept. 1, 2019 through Nov. 30, 2019	Providers receive audit finding letters, but no recoupment will come from Blue Care Network. Audits are educational only.	Data period: Dates of service Jan. 1 through April 30, 2019
Phase 2: Dec. 1, 2019 through Feb. 28, 2020	Recoupment begins on claims with DRG findings. Providers won't be charged for appeals on claims.	Data period: Dates of service May 1 through Nov. 30, 2019
Phase 3: March 1, 2020	DRG clinical validation audits are fully implemented. Providers follow existing audit and appeal process. Recoupment occurs.	Claims selected from those not previously selected within the proper audit review period.

Questions? During an audit, you can call 1-866-875-1749 to speak with an HMS representative.

BCN Advantage audits to use Sepsis-3 criteria

HMS® began auditing BCN AdvantageSM-reimbursed diagnosis-related group claims for clinical and coding validation on Sept. 1, 2019. (See separate article above.)

The audits will review medical records to ensure that:

- Claims were billed in accordance with coding guidelines
- Diagnoses were supported by documentation in the medical record

Regarding a sepsis diagnosis, BCN Advantage will use Sepsis-3 as the evaluation criteria for payment purposes. Sepsis-3 is the most recent evidence-based definition of sepsis, defined as a life-threatening organ dysfunction caused by a dysregulated host response to infection.

Learn more about Sepsis-3 criteria by reviewing the article titled **Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)**, published in JAMA®.

Be ready to share medical charts for review during an audit. After an audit, HMS will send the findings and information on how you can ask for an appeal, if necessary.

If you have questions during an audit, call 1-866-875-1749 to speak with an HMS representative.

Medicare Plus BlueSM PPO-reimbursed diagnosis-related group claims are being audited in the same way. We communicated this in the October issue of *The Record*.

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Skilled nursing facilities must follow CMS guidelines for issuing NOMNC forms to Medicare Advantage members

BCN AdvantageSM and Medicare Plus BlueSM PPO members sometimes remain in skilled nursing facilities for days beyond the service end date on the *Notice of Medicare Non-Coverage* form. Sometimes the extended stay is due to a provider's failure either to deliver a completed NOMNC form in a timely manner or to comply with Centers for Medicare & Medicaid Services guidelines to respond to requests from Livanta, LLC, the quality improvement organization assigned to Medicare Advantage members in Michigan. This results in days added to the member's stay that may not be medically necessary.

On behalf of Blue Cross Blue Shield of Michigan, naviHealth will issue an administrative denial for these days if they occur because the SNF provider didn't handle the NOMNC in accordance with CMS guidelines. In an administrative denial, the authorization is approved but the reimbursement for the extra days is denied.

Examples of improper handling and delivery of the NOMNC include:

- *Late delivery of the NOMNC.* Members must receive the NOMNC 48 hours before the planned discharge date.
Note: naviHealth completes as much of the NOMNC as possible and tells the provider when to issue the NOMNC.
- *Failure to fill out the NOMNC completely.* All fields in the NOMNC must be completed, including all date and signature fields. For more information, see the **Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123.**
- *Not submitting the requested medical information to the QIO in a timely manner, when the member appealed the service end date with the QIO*
Note: To view CMS instructions about appropriate delivery of the NOMNC, see sections 260.2 to 260.4.5 of the **CMS Manual System: Pub 100-04 Medicare Claims Processing, Transmittal 2711.**

When SNF providers have repeated difficulties handling the NOMNC according to CMS guidelines, their naviHealth care coordinators will reach out to provide education about CMS guidelines and health plan requirements. If, after receiving education, a SNF provider continues to have difficulties, naviHealth will deliver an administrative denial letter to the provider when members stay beyond the end date stated on the NOMNC.

The administrative denial letter will include details on the specific CMS guideline violations. Blue Cross and Blue Care Network will hold the provider responsible for the additional days the member stayed in the SNF. Per CMS guidelines, providers can't bill members for the additional days.

You can find information about CMS guidelines and Medicare Plus Blue and BCN Advantage requirements in the following locations.

- **Medicare Claims Processing Manual, Chapter 30:** See section "260.3.6 — Financial Liability for Failure to Deliver a Valid NOMNC."
- **Medicare Plus Blue PPO Manual:** See the Utilization Management section. Look under the "Post-acute care skilled nursing, inpatient rehabilitation and long-term acute care facilities" heading.
- **BCN Provider Manual:** See the **BCN Advantage chapter.** Look in the "BCN Advantage provider appeals" section.

As a reminder, naviHealth manages 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.

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



Study calls incidence of untreated mental illness and substance abuse 'staggering'

Hundreds of thousands of Michigan residents with a mental illness or substance use disorder are untreated, a crisis compounded by a shortage of health professionals and treatment facilities, according to the findings of a **report** released July 30. Commissioned by the Michigan Health Endowment Fund, the analysis cites anxiety disorders, depression and alcohol use disorder as among conditions most left untreated. The fund is a grant-making arm of Blue Cross Blue Shield of Michigan. (See related article in the behavioral health section titled, **Study says many Michiganders with mental illness fail to receive treatment**, **Page 18**.)

Patients taking opioids could face health care access problems

Taking opioids for chronic pain may make it hard to find primary care, according to a **University of Michigan Health Lab blog**. According to a new study, 40% of 194 primary care clinics contacted said they wouldn't accept a new patient who takes Percocet daily for pain from a past injury, no matter what kind of health insurance they had. Another 17% said they would want more information before deciding whether to take on the patient. However, the team did find that larger clinics and those that offer safety net coverage were three times more likely than others to accept patients who currently take opioids for chronic pain. The findings were published in **JAMA Network Open**.

Michigan doctors writing fewer opioid prescriptions

Michigan doctors wrote 1.4 million fewer opioid prescriptions in 2018 — a 15% drop — than they did in 2017, according to newly released data from state officials, **MLive.com** reported July 1. Overall, the number of prescriptions of controlled substances dropped 11.5% in 2018. It's the biggest year-over-year decrease in prescriptions Michigan has seen in recent history, a decline that began in 2015. Part of that is due to the state's tracking system, called the Michigan Automated Prescription System, or MAPS, which launched in 2017.

Where did all the pain pills go?

New information provides a look at where the drugs responsible for the opioid epidemic ended up, the **Detroit Free Press** reported July 19. Michigan was flooded with almost 3 billion prescription pain pills between 2006 and 2012, fueling the opioid crisis, according to a **Washington Post** analysis of a government database. Ogemaw County, home to the northern Michigan communities of West Branch and Rose City, had the heaviest saturation of pills: 125.7 pills per person a year. Overall, it received just over 19 million pills.

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Opioids, continued from Page 12

Number of Michigan's drug overdose deaths down slightly

Are the country's united efforts to fight the opioid epidemic starting to have an effect? New information shows that may be the case. The **Detroit Free Press** reported July 19 that the number of drug overdose deaths declined slightly in Michigan and across the nation in 2018, according to preliminary information released by the U.S. Centers for Disease Control and Prevention. Drug overdose deaths fell 3.7% in Michigan, from 2,690 in 2017 to 2,591 in 2018, according to the CDC report. Nationally, there were about 68,557 overdose deaths, a 5% decline from 72,224 deaths in 2017. It is the first decline in drug overdose deaths since 1990.

Helping expectant mothers with mental illness, substance abuse

Blue Cross recently awarded a \$90,000 grant to Cherry Health in Grand Rapids to help fund services for high-risk expectant mothers with mental illness, substance use disorder or insufficient prenatal care. The grant supports Blue Cross' mission to address the growing opioid epidemic in Michigan.

"More than 100 Kent County residents died of an opioid overdose in 2017," said Kelley Root, West Michigan regional sales director at Blue Cross. "We also know from the National Institute of Drug Abuse that untreated opioid use disorder during pregnancy can have devastating consequences on an unborn child."

Cherry Health is Michigan's largest federally qualified health center. More than 20% of its patients are uninsured, and 95% earn below the federal poverty level.

The grant is part of Blue Cross' "Strengthening the Safety Net" program. The program has provided more than \$14 million in grants since 2005.

Prescribing opioids for a sprained ankle?

While ankle sprain injuries are common, a new report from **Michigan Medicine** suggests that the rate of opioids prescribed to those patients has become uncommonly high. The authors urge fellow physicians to be aware of the current treatment guidelines.

Pilot program helps members understand surgery alternatives

Blue Care Network is starting a pilot in October to help members understand and make decisions about shoulder, back, hip and knee surgeries.

We've entered into an agreement with 2nd.MD, which gives members access to personalized second opinions (by video or phone) from medical specialists at top institutions.

The pilot is only available for BCN commercial individual business accounts. Talking to specialists from the company is voluntary.

The benefits to members considering surgery include:

- Providing members with access to specialists at top institutions, including Massachusetts General, Mayo Clinic and Hospital for Special Surgery
- Helping patients make better decisions and understand alternatives to surgery, if appropriate

The pilot will affect a small number of BCN members. We'll evaluate the results before determining whether to continue or expand the program.

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Remind patients to get the flu vaccine

Most people who get the flu experience a mild illness but won't need medical care or antiviral drugs. Most will recover in less than two weeks without treatment. But because of possible complications, the Centers for Disease Control and Prevention recommends flu vaccinations for everyone age 6 months and older, and especially for those at higher risk of complications. This group includes:

- Adults age 65 and older
- Children younger than age 2
- Pregnant women and women up to two weeks after the end of pregnancy
- American Indians and Alaska natives
- People who live in nursing homes and other long-term care facilities

Additionally, certain chronic conditions, such as heart disease, asthma, diabetes and chronic obstructive pulmonary disease, increase a patient's risk of complications due to the flu.

There are also other health conditions that put patients at a higher risk for complications. Some of these include:

- Blood disorders, such as sickle cell disease
- Cystic fibrosis
- Kidney disorders
- Liver disorders
- Patients with a body mass index of 40 or higher
- Patients with a weakened immune system due to a condition or medications
- Neurologic and neurodevelopment conditions



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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:

We have numerous requests for inpatient admissions for patients with chief complaint of abdominal pain, suspicious of cholecystitis. However, imaging findings show cholelithiasis, no evidence of cholecystitis. Interventions are medical, non-surgical. No findings of ascending cholangitis or biliary sepsis, just gallstones. No other findings except for cholelithiasis. Would it be appropriate to use the Cholecystitis subset to review this despite no evidence of cholecystitis? If not, what other subsets would be reasonable to use?

Answer:

Cholelithiasis may lead to cholecystitis due to blockage of the ducts or irritation from the stones, but cholelithiasis is not cholecystitis and cannot be applied to this criterion as such. The Acute Cholecystitis subset should not be used for a patient with cholelithiasis but not cholecystitis, and it should not be used for surgical patients.

The General Medical subset may be appropriate at the Observation level of care, pain, severe or the Acute level of care for jaundice (if this is true for this patient).

Question:

Under the Infection: General Subset, Laboratory result indicative of infection, source, Effluent Smear. Is a wound culture considered an effluent smear?

Answer:

"Effluent" is defined in the note attached to the criteria:

"Effluent is the liquid by-product of any internal organ eliminated through a surgically placed drain. It is generally applied only to liquids that are expected to be sterile at the point the drain is installed. It is not applied to liquids that are externally collected through normal body excretions (for example, feces or clean-catch urine)."

A wound culture is not the liquid by-product of an organ, so cannot be used to meet this criterion. Wound infection is addressed in the Infection: Skin subset.

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

- Measurement of exhaled nitric oxide and exhaled breath condensate in the diagnosis and management of respiratory disorders
- Orthopedic applications of stem-cell therapy (including allografts and bone substitutes used with autologous bone marrow)

Covered services

- Transcatheter mitral valve repair
- Hyperbaric oxygen therapy
- Corneal collagen cross-linking
- Pneumatic compression pumps and appliances for venous ulcers
- Leadless cardiac pacemakers
- Aqueous shunts and stents for glaucoma
- Myoelectric prosthetic and orthotic components for the upper limb
- Pneumatic compression pumps and appliances (Flex touch™ System) for lymphedema
- Intermittent (72 hours or greater) or continuous invasive glucose monitoring
- Phrenic nerve stimulation and diaphragm pacing
- Telemedicine services



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Quality corner: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

What does this measure focus on?

Initiation and engagement of alcohol and other drug dependence treatment is a HEDIS® measure. It looks at the percentage of patients ages 13 or older with a new episode of alcohol or other drug abuse or dependence.

Two parts are examined:

- Initiation of AOD treatment — Treatment must be initiated within 14 days of the diagnosis. Treatment can be initiated through:
 - An inpatient alcohol or other drug admission
 - An outpatient visit
 - An intensive outpatient encounter
 - A partial hospitalization
 - Telehealth
 - Medication treatment (also known as medication-assisted treatment, or MAT)
- Engagement of AOD treatment — Considered complete if the **first** bullet and **one** of the other two are completed.
 - Member initiated treatment (above)
 - Member whose initiation of AOD treatment was not a medication treatment: Member received two or more AOD engagement visits or one medication treatment event 34 days after the initiation treatment
 - Member whose initiation of AOD treatment was a medication treatment: Two or more AOD engagement events (only one can be a medication treatment event) within 34 days after the initiation event

Why is this important?

Higher morbidity and mortality rates are associated with substance abuse than any other preventable health problem. The treatment costs of health conditions caused by substance abuse are a strain on the health care system, totaling more than \$165 billion each year in health care expenditures alone. Unfortunately, even though treatment of AOD dependence leads to improved health and productivity, only 10% of the 23.1 million Americans who need treatment actually receive it, according to a 2012 estimate from the National Institute on Drug Abuse.

Ensuring patients get care and it counts

Many providers do administer the care, but HEDIS looks at specific timeframes and circumstances to ensure the best quality. Providers need to keep timing in mind.

- If you diagnose a patient with AOD dependence, schedule a visit at your own practice or refer the patient to a behavioral health provider as soon as possible so treatment can be started within 14 days of the diagnosis.
- Schedule engagement events within 34 days of the initiation event.

HEDIS also specifies certain stipulations when looking at what does and doesn't count. These two important tips can affect whether the service is considered complete by HEDIS standards:

- The date of an eligible AOD diagnosis and the initiation visit can be on the same day, but must be with two different providers, unless the provider is offering medication treatment
- The patient can complete more than one engagement visit on the same day, but the visits must be with different providers. Engagement visit and engagement medication treatment can be on the same date with the same provider.

Note: For members in the "other drug abuse or dependence" cohort (for example, members with an AOD diagnosis unrelated to alcohol or opioids), medication treatment does not meet the criteria for either initiation or engagement.

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Reminder: Blue Cross and BCN now accepting applied behavior analysis claims with 2019 procedure codes

Blue Cross Blue Shield of Michigan and Blue Care Network began accepting claims for behavior analysis services billed with the following codes, for dates of service on or after June 1:

- | | | | | |
|----------|----------|----------|----------|----------|
| • *97151 | • *97153 | • *97155 | • *97157 | • *0362T |
| • *97152 | • *97154 | • *97156 | • *97158 | • *0373T |

Claims billed with the following codes will still be honored:

- | | | |
|---------|---------|---------|
| • H0031 | • H2019 | • S5108 |
| • H0032 | • H2014 | • S5111 |

This applies to Blue Cross' PPO and BCN HMOSM members. All services continue to require authorization.

Billing guidelines

We've updated the ABA billing guidelines to reflect the 2019 codes. Look for the updated guidelines on the Autism pages within Provider Secured Services.

To find them, visit bcbsm.com/providers and log in to Provider Secured Services. Then:

To access the **BCN Autism** page:

- Click *BCN Provider Publications and Resources* (on the right).
- Click *Autism* (in the left navigation).
- Click *Applied Behavior Analysis Billing Guidelines and Procedure Codes* under the "Autism provider resource materials" heading.

To access the **Blue Cross Autism** page:

- Click *BCBSM Provider Publications and Resources* (on the right).
- Click *Clinical Criteria & Resources* (in the left navigation).
- Scroll down and click *Autism* (in the Resources section).
- Click *Applied Behavior Analysis Billing Guidelines and Procedure Codes* under the "Autism provider resource materials" heading.

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Study says many Michiganders with mental illness fail to receive treatment

More than 650,000 Michiganders with a mental illness and over 500,000 with a substance use disorder fail to receive any treatment for their conditions, according to a new study by Altarum, a nonprofit health care consulting institute, which examined access to behavioral health services in Michigan by payer type.

The report defines treatment as receiving any care at all, and not necessarily what may be considered the appropriate type and volume of care for the condition. The assessment was conducted using administrative claims data from 2016. Details on data sources and methods are documented in the **full report**. A one-page **summary** is also available.

Please see [Michiganders](#), continued on Page 19

Populations with the highest share of individuals going untreated for a mental illness include the uninsured (65%) and Medicaid enrollees (49%), while populations with the highest share of people going untreated for a substance use disorder include the privately insured (87%) and Medicare Advantage enrollees (80%).

The study was commissioned and funded by the Michigan Health Endowment Fund to better understand the current state of access in order to address gaps in care amid rising rates of behavioral health-related conditions in Michigan and across the United States, especially among young adults.

Behavioral health conditions that are most prevalent among Michiganders are also the most likely to go untreated. For instance, 46% of people with anxiety disorders, 53% of people with depressive episodes, and 85% of people with alcohol use disorders are not treated for their conditions.

Unmet need for behavioral health care in Michigan

Some key findings from the study

- Thirty-eight percent of the 1.76 million Michiganders who experience any mental illness are not receiving care. The most common unmet needs for mental illnesses are anxiety disorder and depressive episode.
- Among the 638,000 Michiganders with a substance use disorder, only 20% receive treatment, leaving more than 500,000 with an unmet need for care. Alcohol, cannabis and opioids are the most common substances resulting in a use disorder.
- The prevalence of any mental illness and substance use disorder are highest among Medicaid enrollees, the uninsured and adolescents.
- Expanding access to behavioral health care in all of Michigan to the same rates of care seen in the best access areas of the state would improve access for 236,400 people with a mental illness and 87,500 people with a substance use disorder.

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Michiganders, continued from Page 18

Barriers to behavioral health access

Michigan, like most of the country, has a shortage of psychiatrists and other behavioral health providers. Central Michigan has the largest share of untreated individuals with a mental illness (41%) and West Central Michigan the largest share of untreated individuals with a substance use disorder (83%). Altarum's analysis shows that shortages of psychiatrists and other behavioral health providers are especially concentrated in the northern half of the lower peninsula and parts of the upper peninsula. Additionally, Michigan has 11 child and adolescent psychiatrists per 100,000 people, far short of the recommended ratio of 47 to 100,000.

The study also includes analysis of data from the 2016 National Survey on Drug Use and Health, which show that cost of care, lack of transportation, and public awareness and perceptions about behavioral health care are also barriers to access.

Strategies to expand behavioral health services

The study authors recommend a near-term goal of achieving the state's best level of access—defined as having the smallest share of currently untreated individuals—for all regions across the state. In such a case, an additional 236,400 residents would receive mental health services, and an additional 87,500 would receive substance use disorder services.

The report contains 15 strategies for achieving the best level of access across the state that address the barriers of provider shortages, affordability and patient willingness to seek care. The six top recommendations are:

- Increasing retention of behavioral health providers in Michigan
- Removing restrictions on the scope of practice to fully leverage all members of the health care team
- Using lay providers, such as peer support specialists
- Using telemedicine to reach people in rural areas and those unable to travel
- Expanding access to services in schools
- Integrating primary care and behavioral health care delivery.

Altarum is a nonprofit organization that creates and implements solutions to advance health among vulnerable and publicly insured populations.

New program offers subspecialty certification in addiction medicine

Michigan State University, University of Michigan, Wayne State University and Spectrum Health are offering a program to help providers apply for addiction medicine subspecialty certification. The program is called MI Cares. There are now only 200 addiction medicine and addiction psychiatry specialists in the state of Michigan.

The program's goals are to:

- Educate providers on how to successfully enter the specialty of addiction medicine by 2021
- Properly assess a provider's current roles and responsibilities and how they can translate to meet the time-in-practice requirements for addiction medicine certification
- Identify areas outside of direct patient care to ensure required hours of experience in addiction medicine research, teaching activities and administration are met, utilizing collaborative resources
- Provide a robust overview of the addiction medicine core content for the board exam
- Provide an efficient and streamlined process for providers applying for addiction medicine subspecialty certification

For information or to enroll in the program, go to micares.msu.edu.

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Children on certain antipsychotic medications require routine blood monitoring

The American Academy of Child and Adolescent Psychiatry recommends routine blood monitoring for children on antipsychotic medications with potentially adverse side effects that include weight gain and diabetes. The HEDIS® measure is **Metabolic Monitoring for Children and Adolescents on Antipsychotics**.

We've sent letters to physicians who have patients taking certain medications to remind them to do routine blood monitoring. It's important that these patients receive these tests annually:

- At least one test for blood glucose or HbA1c
- At least one test for LDL-C or cholesterol

If you have questions, call BCN Behavioral Health at 1-800-482-5982 from 8 a.m. to 5 p.m. Monday through Friday.

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Blue Care Network offers crisis assessment and placement program with Common Ground

Blue Care Network's Behavioral Health department has entered into an agreement with Common Ground to provide crisis evaluation for members receiving behavioral health services, starting Oct. 1. We're responding to a need for quality of care, timely evaluation and appropriate level of placement and stabilization for members.

Common Ground can assist with on-site facility and community-based emergency assessments with placement into the most appropriate level of care. Common Ground also provides access to a multitude of community-based resources. The program can also assist those who have a history of being non-adherent or non-responsive to traditional behavioral health services or are at risk for decompensation.

Common Ground professionals are approved by Blue Care Network under this initiative to complete a crisis assessment and treatment plan in collaboration with providers to ensure that a clinical service plan is in place.

We're communicating to providers and emergency room physicians to let them know they can work with Common Ground to assess patients who choose to participate in this service. BCN-contracted facilities can benefit by working collaboratively with the Common Ground team on-site to confirm placement for inpatient, partial or other special services.

Currently, these assessments and placements are available in Oakland County. We plan to develop these services in southeast counties, mid-Michigan counties and on the West side of the state.

Providers who want to refer patients for assessment or placement can call Common Ground at 248-456-1991.

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Concurrent billing is allowed for some ABA procedure codes for commercial members

Board-certified behavior analysts can bill for services provided to the same client by two providers at the same time for the following applied behavior analysis procedure codes. This was effective Sept. 1, 2019:

- *97153 and *97155
- *97154 and *97155

This applies to Blue Cross' PPO (commercial) and BCN HMOSM (commercial) members.

We updated the *Applied Behavior Analysis Billing Guidelines and Procedure Codes* document to reflect this change. To access this document:

- Visit bcbsm.com/providers.
- Click *Login*.
- Log in to Provider Secured Services.
- Click *web-DENIS* on the Provider Secured Services welcome page.
- Click *BCN Provider Publications and Resources*.
- Click *Autism* on the left.
- Click *Applied Behavior Analysis Billing Guidelines and Procedure Codes* under the Autism provider resource materials

*CPT codes, descriptions and two-digit modifiers only are copyright 2018 American Medical Association. All rights reserved.

We've updated medical record documentation requirements for ABA services

We updated the medical record documentation requirements for applied behavior analysis services to clarify documentation requirements for services involving tutors and technicians.

These guidelines apply to services for Blue Cross' PPO (commercial) and BCN HMOSM (commercial) and members.

You can view the guidelines by visiting ereferrals.bcbsm.com, clicking *BCN* or *Blue Cross* and then clicking *Behavioral Health*. Finally, click the **Documentation requirements for applied behavior analysis services** link.

You can also view the guidelines within Provider Secured Services. Here's how:

- Visit bcbsm.com/providers.
- Click *Login* and log in to Provider Secured Services.
- Click *web-DENIS*.
- Click *BCN Provider Publications and Resources*.
- Click *Autism*.
- Click *Documentation requirements for applied behavior analysis services*.

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Best Practices

Childhood immunizations

Interview with Dr. Judy Tosto,
IHA Canton Family Medicine

What accounts for the high childhood immunization rates in your practice?

First and foremost, all the providers in our office have established trusting relationships with our families, allowing parents and patients to ask questions about immunizations in a safe and nonjudgmental environment. The ability to have clear, comfortable and open communication with your child’s medical provider is paramount.

We also have a nurse in our office who functions as a panel coordinator whose job it is to review the Michigan Care Improvement Registry daily. She can see which patients are behind on their vaccines and will call parents to get these children in for nurse visits to get them caught up on vaccinations.

In addition, our medical assistants review the immunization registry at every visit, regardless if it’s a sick visit or well child exam. If a child is behind on a vaccine, it will be offered at a sick visit if the child is well enough to receive it.

Our receptionists also ensure that parents schedule the next well child exam at check out. All members in our office — receptionists, medical assistants, nurses, nurse practitioners and pediatricians — play an important role in keeping up our high childhood immunization rates.



Dr. Judy Tosto and patient Colin Lambert

Photo by Deepa Elangainathan

What are the specific challenges related to flu vaccines?

Giving flu vaccines in a timely fashion can be challenging due to the seasonality of administration of the vaccine. If a child doesn’t have a well child exam scheduled during the fall or early winter, parents may not remember to call the office to get the vaccine, or it may not be convenient to come back to receive it. It also isn’t a required vaccine for school entrance, so there may be less motivation for parents to give the vaccine to their children.

Perhaps a bigger issue is the common misconception that influenza is the “stomach flu” that causes fever and diarrhea. Many parents and patients are unaware that influenza is a potentially life-threatening respiratory illness. In addition, the normal side effects of the vaccine, such as low-grade fevers and body aches, can be misinterpreted as actually having influenza.

We tackle all these challenges by educating parents and patients about the importance of flu vaccine and making the vaccine easily accessible for our pediatric population. We offer flu clinics on the weekends to accommodate working families. We also offer online scheduling for nurse visits. We also offer the flu vaccine to the siblings and parents of patients we’re seeing on a particular day.

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Immunizations, continued from Page 22

What kind of patient education do you offer about immunizations?

We give every newborn family a binder explaining our office policies and the Centers for Disease Control and Prevention's recommended immunization schedule that we follow. The binders include educational handouts, or vaccine information statements, published by the CDC.



These go over what each vaccine is, why it's important to get the vaccine, potential reactions, contraindications to getting the vaccine and what to do if a problem occurs. We also provide these handouts at each well child exam where we're administering a vaccine.

Our office sponsors a monthly prenatal night where expectant families or those looking for a new pediatrician can ask questions and learn about our policies.

Potential patients are always welcome to schedule a meet-the-doctor interview if they're looking for a new pediatrician. Usually, many vaccine questions are asked at these interviews.

Is there targeted education about the flu vaccine?

Each provider at our office educates patients and families about the importance of flu vaccine during well child exams during cold and flu season. We explain how prevalent flu is and the serious complications that can occur. As with all vaccines, being vaccinated against influenza is also about protecting those around you, especially if you spend time around infants who are too young to get the vaccine, children who are immunocompromised or senior citizens.

Often, we can convince parents and patients who were initially hesitant to get the vaccine.

Remind your patients of the importance of colorectal cancer screening

Colorectal cancer is the third most common cancer diagnosed in both men and women in the United States, according to the American Cancer Society. Your patient may be under the assumption that a colonoscopy is the only way to test for colorectal cancer. Talk to your patients about the importance of early detection and the types of tests available, including those that are non-invasive.

There are many screenings available for patients to choose from and it's important for providers to document the type of screening performed or any exclusions in the patient's medical record. Exclusions for this HEDIS® measure have changed to include advanced illness and frailty of the patient.

View the Colorectal Cancer Screening tip sheet to learn more about the measure, information to include in a patient's record, CPT codes that should be included in claims and tips for talking with patients. You can find it in Provider Secured Services. Go to *BCN Provider Publications and Resources*. Click on *Clinical Quality Corner* under Other Resources. Then scroll down to Star Measure tip sheets.

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What are some of the challenges to getting 100% of your patients vaccinated?

Perhaps the biggest challenge is social media. Myths about vaccines, vaccine fears and anecdotal experiences are easily and widely communicated and propagated.

IHA has had a policy for a few years that we're unable to accept families who decline to vaccinate their children according to the CDC schedule. When that policy went into place, we grandfathered our current families who have decided to not vaccinate or vaccinate on a delayed schedule. We obviously have some work to do with those families and continue to offer education every opportunity that we can.

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Save time and submit prior authorization requests electronically for pharmacy benefit drugs

Providers can now use their electronic health record or CoverMyMeds®* to submit prior authorizations for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members with commercial pharmacy benefits.

Electronic prior authorization, or ePA, replaces faxing and phone calls so providers can focus less on administrative tasks and more on patient care. Other benefits of ePA include automatic approvals for select drugs and improved turnaround time for review and decisions. It's easy for prescribers, nurses and office staff to use. All documentation and requests are kept conveniently in one place.

Here are some answers to frequently asked questions about ePA:

Why should I use ePA?

You'll save time. You can send 11 ePAs in the time it takes to fax just one (based on Comcast and Verizon broadband rates and fax speed of 33.6 kbps) and patients can receive medications faster.

The process is easy and intuitive. Providers and authorized personnel can use the electronic health record, or EHR, tool or log in online.

What is the cost of ePA?

Some EHR vendors charge an additional fee for this added functionality. There is no cost to use online portals.

What makes ePA better?

Both the online portals and ePA within your electronic health record make it easy to submit fully electronic requests and give you:

- Clear direction on clinical requirements
- The ability to attach documentation, if required
- Secure and efficient prior authorization administration all in one place
- The capability to proactively renew existing prior authorizations up to 60 days before they expire
- Streamlined questions pertaining only to information needed for the prior authorization

How do I get started?

ePA can integrate into your current electronic health record workflow. Check with your vendor to ensure you have the latest software version enabling ePA.

If ePA in your electronic health record tool isn't available, create a free account online for the tool that works best for your office. Registration is free and takes only a few minutes.

To complete an ePA, follow these steps:

1. Go to covermymeds.com/epa/express-scripts.
 - Create a free account if you don't already have one.
2. Start a prior authorization
 - Click *New Request* and enter the patient's state and medication.
 - Type Blue Cross Blue Shield of Michigan into the Plan, PBM and Form Name field.
 - Select the appropriate form and click *Start Request*.
3. Complete
 - Enter all demographic fields marked Required and click *Send to Plan*.
 - Complete the returned list of patent-specific, clinical questions marked Required.
4. Confirmation
 - Click *Send to Plan* again to complete the ePA request.
 - After Blue Cross or BCN has reviewed your submitted prior authorization request, the determination will appear in your CoverMyMeds account.

Approval decisions are often returned within moments of submission depending on the complexity or need for further review.

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

Click [here](#) for a brochure detailing the benefits of ePA.

* Other free ePA services include Surescripts® and ExpressPath®

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We'll cover hemophilia drugs under the pharmacy benefit for most commercial HMO and PPO members, starting Jan. 1

Blue Cross Blue Shield of Michigan and Blue Care Network will change how we cover hemophilia drugs, starting Jan. 1, 2020. If a member has Blue Cross or BCN pharmacy coverage, all hemophilia drugs should be billed under the patient's pharmacy benefits.

This change doesn't affect all commercial members. For example, if a member has pharmacy coverage through a company other than Blue Cross or BCN, hemophilia drugs will continue to be covered under the medical benefit.

To determine whether this change applies to a specific member:

- For BCN HMOSM members, review the member's benefits in web-DENIS.
- For Blue Cross' PPO members, review the member's benefits in Benefit Explainer.

We'll notify affected members of these changes. Members don't have to do anything. Their medication and treatment won't change.

What changes will occur on Jan. 1, 2020?

For affected members, hemophilia drugs and supplies that are currently covered under the medical benefit will be covered under the pharmacy benefit. In addition:

- Members will be limited to a 30-day supply of hemophilia drugs.
- The hemophilia drug Hemlibra[®] will continue to require authorization.

Which groups and members are affected?

This change affects most commercial Blue Cross' PPO and BCN HMO members who have Blue Cross or BCN pharmacy coverage, including those covered by individual plans and those covered through groups with administrative service contracts.

Note: ASC groups can opt out of the program. Groups that opt out will continue to use the medical benefit for hemophilia drugs.

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Hemophilia drugs, continued from Page 25

Which groups and members aren't affected?

The following groups and members aren't affected:

- HMO and PPO members with a carved-out pharmacy benefit
- Medicare and Medicaid members
- Groups with pharmacy benefits that involve limited and religious accommodations that cover only the pharmacy benefits mandated by the Affordable Care Act

How will this change affect members who are currently undergoing hemophilia therapy?

There won't be any change to members' therapy. Drug selection, dosage and frequency will remain the same. Members will continue to receive care from their current providers.

These hemophilia drugs are being added to the formulary as branded, nonspecialty medications. Depending on their pharmacy benefits, copays may increase for some members.

How will providers and specialty pharmacies know to bill the pharmacy benefit starting Jan. 1, 2020?

We'll send letters to providers and specialty pharmacies about billing Blue Cross and BCN members under the pharmacy benefit, unless the member's group has opted out of the hemophilia program.

If a hemophilia drug is processed under the pharmacy benefit and the group has opted out, a point-of-sale message will let the specialty pharmacy know immediately that the place of service isn't covered. The provider or specialty pharmacy will be instructed to bill the medical benefit, as they did previously.

Why are we making this change?

Quality of care: We provide our members access to the best health care at the lowest cost. By adding this drug class to the pharmacy benefit, we can continue to offer hemophilia therapy to our members while increasing the quality of care and possibly reducing the cost to the plan and our members.

Data capability: We'll be able to get real-time data about units dispensed, dosing and the dates on which each member receives medication. This data isn't always available under the medical benefit. In addition, we can see where the member is receiving therapy and direct him or her to higher-quality centers with better pricing.

Evenity will be added to the Medicare Part B medical drug prior authorization list in November

We're adding Evenity® (J3111) to the Medicare Plus BlueSM PPO and BCN AdvantageSM Part B medical drug prior authorization lists.

For dates of service on or after Nov. 1, 2019, Evenity will require prior authorization.

See article on [Page 36](#) for details.

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We'll stop covering Zytiga 500mg starting Nov. 1

We'll no longer cover Zytiga® (abiraterone) 500mg, starting Nov. 1, 2019. However, members can continue to fill their prescriptions for Zytiga 500mg until Jan. 1, 2020. If they fill prescriptions for Zytiga 500mg on or after this date, they'll be responsible for the full cost.

Members can continue their current treatment with **generic** Zytiga 250mg and may pay less for this prescription than what they pay currently.

The following table includes some information to compare the available strengths of Zytiga.

Zytiga strength	Available as generic drug	Member cost	Number of tablets per day (for 1000mg dose)
250mg	Yes	Generic specialty copayment	4
500mg	No	Full cost (not covered)	2

We'll let members know about this change and encourage them to speak with their doctors about getting a prescription for generic Zytiga 250mg and to discuss any concerns.

For a complete list of covered drugs go to bcbsm.com/pharmacy and click Drug lists.

If you have questions, call the Pharmacy Services Clinical Help Desk at 1-800-437-3803 and select option 1.

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Did you know?

Approximately 16 million Americans have chronic obstructive pulmonary disease, or COPD. *Here's an overview of COPD and tips for documenting and coding it appropriately.*

About COPD

COPD is a chronic inflammatory lung disease that results in the obstruction of smaller airways within the lungs. Symptoms may be mild at first, beginning with a cough and shortness of breath with exertion. As it progresses, shortness of breath worsens and may be present at rest. Abnormal levels of oxygen and carbon dioxide in the blood may also be found in patients with advanced COPD. Ultimately, progression of the disease leads to chronic respiratory failure.

COPD is a collective term that includes three specific diseases:

- Chronic bronchitis
- Emphysema
- Asthma with chronic obstruction

Emphysema is characterized by the slow progressive destruction of lung tissue, mainly the small air sacs in the lungs known as alveoli. This interferes with outward air flow from the lungs.

Chronic bronchitis mainly causes inflammation of the bronchial tubes, which allows mucus to build up and obstruct the airways. It also causes some constriction and narrowing of the airways. Patients with longstanding asthma may develop chronic obstruction of the airways and chronic inflammation, similar to chronic bronchitis.

Most patients with COPD have a combination of both emphysema and chronic bronchitis features. Emphysema features will be predominant in some patients, while chronic bronchitis features will be predominant in others.

Symptoms of COPD can vary from one patient to the next, but common symptoms are:

- Shortness of breath
- Frequent coughing, with or without mucus production
- Fatigue
- Wheezing
- Tightness in the chest

Stages of COPD

The stages of COPD are based on the forced expiratory volume, or FEV1. This is the maximal amount of air someone can forcefully exhale in one second. It is then converted to a percentage of normal. The lower the FEV1, the more severe the disease.

- Stage I (early or mild) — FEV1 about 80% or more of normal
- Stage II (moderate) — FEV1 between 50% and 80% of normal
- Stage III (Severe) — FEV1 between 30% and 50% of normal
- Stage IV (very severe or end stage) — FEV1 less than 30%, or people with low blood oxygen levels and a Stage III FEV1

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COPD, continued from Page 28

Treatments for COPD

- Bronchodilators to open airways — Most come in the form of inhalers. Both short- and long-acting bronchodilators are available.
- Steroids — These reduce inflammation, swelling and mucus production. Less swelling allows more space through which air can travel. Steroids can be inhaled, taken orally or injected.
- Immunization — Centers for Disease Control and Prevention recommends that individuals with COPD get flu and pneumococcal vaccinations to help protect against complications of COPD.
- Oxygen therapy — Because COPD can lower blood oxygen levels, this treatment provides the body the extra oxygen it needs.

Documentation and coding tips

Always document and code COPD to the highest specificity. **The term “COPD” is less specific than the individual diseases it includes.** If a patient predominantly exhibits features of one specific disease over another, such as emphysema, chronic obstructive asthma or chronic bronchitis, then this should be documented rather than COPD.

Since conditions under the COPD umbrella can be coded in a variety of ways, the final code selection must consider all the specific details of a patient’s condition as documented by the provider.

With the increased specificity in documentation required by ICD-10-CM guidelines, here are some key points to remember:

- Specify the **acuity**: acute, chronic, intermittent or chronic with an acute exacerbation.
- Describe the **severity**: mild, moderate or severe.

- Document **clinical signs** and **symptoms**: coughing, wheezing, sputum production, shortness of breath.
- List any history of **tobacco use**, environmental exposure or occupational exposure.
- Note **any diagnostics test**: ABGs (arterial blood gas test), PFTs (pulmonary function test), chest X-rays.
- Document any **treatment**: oxygen, bronchodilators, steroids, pulmonary rehabilitation.

Some examples of COPD codes are given in the chart below:

ICD-10-CM category	Condition
J41.0	Simple chronic bronchitis
J42	Unspecified chronic bronchitis
J43.1	Panlobular emphysema
J43.9	Emphysema, unspecified
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified
J45.901	Unspecified asthma with (acute) exacerbation
J45.909	Asthma, unspecified
J96.10	Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia

Sources:

- copdfoundation.com
- 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.

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Use correct coding to avoid some clinical edits

Do you see trends in the clinical edits that you receive? Some of these edits can be avoided through use of correct coding or consistent, detailed modifier use and ICD-10 coding.

If you're receiving consistent edits on one particular CPT code or diagnosis code, review the information to see if adding a specific modifier or diagnosis code will provide more detail to the claim line.

Here are modifiers that provide more specificity. (Note that modifiers 25 and 59 are not good examples of more specificity.)

- LT and RT, 76 and 77, or the approved behavioral health modifiers
 - For example, if physician A reads a two-view complete shoulder X-ray and physician B reads a second film from a separate session, physician B should report 73030-26, 77, and RT/LT.

Diagnosis codes should be billed to the same, high level specificity. When an unspecified ICD-10 code is selected, but there is an alternative code with a specific added detail of the condition, the specific code should be reported.

- The ICD-10 official guidelines offer the proper use of the appropriate level of detail.
- Using codes with greater specificity could potentially help avoid a clinical edit.
 - One example would be a three-character code (category) requiring a fourth character (subcategory) with a notation in red under the category stating, *Code first the underlying physiological condition*. That notation applies not only to the category but also to the subcategories below each category. Submitting the underlying physiological condition first followed by the intended code can avoid an edit.

Facilities: CMS guidelines for billing more than one emergency room visit on the same date

Facilities can bill for two emergency room visits on the same date when multiple medical visits occur on the same day in the same revenue center, but visits were distinct and independent visits.

The Centers for Medicare & Medicaid Services guidelines specify that the first emergency room visit claim should be reported with the revenue code 045X plus an evaluation and management code with ancillary services rendered on that day.

Then on the second claim, report only the unrelated emergency room visit (revenue code 045X plus E&M code) with condition code G0.

Clinical editing billing tips

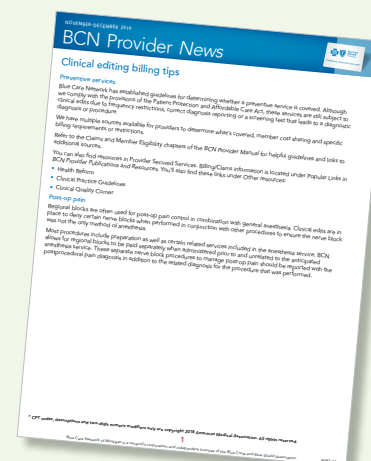
In most issues, we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that the performed procedure is correctly reported to us.

This issue's tip includes:

- Preventive services
- Post-op pain



*Clinical editing
billing tips*



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Reminder: New edits for claims reporting V, W, X or Y diagnosis codes

Beginning Oct. 7, 2019, BCN HMOSM and BCN AdvantageSM electronic claims submitted with a diagnosis involving an external cause of morbidity reported as primary or principal will receive an EDI front-end edit on either a 277CAP transaction or a R277CAI (Institutional) or R277CAH (Professional) report.

These edits will apply to electronic claims with ICD-10 codes V00 through Y99 submitted to either BCN HMO or BCN Advantage. Currently, claims with V, W, X or Y diagnosis codes get denied by BCN, but beginning on Oct. 7 these claims will instead get a front end edit.

Institutional edits:

- F112 EXTERNAL CAUSE OF INJURY NOT VALID AS PRINCIPAL DIAGNOSIS
- F113 EXTERNAL CAUSE OF INJURY NOT VALID AS ADMITTING DIAGNOSIS
- A3:254 or A3:232 in the 277CAP transaction

Professional edit:

- P112 EXTERNAL CAUSE OF INJURY NOT VALID AS PRINCIPAL DIAGNOSIS
- A3:254 in the 277CAP transaction

We previously communicated this information in a web-DENIS message on Aug. 28.

Call the EDI help desk at 1-800-542-0945 if you have questions.

How to bill vision exams for University of Michigan student health plan members

Here's how to bill vision exams for BCN HMOSM (commercial) members covered under these University of Michigan student health plans:

- Domestic Student Health Plan, available starting Aug. 24, 2019
- International Student and Scholar Health Plan, available starting Sept. 1, 2019

To bill vision exams for these members, do the following:

- **For members 19 years old and older, bill BCN directly.**
This applies to procedure codes *920XX and *992XX. Vision exams for members 19 and older are covered under the member's medical benefits.
- **For members younger than 19, bill VSP[®] Vision Care.**
Vision exams for members younger than 19 are covered under the member's vision benefits.

Typically, for most plans, you'd bill vision exams to VSP for all age groups. However, for the University of Michigan student health plans, vision exams are covered differently than they are for most other plans and you need to bill them differently. We first communicated about this in a web-DENIS message in September.

You can check web-DENIS to confirm the member's date of birth and coverage under one of the University of Michigan student health plans, and then bill according to the instructions outlined in this article.

If you have questions or want to confirm that a member is covered under the University of Michigan student health pediatric vision plan administered through VSP, you can call VSP at the number on the back of the member's BCN member ID card.

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Reminder: naviHealth authorizes PDPM levels for Medicare Advantage SNF admissions, starting Oct. 1

naviHealth authorizes patient-driven payment model levels during a patient's stay (from preservice through discharge) for Medicare Plus BlueSM PPO and BCN AdvantageSM skilled nursing facility admissions with dates of service on or after Oct. 1, 2019. This aligns with the Centers for Medicare & Medicaid Services payment methodology. As a result, the payment methodology will change from RUG levels to PDPM levels on Oct. 1, 2019.

We first communicated this change in late July.

When submitting claims for stays with dates of service starting on or before Sept. 30, 2019, and extending through or beyond Oct. 1, you need to include both the resource utilization group levels and the PDPM levels that naviHealth authorized.

You can view additional information on [The Patient Driven Payment Model \(PDPM\) — Information and Resources for Provider Partners](#) page of the naviHealth website.

As a reminder, naviHealth manages authorization requests for Medicare Plus Blue PPO 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.



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New and updated questionnaires now open in e-referral system

New and updated questionnaires started opening in the e referral system for certain procedures on Aug. 25 and on Sept. 29, 2019. In addition, new and updated preview questionnaires, authorization criteria and medical policies are available on the ereferrals.bcbsm.com website.

We use our authorization criteria, medical policies and your answers to the questionnaires when making utilization management determinations about your authorization requests.

New questionnaires

Effective Aug. 25, questionnaires started opening for the first time in the e-referral system for authorization requests for BCN HMOSM and BCN AdvantageSM for the procedures listed below, which already require authorization.

Service	Age	Procedure codes
Bariatric surgery — BCN HMO	Adult and adolescents	*43644, *43645, *43770, *43771, *43772, *43773, *43774, *43775, *43842, *43843, *43845, *43846, *43847, *43848, *43886, *43887, *43888 and *44130
Bone-anchored hearing aid	Adult and pediatric (5 years old and older)	*69714, *69715, *69717 and *69718
Cardiac rehabilitation — BCN HMO	Adult and pediatric	*93797 and *93798 (for select diagnoses)
Cardiac rehabilitation — BCN Advantage		
Pregnancy termination — BCN HMO	Adult	*01966, *59100, *59840, *59841, *59850, *59851, *59852, *59855, *59856, *59857, *59866, *88304, *88305, S0190, S0191, S0199, S2260, S2265, S2266 and S2267
Pregnancy termination — BCN Advantage		
Pulmonary rehabilitation	Adult and pediatric	G0237, G0238, G0239, G0302, G0303, G0304, G0424 and S9473
Radiofrequency ablation, peripheral nerves	Adult	*64640
Visual training, orthotic and pleoptic	Adult and pediatric	*92065

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Updates to existing questionnaires

In addition, updated questionnaires started opening in the e-referral system on the dates specified below for BCN HMO, BCN Advantage and Medicare Plus BlueSM PPO authorization requests (unless otherwise noted), for the following services.

- Cervical spine surgery — Aug. 25; opens only for BCN HMO and BCN Advantage
- Cervical spine fusion with artificial disc replacement — Sept. 29
- Cholecystectomy (laparoscopic) — Aug. 25; opens only for BCN HMO and BCN Advantage
- Dental anesthesia or repair of trauma to natural teeth — Sept. 29; opens only for BCN HMO and BCN Advantage
- Endovascular intervention, peripheral artery — The updated questionnaire for this service was originally scheduled to open starting on July 28 for Medicare Plus Blue requests but actually started opening on Aug. 25.
- Ethmoidectomy — Aug. 25
- Hammertoe correction surgery — Aug. 25
- Hip arthroplasty, total, revision — Aug. 25
- Knee arthroplasty, total, revision — Aug. 25
- Noncoronary vascular stents — Sept. 29
- Sacral nerve neuromodulation/stimulation — Aug. 25
- Sinusotomy, frontal, endoscopic — Aug. 25
- Sleep studies, outpatient facility or clinic-based setting — Aug. 25; opens only for BCN HMO and BCN Advantage
- Vascular embolization or occlusion of hepatic tumors (TACE/RFA) — Aug. 25

Preview questionnaires

For all of these services, you can access preview questionnaires at ereferrals.bcbsm.com. The preview questionnaires show the questions you'll need to answer in the actual questionnaires that open in the e-referral system. This can help you prepare your answers ahead of time.

To find the preview questionnaires:

- For BCN: Click *BCN* and then click **Authorization Requirements & Criteria**. Scroll down and look under the *Authorization criteria and preview questionnaires* heading.
- For Medicare Plus Blue: Click *Blue Cross* and then click **Authorization Requirements & Criteria**. In the Medicare Plus Blue PPO members section, look under the *Authorization criteria and preview questionnaires* — *Medicare Plus Blue PPO* heading.

Authorization criteria and medical policies

We also posted links to the pertinent authorization criteria and medical policies on the *Authorization Requirements & Criteria* pages.

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Don't add clinical documentation to denied requests in the e-referral system

When we deny an authorization request in the e-referral system, we contact your office to inform you of that determination and then we close the case, which means that the case no longer appears in our queues.

We don't receive notification of changes to authorization requests that have been closed.

For this reason, we ask that you don't submit additional clinical documentation or make any other changes on denied requests. Instead, submit the clinical documentation during the appeals process. This will help to ensure that we see and review the additional documentation.

The denial letter includes instructions for submitting an appeal.

You can also find information about appealing utilization management decisions in the following chapters of the *BCN Provider Manual*.

- **BCN HMO:** See the **Care Management** chapter. Look in the "Appealing utilization management decisions" section.
- **BCN Advantage:** See the **BCN Advantage** chapter. Look in the "BCN Advantage provider appeals" section.

Authorization requirement changes for BCN members

We've made changes in authorization requirements for these procedures: transcatheter aortic valve implantation and replacement, endometrial ablation and excisional breast biopsy procedures.

Transcatheter aortic valve implantation and replacement procedures no longer require authorization and clinical review for BCN HMOSM (commercial) and BCN AdvantageSM members.

You no longer need to submit clinical documentation for these requests. However, this procedure requires plan notification to facilitate claims payment. Refer to the **e-referral User Guide** for instructions on how to submit a plan notification.

This change applies to the following procedure codes: *33361, *33362, *33363, *33364, *33365, *33366, *33367, *33368 and *33369.

Neither plan notification nor authorization are required for endometrial ablation and excisional breast biopsy procedures for BCN HMOSM (commercial) and BCN AdvantageSM members. Standard regional referral requirements still apply. For example, a global referral is still required where applicable.

This change applies to the following procedure codes:

- Endometrial ablation: *58353, *58356 and *58563
- Excisional breast biopsy: *19101, *19120, *19125 and *19126

*CPT codes, descriptions and two-digit modifiers only are copyright 2018 American Medical Association. All rights reserved.

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Evenity will be added to the Medicare Part B medical drug prior authorization list in November

We're adding Evenity® (J3111) to the Medicare Plus BlueSM PPO and BCN AdvantageSM Part B medical drug prior authorization lists.

For dates of service on or after Nov. 1, 2019, Evenity will require prior authorization.

BCN Advantage

For BCN Advantage, we require authorization for this medication for the following sites of care when you bill the medication as a professional service or as an outpatient facility service, and when 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 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 authorization for this medication for the following sites of care when you bill the medication 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 an authorization before administering this medication. Use the NovoLogix® online tool to submit your authorization requests. It offers real-time status checks and immediate approvals for certain medications.

If you need access to Provider Secured Services or the NovoLogix online tool

If you have access to Provider Secured Services but you need access to NovoLogix, do one of the following:

- For BCN Advantage, access to Provider Secured Services gives you automatic access to NovoLogix. There's nothing more you need to do.
- For Medicare Plus Blue, if you have a Type 1 (individual) NPI and you checked the "Medical Drug PA" box when you completed the Provider Secured Services Application form, you already have access to NovoLogix. If you didn't check that box, you can complete an **Addendum P form** to request access to NovoLogix and fax it to the number on the form.

If you need to request access to Provider Secured Services, complete the **Provider Secured Services Application** form and fax it to the number on the form.

To access NovoLogix through Provider Secured Services

1. Visit **bcbsm.com/providers**.
2. Click *Login*.
3. Log in to Provider Secured Services.
4. Click one of the following links on the Provider Secured Services welcome page.
 - *BCN Medical Benefit – Medication Prior Authorization*
 - *Medicare Advantage PPO Medical Benefit – Medication Prior Authorization*
5. Enter or select your NPI and click *Go*.

If you can't log in to Provider Secured Services, call 1-877-258-3932 Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

If you have questions about authorizations, you can call the Pharmacy Clinical Help Desk at 1-800-437-3803 Monday through Friday from 9 a.m. to 4 p.m. Eastern time.

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Take a few minutes to tell us how satisfied you are with our utilization management services

Blue Cross Blue Shield of Michigan and Blue Care Network want to know how satisfied you are with our utilization management services. Let us know by completing a short **survey**. The survey opened Oct. 14 and closes on Dec. 1, 2019.

Encourage your office colleagues, including physicians, nurses and referral coordinators, to take the survey as well. Your responses will help us evaluate our efforts and make improvements to our utilization management processes to better support you as you care for our members.



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We'll cover hemophilia drugs under the pharmacy benefit for most commercial HMO and PPO members, starting Jan. 1Page 25

Evenity will be added to the Medicare Part B medical drug prior authorization list in NovemberPage 26

We'll stop covering Zytiga 500mg starting Nov. 1.Page 27

Quality Counts

Childhood immunizationsPage 22

Remind your patients of the importance of colorectal cancer screeningPage 23

Referral Roundup

Reminder: naviHealth authorizes PDPM levels for Medicare Advantage SNF admissions, starting Oct. 1Page 32

New and updated questionnaires now open in e-referral system.Page 33

Don't add clinical documentation to denied requests in the e-referral system.Page 35

Authorization requirement changes for BCN membersPage 35

Evenity will be added to the Medicare Part B medical drug prior authorization list in NovemberPage 36

Take a few minutes to tell us how satisfied you are with our utilization management servicesPage 37