BCN Advantage earns 4.5 stars for 2016 rating

BCN Advantage℠ earned an overall 4.5-star rating for 2016 from the Centers for Medicare & Medicaid Services. It’s the fourth consecutive year the plan received 4.5 stars out of 5.

“Our consistently high ratings are proof that we are delivering higher-quality products and services, increasing member satisfaction and partnering with our network providers to help members get the care they need,” said Daniel J. Loepp, president and CEO of Blue Cross Blue Shield of Michigan.

Blue Care Network maintained our 5-star rating on pharmacy measures for Part D. To maintain our pharmacy success and manage readmissions, BCN Advantage implemented a medication reconciliation program for patient discharges for University of Michigan, St. Joseph Ann Arbor, McLaren and Sparrow hospitals.

Other initiatives to increase member satisfaction included the following:

- BCN printed and mailed a wallet-sized medical out-of-pocket costs card that provided members with easy access to benefit copayments.
- The BCN team traveled across Michigan to offer 10 member seminars to help members understand their benefits, a key driver for improving the member score and Consumer Assessment of Healthcare Providers and Systems, or CAHPS®, results.
- BCN and a vendor partnered to implement a project to improve measures related to osteoporosis and chronic obstructive pulmonary disease by ensuring members receive their proper medications and bone mass density screenings.
Use CAQH ProView™ Universal Provider Datasource for enrollment changes and credentialing

The Universal Provider Datasource®, or UPD, developed by the Council for Affordable Quality Healthcare®, is a single, national process that eliminates the need for multiple credentialing applications.

The database is designed to gather extensive provider information, including demographic and credentialing data, in a single repository that can be accessed by participating health plans and other health care organizations.

Blue Cross Blue Shield of Michigan and Blue Care Network require all practitioners, including hospital-based practitioners, to sign up and use UPD for enrollment changes, credentialing and recredentialing.

It is imperative to keep your information updated on CAQH because we use it as the official source for updating our systems. CAQH requires application re-attestation every 120 days, regardless of whether you are practicing at an office location or practicing exclusively in an inpatient hospital setting. If practicing exclusively in an inpatient hospital setting, indicate that on your CAQH application because this information is used to determine whether full credentialing is required.

For more information about CAQH, including the credentialing process, or for a demonstration of the UPD, visit the CAQH website.

For user assistance, contact CAQH ProView Help Center:

<table>
<thead>
<tr>
<th>Call</th>
<th>1-888-599-1771</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td><a href="mailto:providerhelp@ProView.CAQH.org">providerhelp@ProView.CAQH.org</a></td>
</tr>
</tbody>
</table>

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Risk adjustment medical record reviews under way

Several medical records request outreach efforts began in November 2015 with an additional request to follow in January 2016. These include medical records reviews conducted by Inovalon. Verisk Health will also conduct a medical records review for select commercial members.

Blue Cross Blue Shield of Michigan and Blue Care Network are required to meet the Centers for Medicare & Medicaid Services’ standards for patient data submission and diagnosis coding accuracy. This medical record review is to ensure that CMS and Department of Health and Human Services’ coding guidelines and quality standards are met.

Providers will be asked for their assistance in providing complete medical records for their respective list of patients who were treated in their office in 2014 and, in some cases, 2015.

Ensuring that office visits take place and diagnoses are appropriately captured and documented ensures quality care, accurate reimbursement from CMS, and ultimately helps keep premiums affordable for members.

Our vendors are contractually bound to preserve the confidentiality of health plan members’ protected health information obtained from medical records, in accordance with HIPAA regulations.

Patient-authorized information releases are not required in order for you to comply with these requests for medical records when both the provider and health plan had a relationship with the patient and the information relates to the relationship [45 CFR 164.506(c)(4)]. For more information regarding privacy rule language, please visit hhs.gov/ocr/privacy.

We encourage providers to contact one of the following Blue Cross Blue Shield of Michigan provider consultants with questions:

• Tom Rybarczyk at 1-313-225-0445
• Corinne Vignali at 1-313-225-7782
• Sue Brinich at 1-313-225-8981

Thank you for your time and assistance in completing these requests.

<table>
<thead>
<tr>
<th>Medical Records Request</th>
<th>Membership</th>
<th>Kickoff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enterprise Risk Adjustment – 2014 dates-of-service</td>
<td>Blue Cross and BCN specialists and facilities</td>
<td>November 2015</td>
</tr>
<tr>
<td>Inovalon – 2014 dates-of-service</td>
<td>Blue Cross</td>
<td>November 2015</td>
</tr>
<tr>
<td>Verisk Health – 2015 dates-of-service</td>
<td>Blue Cross and BCN</td>
<td>November 2015</td>
</tr>
<tr>
<td>Inovalon – 2015 dates-of-service</td>
<td>Blue Cross and BCN</td>
<td>January 2016</td>
</tr>
</tbody>
</table>
Tobacco cessation office staff contest winners

Congratulations to Dr. Harold Roth’s office staff in Lansing, Blue Care Network’s latest winner of the monthly smoking cessation office staff contest. The staff will share $1,000 in Visa® gift cards, with the possibility of adding an extra $500 if BCN hits its goal of receiving 5,000 surveys between July 1 and Dec. 31.

We are in the process of choosing and contacting winners for the October, November, and December drawings. Please continue to hand out our survey and Quit Guide to all BCN commercial members ages 18 - 65. If you need additional supplies, please call 248-799-6959 to request them.

In the last issue of BCN Provider News, Sparrow Medical Group North was listed as one of the monthly winners. Due to Sparrow corporate policy, the group isn’t able to accept the reward. Instead, BCN will donate the $1,000 to the Sparrow Foundation and provide lunch to the office staff to show our gratitude.

Because of its success in 2015, BCN will continue the tobacco cessation office staff contest in 2016, with $1,000 to be shared by each month’s office winner. Look for more details in coming issues of BCN Provider News and on web-DENIS.

BCN introduces new incentive for PCPs to reduce tobacco usage

As part of our tobacco cessation campaign, Blue Care Network is offering an incentive as part of the 2016 Performance Recognition Program to primary care physicians.

PCPs can receive the incentive for mailing a follow-up letter to each of their BCN commercial patients who use tobacco. This letter should be sent as a follow-up to a face-to-face visit where the PCP has provided counseling to the patient about quitting tobacco use. To receive the incentive, providers must send letters to members as written by BCN. Copies of sent letters must be faxed to BCN for credit. The incentive does not apply for letters sent to Medicare members.

Blue Care Network PCPs should look for information about the 2016 PRP program in Health e-Blue to view details about this new incentive.

We hope this incentive encourages PCPs to provide more counseling and follow-up support to smokers who are trying to quit.
Blue Care Network is closed during the holidays

Blue Care Network offices will be closed on Dec. 24, 25, 31 and Jan 1, for the holidays and Jan. 18 for the Martin Luther King holiday.

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

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

**Note:** Clinical review for admissions to skilled nursing facilities and other types of transitional care services should be called in during normal business hours unless there are extenuating circumstances that require emergent placement.

The after-hours care manager phone number can also be used after normal business hours to discuss urgent or emergent determinations with a plan medical director.

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

As a reminder, when an admission occurs through the emergency room, we ask that you contact the primary care physician to discuss the member’s medical condition and coordinate care before admitting the member.
Chiropractors may provide some physical medicine services for BCN commercial members

Effective Aug. 1, 2015, chiropractors contracted with Blue Care Network may provide some physical medicine services for BCN HMO™ (commercial) members with coverage through groups that offer standard chiropractic benefits. This applies to services represented by select *97XXX procedure codes, provided in office and outpatient care settings.

The member’s primary care physician must issue a global referral for “office visits” when the member:

- Is from the East or Southeast region
- Has a plan with a designated provider network the chiropractor does not belong to

The chiropractor may then submit an authorization request for an episode of care via ereferral or by contacting Care Management at 1-800-392-2512.

You’ll find additional information about the referral and authorization process for these services in the Care Management chapter of the BCN Provider Manual. This section has been updated to reflect the details that primary care physicians, specialists and chiropractors need to know.

The document Outpatient rehabilitation services: Frequently asked questions has also been updated with these changes.

These documents are available through hyperlinks on the Outpatient Physical, Occupational and Speech Therapy Management Program page at ereferrals.bcbsm.com.

*CPT codes, descriptions and two-digit modifiers only are copyright 2015 American Medical Association. All rights reserved.

Online e-Learning available for chiropractors

Blue Cross Blue Shield of Michigan and Blue Care Network hosted webinars in July for chiropractors to learn about the expansion of services that went into effect Aug. 1, 2015. If you were unable to attend one of these webinars, but would still like to learn about these changes, please view our online e-Learning located on web-DENIS. The e-Learning includes the expanded list of payable procedures, new process change requirements and how to check a member’s eligibility and benefits. Please see the article on Page 41 for details.
BCN Advantage has introduced a member incentive for BCN Advantage™ HMO-POS Basic members to encourage members to visit their primary care physicians for an annual physical. There will be no Blue Advantage Rewards program for 2016.

BCN Advantage targeted members of the Basic plan because they’re the largest and growing percentage of our Medicare population and are less likely to visit the doctor. Our goal is to get members focused on visiting the doctor earlier in the year.

We want doctors to document their diagnoses and close their HEDIS® gaps. Doctors will receive an incentive through the current Stars program.

Members will receive a $50 gift card choice — Meijer, Walmart, CVS or Amazon — if they visit the doctor and one of the wellness and physical exam visit codes is entered on the claim. Members will be required to complete an attestation form confirming that they visited the doctor. The form needs to be signed by the member and the PCP.

In the meantime, BCN Advantage is also reminding these members about the importance of preventive services, such as mammograms, diabetes testing, flu vaccines and retinal eye exams, by mailing them letters and by including information about the procedures in the incentive program materials.

### Wellness and physical exam codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Code</th>
</tr>
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<tbody>
<tr>
<td>*99385</td>
<td>*99395</td>
<td>G0438</td>
</tr>
<tr>
<td>*99386</td>
<td>*99396</td>
<td>G0439</td>
</tr>
<tr>
<td>*99387</td>
<td>*99397</td>
<td>G0402</td>
</tr>
</tbody>
</table>

*CPT codes, descriptions and two-digit modifiers only are copyright 2015 American Medical Association. All rights reserved.
Managing patient care begins with accurate documentation and coding. You can participate in a 30-minute on-line training module to learn more about proper medical documentation.

After completing the course, if you take a 10-question assessment and score 80 percent or better, providers will receive one continuing education unit credit from the American Academy of Professional Coders.

Navigate to the training module by following these steps:

1. Go to bcbsm.com/providers and log in to Provider Secured Services using your user name and password.
2. Click on web-DENIS.
3. Click on BCN Provider Publications and Resources.
4. Click on Newsletters & Resources.
5. Click on Patient Care Reporting for Risk Adjustment.
6. In the Training Resources section, click on New online training: Best Practices for Medical Record Documentation (October 2015).

The training module provides helpful information about medical record documentation according to the Centers for Medicare & Medicaid Services, including:

- How to demonstrate the condition of the patient
- Principles of sound documentation
- Tips for maintaining quality medical records

The training module also covers the documentation elements needed for different types of Medicare office visits, such as:

- Initial preventive physical examination, also known as a “Welcome to Medicare” visit
- Annual wellness visit for Medicare beneficiaries
- Preventive medicine services
- Problem-oriented office visit E/M

We strive to ensure all patients with chronic conditions are seen at least once a year and that they receive appropriate care. Your detailed documentation and coding of diagnoses, along with any treatment or care each year, are crucial to managing patient care.

To properly document and code, doctors must manage, evaluate, assess or treat every patient and every condition, every year.

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Want to learn more?

You may also view a presentation titled, “Risk Adjustment, Best Practices for Documentation and Diagnosis Coding.”
Clarification on CMS training requirements for Medicare providers

The November-December 2015 BCN Provider News contained an article about the need for providers and vendors to take required Centers for Medicare & Medicaid Services fraud, waste and abuse and general compliance training.

Here’s clarification of what you need to do:


2. Scroll down to the Downloads section and click on Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training [ZIP, 2MB].

3. This will download two files — one in Microsoft PowerPoint and one that is a PDF document (for those who do not have PowerPoint software). Both documents contain the same training information and certificates. Only one of these documents needs to be used for training.

4. Have staff complete the training within 90 days of hire or contract and annually thereafter.

5. Both the PowerPoint slide deck and the PDF document contain two sections:
   a. CMS Parts C & D Fraud, Waste, and Abuse Training* (58 slides)
   b. Medicare Parts C & D Compliance Training (31 slides)

After each section, there is a Congratulations slide. If you use the PowerPoint version, the trainee can type his or her name and date on the slide and either print and file the copy or electronically save the document as proof of training completion. The PDF version of the training can’t be typed on, so trainees should print out the Congratulations page and print their name and date on it and keep it on file.

Each employee, contractor, volunteer, governing body member or downstream entity that provides health or administrative services for Medicare Advantage must have a Congratulations certificate on file from each training section (Fraud, waste and abuse training and general compliance training — two certificates total).

If the provider wishes to use his or her own training program, that provider must include the material from the Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training modules without modification and keep a record demonstrating completion of the training.

Certificates or other evidence of training completion must be kept on file for 10 years following the expiration of the contract.

*If the provider is enrolled in Medicare Parts A or B, the provider is “deemed” to have satisfied the FWA training requirement and is not required to take additional FWA training. However, the provider must still complete the general compliance training section and maintain a certificate as evidence of training completion.
BCN Advantage expanding specialty medical drug approval program on March 1, 2016

BCN AdvantageSM is expanding our medical drug prior authorization program for Medicare Advantage members to encourage proper use of high-cost specialty medications administered by a health care provider.

Beginning March 1, 2016, BCN Advantage will require prior authorization before these drugs will be covered under members’ medical benefits.

Prior authorization criteria include, but are not limited to diagnosis, lab results, dosing and frequency of administration. We may also require documentation regarding medications previously used to treat the member’s condition, including dosage, regimens, dates of therapy and response, as well as additional pertinent medical information.

Submit requests, along with the appropriate clinical information, for one of these medications electronically at ereferrals.bcbsm.com or by faxing the request to 1-800-675-7278. If the request is urgent contact our Care Management team at 1-800-392-2512.

For a full 2016 list of all medications and procedure codes that require prior authorization, refer to the BCN Referral and Clinical Review Program, available by visiting ereferrals.bcbsm.com and clicking on Clinical Review & Criteria Charts. Details on medical necessity criteria are posted on the same page. Just scroll down to the medical necessity criteria section and click Clinical Information for Drugs Covered under the Medical Benefit That Require Medical Necessity Review. The updated documents will be posted to the website by the end of February.

<table>
<thead>
<tr>
<th>J code</th>
<th>Brand name</th>
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<tbody>
<tr>
<td>J2504</td>
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</tr>
<tr>
<td>J1931</td>
<td>Aldurazyme®</td>
</tr>
<tr>
<td>J0256</td>
<td>Aralast™NP, Prolastin-C®, Zemaira®</td>
</tr>
<tr>
<td>J0881</td>
<td>Aranesp®</td>
</tr>
<tr>
<td>J1786</td>
<td>Cerezyme®</td>
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<td>Dysport®</td>
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<td>Elaprase®</td>
</tr>
<tr>
<td>J3060</td>
<td>Elelyso™</td>
</tr>
<tr>
<td>J0885</td>
<td>Epogen®, Procrit®</td>
</tr>
<tr>
<td>J0178</td>
<td>Eylea®</td>
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<tr>
<td>J0180</td>
<td>Fabrazyme®</td>
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<tr>
<td>J0257</td>
<td>Glassia®</td>
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<tr>
<td>J2778</td>
<td>Lucentis®</td>
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<tbody>
<tr>
<td>J0221</td>
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<td>J0220</td>
<td>Myozyme®</td>
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<tr>
<td>J1458</td>
<td>Naglazyme®</td>
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<tr>
<td>J2505</td>
<td>Neulasta®</td>
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<tr>
<td>J0897</td>
<td>Prolia®, Xgeva™</td>
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<tr>
<td>J1745</td>
<td>Remicade®</td>
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<tr>
<td>J7686</td>
<td>Tyvaso®</td>
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<td>J3590</td>
<td>Unclassified Biologics</td>
</tr>
<tr>
<td>J3490</td>
<td>Unclassified Drugs</td>
</tr>
<tr>
<td>J1325</td>
<td>Veletri®</td>
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<tr>
<td>J3385</td>
<td>VPRIV®</td>
</tr>
<tr>
<td>J0558</td>
<td>Xeomin®</td>
</tr>
<tr>
<td>J0775</td>
<td>Xiaflex®</td>
</tr>
</tbody>
</table>
Providers who prescribe drugs for Part D must enroll in Medicare or use opt-out process

Centers for Medicare & Medicaid Services rules require nearly all providers — dentists, physicians, psychiatrists, residents, nurse practitioners and physician assistants — including Medicare Advantage providers, who prescribe drugs for Part D patients to enroll in Medicare (or validly opt out, if appropriate).

Beginning June 1, 2016, CMS will enforce a requirement that Medicare Part D prescription drug benefit plans may not cover drugs prescribed by providers who are not enrolled in — or validly opted out of — Medicare, except in very limited circumstances.

For helpful information about the new requirement, such as resources to check your application status, or to sign up to receive updates go to go.cms.gov/PrescriberEnrollment.

If you have any questions about the notice, send an email to CMS at providerenrollment@cms.hhs.gov.
Our Chronic Care Improvement program, designed to prevent cardiovascular disease in BCN Advantage members has completed its fourth year. If you’re a frequent reader, you’ll remember that we’ve adopted the clinical interventions championed by Million Hearts™. Million Hearts is a public initiative led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services to prevent 1 million heart attacks and strokes in the U.S. over the next five years by focusing the nation on evidence based community and clinical prevention actions.

The table below is a summary of our audit findings.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator/Denominator</th>
<th>Percent</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of diabetic members represented in the sample</td>
<td>323/447</td>
<td>72%</td>
<td>N/A</td>
</tr>
<tr>
<td>Diabetic measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the diabetic patient have HgA1c testing?</td>
<td>316/323</td>
<td>98% ↑</td>
<td>97%</td>
</tr>
<tr>
<td>Was the diabetic patient’s HgA1c level below 9 percent?</td>
<td>310/316</td>
<td>98% ↑</td>
<td>95%</td>
</tr>
<tr>
<td>Tobacco cessation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there documentation of tobacco screening in the record?</td>
<td>384/447</td>
<td>86%</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of tobacco users</td>
<td>109/447</td>
<td>24%</td>
<td>N/A</td>
</tr>
<tr>
<td>Was there documentation of counseling on the importance of quitting smoking in the record?</td>
<td>30/109</td>
<td>28% ↓</td>
<td>44%</td>
</tr>
<tr>
<td>Aspirin use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there documentation that aspirin use was not appropriate for the member?</td>
<td>90/447</td>
<td>20%</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of medical records with documentation that daily aspirin was ordered</td>
<td>184/357</td>
<td>52% ↑</td>
<td>56%</td>
</tr>
<tr>
<td>Number of medical records that contained evidence of aspirin counseling</td>
<td>124/357</td>
<td>35% ↑</td>
<td>31%</td>
</tr>
<tr>
<td>Blood pressure control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For members under 59 years: BP below 140/90</td>
<td>25/28</td>
<td>89%</td>
<td>N/A</td>
</tr>
<tr>
<td>For members over 60 years BP below 150/90</td>
<td>321/419</td>
<td>77%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Please see Chronic Care Improvement Program, continued on Page 13
Opportunities for improvement

**Diabetic measures**
Both diabetic measures exceeded the threshold. Our efforts will continue to improve both. BCN’s Performance Recognition Program will continue in 2016 by providing rewards to practitioners who encourage their patients to control their blood sugar levels by getting HgA1c testing done at least annually and by keeping their HgA1c below 9 percent.

**Tobacco cessation**
The goal for tobacco cessation counseling wasn’t met. While 86 percent of the records audited contained evidence of screening for tobacco use, only 28 percent contained documentation of counseling on the importance of quitting.

Quitting smoking is hard and may require several attempts.\(^1\)\(^2\) People who stop smoking often resume the habit because of withdrawal symptoms, stress and weight gain.\(^1\)\(^2\)\(^3\) Don’t stop counseling your patients about the health benefits they can reap if they quit smoking. Members can enroll in BCN’s free online smoking cessation program powered by WebMD®.

**Aspirin use**
We fell short of meeting our goals for aspirin use and counseling despite the fact that the rates improved from the baseline. Aspirin use for high-risk patients, unless contraindicated, is one of the preventive actions recommended by the Million Hearts initiative and also by the Michigan Quality Improvement Consortium Guideline for the Management of Diabetes Mellitus.

BCN Advantage’s CMS Million Hearts Incentive Program and BCN’s Performance Recognition Program reward practitioners for the roles you play in helping us achieve our goals of preventing cardiovascular disease in BCN Advantage members.

The 2015 CMS Million Hearts Incentive Program document that explains this program in detail is available in BCN’s Health e-Blue™. The document is located in the Resources section under Incentive Documents.

In the coming year, we’ll continue to work on this very important initiative by focusing on the ABCs — **aspirin** for those who need it, **blood pressure** control, and quitting **smoking**. If you would like more information about the Million Hearts initiative, please go to the Million Hearts website.

**What you can tell your patients**
Here are some simple things you can do for your patients that will help us reach our goals and, more importantly, save lives by preventing heart attacks, strokes and related deaths in BCN Advantage members.

- Talk to your BCN Advantage patients about the CMS Million Hearts initiative and how following the ABCs will help them reduce their risk of heart attack and stroke.
- Prescribe aspirin or antiplatelet therapy for those who would benefit from it and document it in the patient’s chart.
- Ask your patients about their smoking habits and provide smoking cessation counseling and tools to help smokers quit. Document your interaction with the patient in the medical record.
- Recommend our free online tobacco cessation program to help BCN Advantage members quit smoking.
- Emphasize the importance of getting prescribed lab work drawn and follow up with those members who don’t get lab work drawn as ordered.

As health care professionals, you play a key role in helping patients reduce their risk for heart disease and stroke and lead longer healthier lives. In 2016, we’ll conduct another medical record audit to check on our progress. In the meantime, watch for updates on our Chronic Care Improvement Program in future issues of BCN Provider News.


Blue Cross Complete awarded additional Michigan counties

Blue Cross Complete of Michigan has been awarded a contract to provide coverage to thousands more lower-income Michigan residents with Medicaid and Healthy Michigan Plan coverage by the Michigan Department of Health and Human Services, effective Jan. 1, 2016.

The new contract expands Blue Cross Complete’s service area from its current counties of Livingston, Wayne, Washtenaw into 29 new counties — Allegan, Barry, Clinton, Eaton, Genesee, Hillsdale, Huron, Ingham, Ionia, Jackson, Kent, Lake, Lapeer, Lenawee, Macomb, Mason, Mecosta, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Osceola, Ottawa, Sanilac, Shiawassee, St. Clair and Tuscola.

Find electronic remittance advice changes on Emdeon website

Blue Cross Complete electronic remittance advices are no longer available on web-DENIS, effective Sept. 14, 2015. Electronic remittance advices will continue to be available on the Emdeon website.

If you have not already enrolled with Emdeon, visit emdeon.com/epayment. If you are already enrolled with Emdeon through another health plan, you can access Emdeon and select Blue Cross Complete using BCC Payer ID 32002.

In order to continue receiving your 835 remittance through Blue Cross, you will need to enroll on the Emdeon website and select BCBSM as your receiver.

Pharmacy resources available for Blue Cross Complete

The Blue Cross Complete Pharmacy and Therapeutics Committee approves formulary changes throughout the year.

These changes are published as a Pharmacy Update document, which can be found in the Pharmacy section at MiBlueCrossComplete.com/providers.

Please visit the site regularly to keep up to date with the latest changes. You can also access the Online Drug Search Tool and prior authorization documents in this section. The drug search lists our guidelines for these drugs, such as any quantity limits, prior authorization requirements and more.
Reminder: New process for Blue Cross Complete provider enrollment and change requests

Effective Oct. 1, 2015, Blue Cross Complete of Michigan made changes to its provider enrollment and change processes. Blue Cross Complete provider data will no longer be managed through the Blue Cross Blue Shield of Michigan Provider Enrollment and Change process.

Please do not send enrollment and change requests to Blue Cross Provider Enrollment and Data Management. Doing so will cause a delay in your request.

How to enroll
Providers who wish to enroll in the Blue Cross Complete Provider Network should complete the “Blue Cross Complete Enrollment Form” located at MiBlueCrossComplete.com/providers in the provider forms section.

Provider change requests
Providers must submit written notice of changes to Blue Cross Complete at least 60 days in advance when possible. Changes include but are not limited to the following:

- Physician staffing
- After hours and/or vacation coverage
- Practice location changes
- Billing address
- Tax ID changes

Changes should be submitted on the Blue Cross Complete Provider Change Form located on the Blue Cross Complete website in the Provider Forms section.

Forms submission
Completed enrollment or change forms must be submitted by the following methods:

Email: bccproviderdata@mibluecrosscomplete.com
Fax: 1-855-306-9762
Mail: Blue Cross Complete of Michigan
Attn: Provider Network Management
100 Galleria Officentre, Suite 210
Southfield, MI 48034

Please contact the Blue Cross Complete Provider Call Center at 1-888-312-5713 with questions.
From the medical director: We need to step up efforts to help members quit smoking

By Duane DiFranco, M.D.

We are so well acquainted with the health statistics* related to smoking that when we hear them repeated they sometimes fail to deliver their deservedly shocking effects. Pause, then, and consider:

- One out of every five deaths in the United States is attributed to smoking — more deaths than from illicit drug use, alcohol use, motor vehicle accidents, murder, suicide and HIV combined.

- Eighty-five percent of lung cancer deaths are attributed to smoking.
- Ninety percent of deaths related to chronic obstructive pulmonary disease are attributed to smoking.
- Four to five times increased risk of heart disease and stroke.
- Thirty-fold increase risk of developing cancer, including leukemia and cancer of the cervix, oral cavity, larynx, esophagus, stomach, pancreas, kidney and bladder.

- Negative effect on women: Infertility, preterm labor, stillbirth, low birth weight, Sudden Infant Death Syndrome, osteoporosis and hip fracture.

It becomes easy to see why experts have argued that quitting tobacco may be the single healthiest thing a user can do and that, for a population, reducing the smoking rate may be the single best preventive health goal to pursue.

But what can we do to help? Nicotine is a powerfully addictive substance and quitting is very difficult, even with the entire arsenal of available interventions aimed at the problem. It would seem to anyone to be a very daunting task indeed. It must seem all the more so for those who are on the “front lines” in this battle — busy primary care physicians.

Recognizing both the importance of the issue of tobacco use and the challenging nature of the problem physicians and smokers face in trying to tackle the problem, BCN has done a number of things to try to help.

- We have published a *Quit Guide* that contains advice and information on both pharmacological and nonpharmacological aids available to smokers as well as regional and national resource lists. Our *Quit Guide* was distributed to primary care offices in September 2014 and is available for download at [bcbsm.com/bcnquit](bcbsm.com/bcnquit).
- We have put a number of member incentives in place. These are described at our member landing page for smoking cessation, [bcbsm.com/bcnquit](bcbsm.com/bcnquit). To increase circulation of our *Quit Guide* among members, we have
From the medical director, continued from Page 16

also created a way for front office staff to earn incentive rewards for distributing the Quit Guide. This program was rolled out in October 2014 and has recently experienced a resurgence, with a 600 percent increased office participation rate. We have created a Web-based presentation that describes the contest. Information can also be requested on our dedicated hotline at 248-799-6959.

- We have added smoking cessation counseling to our 2016 Physician Recognition Program, or PRP.

Our collective efforts may seem inadequate when contrasted with the magnitude of the problem, but your efforts can and do matter. Remember, research shows that even a very brief word of encouragement and advice from you can increase a smoker’s chance of quitting. Tell your patients about our incentives. Distribute our Quit Guides and, if it suits your office, engage your front office staff in our reward contest. Your provider consultant can get you supplies and answer questions.

It may be true that most quit attempts fail, but that should not discourage you. Research shows that simple advice and information, counseling, nicotine replacement and other pharmacotherapy all can have a positive impact. Together, we believe we can increase the quit rate among the people we serve.

*Centers for Disease Control and Prevention, [http://www.cdc.gov/tobacco/basic_information/health_effects/index.htm](http://www.cdc.gov/tobacco/basic_information/health_effects/index.htm).

Tell your patients about Blue Care Network’s smoking cessation video

Blue Care Network has posted a video on YouTube to help members quit smoking. Dr. Duane DiFranco, a BCN medical director, reviews smoking cessation strategies, coping mechanisms and prescriptions drugs that patients may want to consider. Give your patients the link to YouTube to help them learn the benefits of quitting.
Preventive Services Guidelines updated for 2015

Blue Care Network follows the Michigan Quality Improvement Consortium clinical guidelines. MQIC has updated preventive services guidelines for ages birth-age ≥50.

These guidelines support several Healthcare Effectiveness Data and Information Set® measures. The National Committee for Quality Assurance® uses these HEDIS measures to determine quality health care practices. NCQA is recognized nationally and by Medicare as a reliable indicator of quality health care.

The updated preventive care guidelines are:

- **Routine Preventive Services for Infants and Children**
  - Birth-24 Months
- **Routine Preventive Services for Children and Adolescents Ages 2-21**
- **Adult Preventive Services Ages 18-49**
- **Adult Preventive Services Ages 50-65+**

The updated recommendations for infants and children include annual health screening, parental education on breast feeding (goal one year), dental health, tobacco use screening and second hand smoke exposure, neonatal screening, hearing screening, dental screening (6 months of age) and immunizations.

Recommendations for children and adolescents updates include:

- Annual health developmental screening (including once at 30 months)
- Risk assessments, including tobacco use screening and second hand smoke exposure
- Obesity screening and counseling, if indicated
- Dietary, physical activity and sedentary behavior assessment

- Parent and child age-appropriate education and counseling
- Dental health education
- Chlamydia and other sexually transmitted infection screening
- Pregnancy prevention
- Preconception counseling
- Psychological, behavioral and depression screening
- Cholesterol screening
- Immunizations

Adult preventive services new and updated recommendations include:

- Depression screening
- Intimate partner violence screening
- Cervical cancer screening and Pap smear screening
- Breast cancer screening
- Colorectal cancer screening
- Hepatitis C screening, lung cancer screening and immunizations

These one-page guidelines are researched using sources from the most current medical and scientific literature.

BCN values its partnership with practitioners in promoting quality health care outcomes for its members. These guidelines were developed as a resource to assist practitioners and aren’t intended to be a substitute for medical judgment. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Choosing Wisely – Avoid prescribing antibiotics for upper respiratory infections

In the last issue of the BCN Provider News we introduced Choosing Wisely®, an initiative that promotes conversations between physicians and patients about medical tests and procedures that may be unnecessary or potentially harmful. In this issue, we discuss the Choosing Wisely campaign on antibiotic use in upper respiratory infections.

The majority of acute upper respiratory infections are viral and antibiotic treatment is ineffective, inappropriate and potentially harmful. Confirmed infection by Group A streptococcal disease (strep throat) and pertussis (whooping cough) should be treated with antibiotics. Treatment for URIs consists of treating the symptoms. It’s important that health care providers talk with their patients and provide education about the consequences of misusing antibiotics in viral infections, which may lead to increased costs, antimicrobial resistance and adverse effects.

Choosing Wisely has materials you can download that explain when it’s appropriate to use antibiotics and when it’s appropriate to avoid them. You can also go to Consumer Health Choices for more information on appropriate antibiotic use.

Consumer Health Choices has the 5 Questions to ask your doctor before you take antibiotics flier that you can print and give to your patients and posters that you can use in your office. The materials are available at Consumer Health Choices.

For additional information on Choosing Wisely, you can visit choosingwisely.org.
Blue Care Network uses McKesson’s InterQual Level of Care when conducting admission and concurrent review activities for acute care hospitals. To ensure that providers and health plans understand the application of the criteria and local rules, BCN provides clarification from McKesson on various topics.

**Question:**
What is the difference between hypertensive emergency and hypertensive urgency?

**Answer:**
Hypertensive emergency is defined as a severe elevation in blood pressure complicated by evidence of impending or progressive target organ dysfunction. Target organs include the brain, heart and kidney as well as the central and peripheral arteries. Hypertensive damage to major organs may include hypertensive encephalopathy, intracerebral hemorrhage, acute myocardial infarction, acute left ventricular failure with pulmonary edema, unstable angina, dissecting aortic aneurism or eclampsia. In this situation the blood pressure has increased beyond the body’s autoregulatory mechanism’s ability to compensate by vasoconstriction.

It’s the goal of treatment to decrease the blood pressure to a range in which autoregulatory forces may be restored. The threshold for the diagnosis of hypertensive emergency varies by patient; most end-organ damage occurs when diastolic pressures exceed 120-130.

A hypertensive emergency is treated with the use of parenteral antihypertensive to maintain blood pressure and it requires close monitoring.

Inpatient clinical reviews should include multiple blood pressure readings and a description of the hypertensive emergency and parenteral treatment in order to be considered for inpatient approval. Some potential symptoms may include chest pain, shortness of breath, headache, confusion or epistaxis.

Hypertensive urgency is defined as patients with extremely high blood pressure who aren’t demonstrating symptoms indicative of potential end organ damage. Hypertensive urgency can be treated in an outpatient or observation setting.

See Glossary Note 58 located in the Glossary Section in the Adult InterQual book for additional information.
February focus is on heart health

February is American Heart Month and Blue Care Network is reminding providers that it’s important for members to be appropriately screened for conditions that can affect heart health. BCN supports Michigan Quality Improvement Consortium guidelines, including those for screening and management of hypercholesterolemia, hypertension, overweight and obesity and tobacco control.

Cardiovascular disease

Hypertension is a serious condition that, if left untreated, can lead to coronary heart disease, kidney disease and possibly stroke. About one in three adults in the United States has hypertension and it usually starts between the ages of 35 and 50. There are no symptoms or warning signs and it can affect anyone regardless of race, age or gender.

Risk factors that can’t be controlled
• Age (45 and older in men, 55 and older for women)
• Family history of early heart disease

Risk factors that can be controlled by the member with guidance from the provider
• High cholesterol (high LDL or bad cholesterol)
• Low HDL (good cholesterol)
• Smoking
• High blood pressure
• Diabetes
• Obesity, overweight
• Physical inactivity

Factors that determine LDL (bad) cholesterol level
• Heredity
• Diet
• Weight
• Physical activity and exercise
• Age and gender
• Alcohol
• Stress

Some highlights from the MQIC guidelines are noted on the next page. For the complete guidelines, visit mqic.org.

Please see Heart health, continued on Page 22
Heart health, continued from Page 21

Lipid screening and management
- Initial screening to include fasting lipid profile (total cholesterol, LDL-C, HDL-C, triglycerides). Repeat every five years if normal.
- Screening of LDL-C levels at least annually for member with a cardiac event (AMI, PTCA, CABG) or diagnosis of ischemic vascular disease.
- Treatment based upon presence of clinical atherosclerotic cardiovascular disease (ASCVD); 10-year ASCVD risk calculation for patients 40-75 without clinical ASCVD, diabetes mellitus (type 1 or 2) or LDL-C >190 mg/dl. (Refer to the ASCVD Risk Estimator Tool from MQIC)
- Statin dosing intensity based upon ASCVD presence and risk.
- Educate patient about therapeutic lifestyle changes, including losing weight, exercising and following a healthy diet.

Management of overweight and obesity in adults
- If body mass index >30 or >27 with other risk factors or conditions, consider referral to a program that provides guidance on nutrition, physical activity and psychosocial concerns.
- Pharmacotherapy only for patients at increased risk because of their weight and coexisting risk factors or comorbidities.
- BMI >40 or >35 with uncontrolled comorbid conditions consider weight loss surgery.

Providers can encourage healthy lifestyles by reminding patients to do the following:
- Develop a healthy eating pattern: Eat foods low in saturated fat and cholesterol.
- Reduce salt and sodium. (The Centers for Disease Control and Prevention reports a potential of 11 million fewer cases of hypertension just by reducing sodium intake from the average 3,400 mg daily to 2,300 mg.)
- Maintain a healthy weight.
- Get regular physical activity for at least 30 minutes most days of the week.
- Limit alcohol.
- Quit smoking.
- Take blood pressure medication as prescribed.

Providers can also refer members to the National Health Lung and Blood Institute website for information about heart disease.
January is cervical cancer awareness month

Please remind your female patients age 21 and older about the benefits of routine cervical cancer screening.

Blue Care Network supports the Michigan Quality Improvement Consortium recommended preventive health clinical guidelines:

<table>
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<th>Recommendation</th>
<th>When</th>
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| Cervical cancer screening – Pap smear   | • Ages 21 to 65  
   Every three years with cytology or, for women age 30 to 65 years who want to lengthen the screening interval, screen with a combination of cytology and human papillomavirus testing every five years. Testing for HPV before age 30 not recommended.  
   • If not high risk, have had adequate screening with normal Pap smears, recommend against screening women older than age 65.  
   • Routine Pap smear screening not recommended in women who have had a total hysterectomy for benign disease or age less than 21. |

Blue Care Network also recommends chlamydia and gonorrhea screening

Screen for chlamydia and gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.

For additional screening information, refer to the Michigan Quality Improvement Consortium adult preventive services guidelines ages 18 to 49 and for ages 50 to 65+.

To read about how one doctor maintains high cervical cancer screening rates, see the Best Practices article on Page 28.

Medical policy updates

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

Noncovered service

• Genetic testing for CHEK2 mutations for breast cancer

Covered service

• Percutaneous left atrial appendage closure devices for stroke prevention in atrial fibrillation
Help patients stay healthy in 2016

As 2016 rolls around, people will make New Year’s resolutions to improve their health. Below is a brief reminder checklist for providers to help their patients stay healthy.

- Get an early start with patients in 2016. Take a body mass index measurement on every patient. (For patients 17 to 21, documentation in the medical record must indicate the height, weight and BMI percentile. For children age 3 to 17 years, you must have counseling for nutrition, for example, eats three meals per day. Complete a checklist verifying nutrition discussion. Counseling for physical activity, for example, exercises one hour per day. Complete checklist verifying discussion of physical activity.

- For diabetics, complete HbA1c, nephropathy monitoring (urine for protein or on ACE/ARB meds, or renal diagnosis), blood pressure. Encourage patient to schedule a diabetic eye exam. Schedule follow-up visits as results indicate.

- For patients with hypertension, follow up on medication regime, document lifestyle changes and blood pressure checks to ensure appropriate management.
  - Age 18-59 years old BP 139/89 or less
  - Age 60-85 years old with a diagnosis of diabetes BP 139/89 or less
  - Age 60-85 years old without a diagnosis of diabetes BP 149/89 or less

- Review history and order colon cancer screening test, if needed (age 50 to 75, colonoscopy every 10 years).

- For all females between the ages 50 and 74, order a mammogram (if they haven’t had one for 27 months) and cervical cancer screening age 21 to 64 (if they haven’t had one in three years or five years, if last Pap and HPV test done together) .

- Talk to every patient about the need for physical exercise, 30 minutes a day.

- For seniors, ask about the risks of falling and do a safe environment check.

- Conduct depression assessments as appropriate.
- Check immunizations record for children on the Michigan Care Improvement Registry and schedule visits to complete missing immunizations.
- Reach out to your assigned patients if they don’t schedule an office visit in the first six months of the year.

Blue Care Network appreciates your efforts in working to keep our members healthy.

For information on preventive services, please call Stars & HEDIS Operations & Data Management at 248-350-7405.

Patient Safety Awareness Week is in March

The National Patient Safety Foundation has designated March 13 - 19 as National Patient Safety Week.

Blue Care Network supports the efforts of the Patient Safety Foundation and encourages its provider community and members to get involved.

Studies show that patients who are more involved in their health care have better outcomes.

Communication between patients and their health care providers plays an important role. Encourage your patients to become an active participant in their health care.

- Provide an environment where patients feel comfortable talking openly.
- Provide information about your patient’s care in a manner that is understandable to them.
- To learn more, visit the National Patient Safety Foundation website.
BCN’s behavioral health utilization management criteria are changing

Effective Jan. 1, 2016, Blue Care Network is using McKesson’s InterQual® Behavioral Health Criteria as utilization management guidelines. InterQual criteria are evidence-based clinical support criteria specifically developed to help move patients safely and efficiently to the appropriate initial and subsequent level of care. The criteria require reviewers to consider the severity of illness as well as episode-specific variables that match the level of care to a patient’s current condition.

InterQual Behavioral Health criteria are developed with evidence-based rigor and are validated through the expertise of a multidisciplinary panel of psychiatrists, psychologists, psychiatric nurses and social workers. McKesson comprehensively reviews medical literature and other respected sources to ensure that the criteria are current with the latest advances in evidence-based medicine as well as with new terminology and diagnostic classifications.

To purchase a copy of the InterQual Behavioral Health criteria, call the InterQual Support unit at McKesson Health Solutions at 1-800-274-8374.

BCN local criteria will be used for specific services

In addition, BCN Behavioral Health will continue to use its own, local utilization management criteria for decisions about specific services, as follows:

- Transcranial magnetic stimulation criteria and guidelines
- Neurofeedback training criteria for attention deficit disorder and attention deficit hyperactivity disorder admission criteria
- Autism spectrum disorder applied behavior analysis admission criteria
- Residential mental health services and adult, adolescent and child admission criteria

These local criteria were developed with guidance from national experts, clinical advisory committees and providers. These criteria are assessed and revised at least annually. To obtain a copy of the BCN local criteria sets, visitereferrals.bcbsm.com and click Behavioral Health.

Requesting criteria related to a specific decision

The review criteria related to a specific case decision are available to practitioners upon request by calling BCN Behavioral Health at 1-800-482-5982.

If you have any questions, please contact BCN Behavioral Health at 1-800-462-5982.
Quality corner: Appropriate glucose monitoring

What are the risks for those taking antipsychotics?
The American Diabetes Association has noted that those taking antipsychotics are at an elevated risk for dyslipidemia, weight gain, obesity and type 2 diabetes.

What should be monitored if patients are taking antipsychotics?
Blue Care Network has reviewed the literature presented by the American Diabetes Association. The ADA suggests monitoring the following:
• Personal history (at baseline and annually)
• Weight (at baseline, 4 weeks, 8 weeks, 12 weeks, quarterly and annually)
• Waist circumference (at baseline, 12 weeks and annually)
• Blood pressure (at baseline, 12 weeks and annually)
• Fasting plasma glucose/A1C (at baseline, 12 weeks and annually)
• Fasting lipid profile (at baseline, 12 weeks and annually)

What is considered appropriate glucose monitoring to receive incentives?
For the Behavioral Health Incentive Program, BCN has included the screening via fasting plasma glucose or A1c at baseline, an initial monitoring test (to be completed within 15 weeks of the patient’s index prescription start date), and a follow-up monitoring test (to be completed by the end of the year).

BCN is offering an incentive for this measure. Each time an office completes the measure according to the technical specifications provided in the program guidelines, the office is qualified to receive $80. To learn more about the incentive program, please see the article about the incentive program on Page 27.

Why is it important?
Regular monitoring of fasting plasma glucose or A1c ensures that:
• Physical health and metabolic issues are taken into account
• Patients can get help early on
• Medications are adjusted accordingly
• In the long term, leads to decreased morbidity and increased life expectancy*

Resources for you
Have questions? Contact your provider consultant for questions related to the BHIP program. If you don’t know your consultant, go to bcbsm.com/providers.

Check out updates to the Behavioral Health Incentive Program

The Behavioral Health Incentive Program, which is entering its third year, has seen a tremendous growth in self-reported form submissions. To accommodate this growth, and to ensure that payments are released efficiently, the second six months self-reported measures payment will be released independently of the annual claims-based payment.

Therefore, the self-reported payment will be released in the spring, while the claims-based payment will be released later in the summer.

To further expedite the process of self-reported submissions, we have launched an electronic option for the self-reported forms. It is not a mandated approach, but simply an option in place of faxing or emailing individual forms. Instructions on how to submit forms electronically can be found on web-DENIS. We encourage providers to use this electronic method because it is quicker, easier, and more accurate.

Now that we have completed a full two years of receiving and uploading the self-reported forms, we wanted to highlight ways that providers can avoid rework and ensure that submissions are processed quickly, always given credit, and are more manageable.

- Include both your type I and type II NPI on all forms. Even if you are an individual provider, you should have a type II NPI (your billing NPI that you use to submit claims, which is different from the rendering provider NPI). If you are submitting as an outpatient clinic and you are not internally keeping track of which provider submitted the forms, you can include your type II only, but please enter it in the type II space provided on the form and not the type I space.

- Please do not send duplicate forms. Monitor which forms you have already sent carefully. When we do receive duplicate forms, we still upload all the information manually, but then exclude duplicates during our final analysis. Uploading the information takes our time and resources and takes you time when faxing, but then no credit is given.

- Please ensure all writing is legible and that the names of providers are spelled consistently on the forms.

Please find the new 2016 program documents on web-DENIS.

- Go to BCN Provider Publications and Resources
- Click on Behavioral Health under Resources
- Scroll down to Behavioral Health Incentive Program

Thank you to all the behavioral health providers who participated. We appreciate your efforts to improve members’ health.

Use e-referral for all referrals and authorization requests

Why wait on the phone? Save yourself time and use e-referral exclusively for your Blue Care Network referral and authorization needs. With a couple of clicks you can submit requests or check on the status of requests.

If you don’t have an e-referral user ID sign up today.

If you don’t know how to use e-referral, please go to training tools on the e-referral website.

Please see the full article on Page 44 for additional details.
Best Practices

Focus on preventive care helps Lake Orion practice maintain high cervical cancer screening rates

Lake Orion-based physician Jennifer Prohow, D.O., has a focus on preventive care that makes physicians, physician extenders and their medical assistants accountable for making sure patients get their preventive screenings.

Orion Family Physicians has a high rate of cervical cancer screening because the providers stress early preventive care and take a team approach to treating patients.

“Preventive care is a really big deal for us,” says Dr. Prohow. “We check the charts of every patient who comes in for a visit, even if it’s a common cold.”

“My medical assistant knows my patients and has a good rapport with them,” she adds. “She actively looks for gaps in care, so when I go in to see the patient she has already evaluated the chart. When the patient comes in, ultimately they have been reminded twice about their overdue testing and they’re more likely to make the appointment to get their screening exams.”

Dr. Prohow says the changing guidelines have helped keep the practice’s cervical cancer screening rates high. “Now, cervical cancer screening is every three to five years based on age and whether they’ve been co-tested for HPV,” she says. “I document when my patient got her screening whether it be with us or a gynecologist. The medical assistant confirms that the patient went and pulls the results. If we find it’s outside the screening period, we make another follow-up call with the patient.”

Since Dr. Prohow serves a large population of childbearing-age women, many still see their gynecologists. “I still feel responsible for their health care so we always follow up to be sure they are up to date.”

All five doctors and their five physician extenders in the practice pay the same attention to detail. They work together with the medical assistants to provide comprehensive chart reviews and devise follow-up plans.

“We also educate patients about the importance of cervical cancer screenings and other preventive care,” says Dr. Prohow. The office distributes patient handouts about screenings during physical exams. “Education is important for younger women because a lot of young girls don’t know about PAP smears, HPV screening and how HPV is transmitted,” says Dr. Prohow.

Some challenges to cervical cancer screening that the office faces is still an element of non-compliance, lack of education about screening and a lack of insurance coverage. If the patient has no insurance, Dr. Prohow refers them to the Michigan Breast and Cervical Cancer Control Program, which provides free cervical and breast cancer screening for women over 40. “I make sure patients get access to all the resources available to them,” she says. “People have to take responsibility for their health, but we do a pretty good job of engaging them and pointing them in the right direction,” she says.

“One of the attributes I liked when I first interviewed with this practice nine years ago is the focus on patients,” said Dr. Prohow. “We spend a lot of time with our patients. With reimbursements decreasing, doctors feel more pressure to see more patients every day. We may see fewer patients, but we like to spend the extra time for those important conversations.”
Quality Improvement Program information available upon request

Blue Care Network provides you with ongoing information about our quality improvement programs and clinical practice guidelines through this newsletter. Approved clinical practice guidelines are available to all BCN primary care physicians, primary care groups and specialists. Copies of the complete guidelines are available on our secure provider portal. To access the guidelines:

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

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

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

In 2015, BCN (commercial HMO) ranked in the top 10 percent of all health plans nationally on the following HEDIS® measures that address important health improvement goals:

- Adult body mass index monitoring
- Adolescent immunizations
- Colorectal cancer screening
- Breast cancer screening
- Follow-up after hospitalization within seven days for mental illness
- Pharmacotherapy management of COPD — Systemic corticosteroid
- Weight assessment and counseling for nutrition and physical activity for children and adolescents

Some measures that scored as needing improvement included:

- Avoidance of antibiotic treatment in adults with acute bronchitis (antibiotics aren’t always needed)
- Childhood immunizations by age 2
- Chlamydia screening
- Follow-up care for children prescribed medication for attention deficit hyperactivity disorder (initiation phase and continuation phase)
- Flu shots
- Postpartum care

Please see Quality Improvement Program, continued on Page 30
Quality Improvement Program, continued from Page 29

In 2015, BCN Advantage received 4 or 5 Stars in the CMS Star rating and the NCQA 90th percentile on the following HEDIS measures that address important health improvement goals:

- Adult BMI assessment
- Breast cancer screening
- Controlling high blood pressure
- Disease modifying antirheumatic therapy in rheumatoid arthritis
- Osteoporosis management in women who had a fracture

Some measures that scored as needing improvement included:

- Advising smokers to quit
- Antidepressant medication management
- Colorectal cancer screening
- Comprehensive diabetic care — eye exams
- Comprehensive diabetic care — HbA1c poorly controlled >9 percent
- Comprehensive diabetic care — monitoring for nephropathy
- Flu shots

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

To ensure accessibility of care to our members, BCN has access and availability standards for the following types of appointments:

- Preventive care
- Routine primary care
- Urgent care
- Emergency care
- After-hours access
- Practitioner waiting room times

Our quality management coordinators monitor access throughout the year. We notify physicians who are noncompliant with access standards and provide them with the opportunity to achieve compliance. More information is available in the BCN Provider Manual. Log in to web-DENIS, click on Provider Manual and open the Access to Care chapter.

If you’d like additional information about our programs or guidelines, please contact our Quality Management department via email at BCNQIQuestions@bcbsm.com. You may also call us at 248-455-2714.
Quick TIPS: Acute pharyngitis in children

Using MQIC’s **Guideline for Acute Pharyngitis in Children 2-18 Years Old** helps you align current assessment, diagnostic and treatment protocols to ensure the right care at the right time for your patients, while also improving HEDIS® scores.

Between 70 and 80 percent of pharyngitis cases in children are the result of viruses and only about 15 to 30 percent are due to primary bacterial pathogens (group A beta hemolytic streptococcus, or GABHS, being the most common). Antibiotics should not be used for apparent viral respiratory illnesses as evidence has shown that unnecessary medication use for those conditions can lead to antibiotic resistance and increase the risks of adverse events. It’s crucial to obtain either a throat culture or rapid strep test if strep is suspected before prescribing an antibiotic.

You may need to help your patients’ parents understand that:

- Strep cannot be diagnosed just by looking at the throat.
- Antibiotics are not warranted unless one of the tests shows strep.
- If antibiotics are prescribed, parents need to make sure their child takes medication as directed, even if their child feels better after a few doses.
- If antibiotic treatment stops too soon, the infection may get worse or spread in the body.

The MQIC Guideline for Acute Pharyngitis in Children 2-18 Years Old and related references and tools can be found at [mqic.org](http://mqic.org). Or you can download MQIC’s free phone app to your phone or tablet by searching “MQIC” in either the App Store or Google Play.

Additionally, the Choosing Wisely Campaign and the Centers for Disease Control and Prevention’s Get Smart initiative have resources available to share with patients and their families.

The Michigan Quality Improvement Consortium is Michigan’s home-grown initiative for the development of evidence-based clinical practice guidelines. Blue Care Network is proud to be a part of this effort to standardize the use of evidence-based clinical practice guidelines and related tools to improve health outcomes for Michigan residents.
Did you know that up to three-quarters of the total cost associated with asthma may be due to poor asthma control, and that adherence to asthma medication ranges anywhere from 30 to 70 percent?

Using Michigan Quality Improvement Consortium’s one-page guideline for General Principles for the Diagnosis and Management of Asthma helps you align current assessment, diagnostic and treatment protocols so that you provide the right clinical interventions at the right time for your patients, and also provides support for quality programs and measures.

The MQIC guideline, which can be found at the MQIC website, addresses:

- Eligible population
- Diagnosis and management goals
- Assessment and monitoring
- Education
- Environmental factors and comorbid conditions
- Medications

Doctors should regularly assess and monitor patients with asthma so they can prescribe appropriate therapy, address asthma triggers, ensure proper medication techniques and identify other barriers to good self-management such as medication costs and availability. Proper management seeks to minimize flare-ups and improve quality of life. Working with your patients to develop personalized asthma action plans can also help with long-term adherence by helping them feel empowered through increased knowledge and awareness.

The MQIC website includes links to several clinical and patient-friendly resources to assist you in the diagnosis and management of asthma. These resources include:

- Classifying Asthma Severity and Initiating Therapy
- Assessing Asthma Control and Adjusting Therapy
- Asthma action plan templates
- Instructions on how to use an asthma inhaler
- Asthma Guideline Implementation Steps & Tools (GIST)

You can download these resources right to your phone or tablet with MQIC’s free iOS and Android apps. Simply, search MQIC in either the App Store or Google Play.

The Michigan Quality Improvement Consortium is Michigan’s home-grown initiative for the development of evidence-based clinical practice guidelines. Blue Care Network is proud to be a part of this effort to standardize the use of evidence-based clinical practice guidelines and related tools to improve health outcomes for Michigan residents.
Price watch feature helps manage drug costs

Blue Care Network strongly encourages the use of generic drugs. As we noted in the September – October issue, prices for some generic drugs are increasing rapidly, which can increase costs for patients. BCN continues to monitor changes in the market and highlight alternatives to high-priced generics. Look for this Generic Price Watch feature in upcoming issues. We’ll identify generics that have experienced price jumps or whose cost never dropped after going generic, and offer lower-cost alternative for consideration.

### Generic Price Watch

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<thead>
<tr>
<th>High-cost generic</th>
<th>Average cost per Rx</th>
<th>Lower-cost alternatives</th>
<th>Average cost per Rx for alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify® (g)</td>
<td>$764</td>
<td>Clozaril (g), Geodon (g), Risperdal (g), Seroquel (g), Zyprexa (g)</td>
<td>$44</td>
</tr>
<tr>
<td>Actonel® (g)</td>
<td>$160</td>
<td>Boniva® (g), Fosamax® (g)</td>
<td>$9</td>
</tr>
<tr>
<td>Skelaxin® (g)</td>
<td>$390</td>
<td>Flexeril (g), Norflex (g), Parafon Forte (g), Robaxin (g)</td>
<td>$20</td>
</tr>
</tbody>
</table>

Blue Cross and BCN drug lists updated, available online

The Blue Cross Blue Shield of Michigan and Blue Care Network Pharmacy and Therapeutics Committee reviewed the pharmaceutical products listed in the PDF below for inclusion in the BCBSM/BCN Custom Drug List 2015, Custom Select Drug List 2015 and the BCN AdvantageSM HMO-POS Formulary.

Please help ensure that our members get the care they need by talking with them about their drug copayment or coinsurance. Note that many members with a commercial drug benefit do not have coverage for Tier 3 drugs.

Blue Cross and BCN regularly update their drug lists. For the most recent updates, go to [bcbsm.com/rxinfo](http://bcbsm.com/rxinfo).
Glumetza requires prior authorization for coverage

Valeant Pharmaceuticals recently increased the price of Glumetza® (metformin extended release) by more than 900 percent. The drug hasn’t changed, but the cost has exploded from about $840 per month to more than $8,000.

Glumetza is available only as a brand-name drug. Generic metformin extended release options are available in the same strengths as Glumetza for a fraction of the cost. Generic metformin extended release provides the lowest copayment to the member.

This price jump may cause members who have a pharmacy benefit that uses percentage copayments on prescription medications to stop taking their medication due to the high cost.

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Generic available?</th>
<th>Average monthly cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glumetza</td>
<td>No</td>
<td>$8,040</td>
</tr>
<tr>
<td>Glucophage® XR</td>
<td>Yes</td>
<td>&lt; $10</td>
</tr>
<tr>
<td>Fortamet®</td>
<td>Yes</td>
<td>$360</td>
</tr>
</tbody>
</table>

*Monthly cost based on 2,000mg daily

Blue Care Network continues to monitor and take action on drug price increases to help our members receive appropriate drug therapy and save money.

Beginning Jan. 1, 2016, BCN will require prior authorization on all prescriptions for Glumetza. Physicians should work with any members currently on Glumetza to change them to a generic metformin extended-release option.

All members will need prior authorization for coverage of Glumetza, and must meet the following criteria:

1. Trial and failure or intolerance to generic metformin extended-release for at least three months

2. A credible explanation as to why Glumetza is expected to work when generic metformin extended-release has not

This requirement affects BCN commercial members with a BCN pharmacy benefit. BCN will write to affected members and their doctors to notify them of this change. Please consider prescribing generic metformin for these members to ensure that they continue to receive appropriate and cost-effective drug therapy.
Reminder: Use NDC for commercial drug claims

In the last issue, we reminded you that as of Nov. 1, 2015, you must include the National Drug Code and the appropriate NDC quantity on your Blue Care Network commercial drug claims. If you do not include the appropriate NDC code and quantity, your claim may be denied or you may not receive the payment you expect.

- A medical drug claim will be denied if it is billed with an invalid NDC and HCPCS/CPT code combination.
  - This medical drug claim scenario will result in the claim being denied BLF: We can decide payment when you send a new claim with a valid NDC, quantity or unit of measure for this procedure code.
  - The 835 remittance advice message will have a claim adjustment reason code (CARC) of 16: Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
  - The RARC will be M119: Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).
- A medical drug will also be denied if the unit of measure and/or the NDC quantity is not valid for the NDC and HCPCS/CPT code combination.
  - These medical drug claim scenarios will result in the claim being denied BTD: For payment review, the claim has to show the correct National Drug Code unit of measure and quantity for the item used with this code.
  - The 835 remittance advice message will have a claim adjustment reason code (CARC) of 16: Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
  - The RARC will be M123: Missing/incomplete/invalid name, strength, or dosage of the drug furnished.

Please refer to the article on Page 49 of the November-December issue for more information. However, please note the following correction on units of measure.

Units of measure

Please do not use milligrams (ME) as a unit of measure on your BCN or Blue Cross professional drug claims. You can use these units of measure:

- Weight – grams (GR)
- Volume – milliliter (ML)
- Count – unit (UN)

What should you do if you receive a BLF or BTD denial?

BLF:

In order for your claim to be accepted and processed by BCN you must ensure that the NDC is correct for the procedure code you submitted, NDC quantity is greater than 0 and/or Unit of Measure is populated.

BTD:

In order for your claim to be accepted and processed by BCN you must ensure that the unit of measure is appropriate or the NDC quantity is correct based on the NDC for the drug you administered.

- Please reference the BCBSM Minimum Injections Fee Schedule. This provides information regarding what unit of measure you should submit your claim with for each HCPCS/CPT code.
- The quantity for the drug will vary based on the member and the drug being administered.
Best practices for documenting pregnancy, childbirth, and the puerperium

The introduction of ICD-10-CM coding on Oct. 1, 2015, brought many changes to how we code pregnancies and the complications of pregnancies. ICD-10-CM coding captures a greater level of specificity for obstetric conditions, as it does for other conditions. Let’s explore some of these changes.

ICD-10-CM official guidelines for reporting and coding

“Pregnancy, Childbirth, and the Puerperium” is found in Chapter 15 of the ICD-10-CM coding manual. The majority of the codes in this chapter have a final character indicating the pregnancy trimester. Trimesters are counted from the first day of the last menstrual period and are defined as follows:

- First trimester — less than 14 weeks, 0 days
- Second trimester — 14 weeks, 0 days to less than 28 weeks, 0 days
- Third trimester — 28 weeks, 0 days until delivery

For example:

- O09.00 — Supervision of pregnancy with history of infertility, unspecified trimester
- O09.291 — Supervision of pregnancy with other poor reproductive or obstetric history, first trimester

Codes from category Z3A are for use only on the maternal record to indicate the pregnancy gestation weeks. Remember to first code complications of pregnancy, childbirth, puerperium (O00-O9A):

- 009.291 — Supervision of pregnancy with other poor reproductive or obstetric history, first trimester
- Z3A.09 — Nine weeks gestation of pregnancy

This is especially important as some providers are submitting Z3A codes as a reason for performing ultrasounds. These informational codes are not payable because they don’t code to an actual condition. These codes should only be reported as a secondary diagnosis.

If a trimester is not a component of a code, it’s because the condition always occurs in a specific trimester or the pregnancy trimester is not applicable. Certain codes have characters for only certain trimesters because the condition doesn’t occur in all trimesters. For example:

- O21.2 — Late vomiting during pregnancy (excessive vomiting that starts after 20 weeks of gestation)

The provider’s documentation of the number of weeks of pregnancy may be used to assign the appropriate code identifying the trimester.

Note: To avoid claim rejection after a patient receives an ultrasound, consider the following:

- **Example A**: A member who is 16 weeks pregnant with twins (monochorionic monoamniotic) arrives for an ultrasound. Apply the complication code, the appropriate gestation code and the appropriate CPT code:
  - O30.012 — Twin pregnancy (monochorionic monoamniotic), second trimester
  - Z3A.16 — 16 weeks of gestation of pregnancy
  - Apply the appropriate CPT code

- **Example B**: A member who is nine weeks pregnant arrives for a routine fetal ultrasound. Apply normal screening code first (uncomplicated pregnancy), followed by the appropriate CPT code:
  - Z36 — Encounter for antenatal screening of mother
  - Appropriate CPT code

Please see Coding Corner, continued on Page 37
Coding Corner, continued from Page 36

Maternal record

Chapter 15 codes are to be used only on the maternal record, never on the newborn’s record. Codes from this chapter should be used for conditions related to or aggravated by the pregnancy, childbirth or by the puerperium (maternal causes or obstetric causes). For example:

- O00.1 — tubal pregnancy

For the category O00, use any additional code from category O08 to identify any associated complications:

- O00.1 — Tubal pregnancy
- O08.1 — Delayed or excessive hemorrhage following ectopic and molar pregnancy

Status codes used only on the maternal record are from category Z37. For example, outcome of delivery category Z37.

Outcome of delivery codes should be included on every maternal record when a delivery has occurred. These codes shouldn’t be used on subsequent records or on the newborn record. Here are a few examples from category Z37:

- Z37.0 — Single live birth
- Z37.50 — Multiple births, unspecified, all live born
- Z37.9 — Outcome of delivery, unspecified

Note: These codes shouldn’t be reported as a primary diagnosis on professional claims because they are informational in nature and don’t code to a reason for the service. They should only be used on the mother’s claim as a secondary diagnosis.

There are codes exclusively for the newborn record, such as category Z38. For example, Z38 “live born infants according to place of birth and type of delivery.” Here are a few examples from category Z38:

- Z38.0 — Single live born infant, born in hospital
- Z38.63 — Quadruplet live born infant, delivered vaginally
- Z38.8 — Other multiple live born infants, unspecified as to place of birth

HIV infection in pregnancy, childbirth and puerperium

During pregnancy, childbirth or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis from subcategory O98.7-, “human immunodeficiency disease complicating pregnancy, childbirth and the puerperium,” followed by the code(s) for the HIV-related illness(es). For example:

- A patient presenting for an HIV-related illness should receive a principal diagnosis code O98.7 — followed by category B20 and the code(s) for the HIV illness(es) such as
  - Pneumonia
  - Herpes zoster
  - HIV wasting syndrome, etc.

- Remember, codes from Chapter 15, “Pregnancy, Childbirth and the Puerperium,” always take sequencing priority
  - O98.713 — HIV disease complicating pregnancy, third trimester
  - B20 — HIV disease
  - J15.4 — Pneumonia due to other streptococci
  - Z3A.30 — 30 weeks gestation of pregnancy

- Patients with asymptomatic HIV infection status admitted (or presenting for a health care encounter) during pregnancy, childbirth or the puerperium should receive codes O98.7- and Z21.

Please see Coding Corner, continued on Page 38
Coding Corner, continued from Page 37

Diabetes mellitus in pregnancy
Diabetes mellitus is a significant complicating factor in pregnancy. Pregnant women who are diabetic should be assigned a code from category O24, first followed by the appropriate diabetes code(s) (E08-E13) from Chapter 4.

Codes for gestational diabetes are in subcategory O24.4, gestational diabetes mellitus. Other codes from category O24, diabetes mellitus in pregnancy, childbirth and the puerperium, shouldn’t be assigned. For example:
- O24.011 — Pre-existing diabetes, type 1, in pregnancy, first trimester
- E10.9 — Type 1 diabetes mellitus, without complications
- Z79.4 — Long term use of insulin
- Z3A.09 — Nine weeks gestation of pregnancy

Consider the codes for gestational (pregnancy-induced) diabetes:
- O24.420 — Gestational diabetes mellitus in childbirth, diet controlled
- Z3A.37 — 37 weeks gestation of pregnancy
- Z37.0 — Single live birth

Remember: Subcategory O24.4 includes diet and insulin-controlled codes. The use of code Z79.4 for long-term use of insulin is not needed.

To ensure complete and accurate documentation and correct coding, be sure to code all pregnancy and pregnancy-related complications to the highest level of specificity.

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 applicable state and federal laws and regulations.
Question: What is the correct way to bill for a colonoscopy where a polyp needs to be removed during a planned screening procedure?

Answer: Reporting colorectal cancer screening procedures are frequently straightforward when the service does not become diagnostic. In these cases, the provider reports the appropriate procedure code indicating the screening sigmoidoscopy or colonoscopy and the claim is typically processed without cost-sharing.

In instances when a planned screening procedure, such as a preventive sigmoidoscopy or colonoscopy, becomes diagnostic what needs to be reported changes slightly. When during a screening procedure it is determined a diagnostic procedure is required (a polyp removal or biopsy of a lesion, for example) the appropriate sigmoidoscopy or colonoscopy code should be reported to indicate the full scope of the care provided to the patient. To avoid patient cost-sharing, the primary diagnosis must be reported as Z12.11 to indicate the procedure was scheduled as a screening examination. If applicable, a secondary diagnosis should be reported.

Note: For dates of service prior to October 1, 2015, the appropriate diagnosis to report would be V76.51.

Have a billing question? If you have a general billing question, we want to hear from you. Click on the envelope icon to open an email, then type your question. It will be submitted to BCN Provider News and we will answer your question in an upcoming column, or have the appropriate person contact you directly. You should contact your provider consultant if your question is urgent or related to a specific claim. Please do not include any personal health information, such as patient names or contract numbers, in your question to us.
How to submit an appeal

Blue Care Network is reprinting this information because we continue to receive questions from providers.

The clinical editing appeal process is located in the BCN Provider Manual on web-DENIS. Clinical appeals must be submitted as follows:

- With a completed Clinical Editing Appeal form
  - Use the most current form from the website.
  - Complete all required fields, as indicated by an asterisk.
  - Make sure the information is legible and accurate. We prefer typed forms.
- Within 180 day of original clinical editing denial
- With all supporting relevant documentation
  - There is only one level of appeal.
  - Ensure documentation is included and legible.
  - Flag or mark key parts of documentation, but avoid highlighter, especially if faxing.

Appeals are loaded into our system, typically within three to five days of receipt. If you want to check the status of your appeal, you can contact Provider Inquiry at 1-800-255-1690.

Do not resubmit an appeal without checking if we already have it.

Changes in eviCore authorization requirements

Effective immediately, the following procedures no longer require authorization by eviCore healthcare:

- Select radiation therapy codes also do not require prior authorization. Click here to see a list of the affected radiation therapy codes.
- The unlisted radiation therapy procedure code *77799 is no longer managed by eviCore. Requests to authorize this procedure should be submitted to BCN Care Management.

Certain services do require authorization through eviCore. Please see Page 45 for full article.

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Add correct servicing provider information when submitting requests to eviCore

Be sure to add the correct servicing provider to the case, including name, address, NPI and other information, when submitting authorization requests to eviCore healthcare.

You’ll find instructions for adding the servicing provider’s information in the e-referral User Guide, which is available on the Training Tools page at e-referrals.bcbsm.com.

The full article is on Page 43.
Online e-Learning available for chiropractors

Blue Cross Blue Shield of Michigan and Blue Care Network hosted webinars in July for chiropractors to learn about the expansion of services that went into effect Aug. 1, 2015. If you were unable to attend one of these webinars, but would still like to learn about these changes, please view our online e-Learning located on web-DENIS. The e-Learning includes the expanded list of payable procedures, new process change requirements and how to check a member’s eligibility and benefits. You can view this e-Learning from your office, home or even from your smart phone or other mobile device.

Here’s how to find the online e-Learning:

- Log in to Provider Secured Services.
- Click on web-DENIS.

**For BCN providers:**
- Click on BCN Provider Publications and Resources.
- Click on Learning Opportunities.
- Click on Chiropractic Update: Expansion of Services Effective August 1, 2015.

**For BCBSM providers:**
- Click on BCBSM Provider Publications and Resources.
- Click on Newsletters & Resources.
- Click on Chiropractic Update: Expansion of Services Effective August 1, 2015.

In addition to the e-Learning, the Care Management chapter of the BCN Provider Manual is also available for chiropractic providers.

Clinical editing billing tips

In most issues we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that we receive reporting of the performed procedure. To view the full content of the tips, click on the Clinical editing billing tips below.

This issue’s billing tips include the following:

- Distinct services modifiers
- Proper reporting of diagnosis codes
- Evaluation and management clinical editing processes
Reminder about billing guidelines for observation stays

As a reminder, here are some guidelines for billing observation stays.

**For BCN HMO**<sup>SM</sup> (commercial) members. Claims for observation services provided during the initial 48 hours of the stay are eligible for reimbursement. Claims for observation services beyond the initial 48 hours will not result in additional payment.

Observation care is payable in the following circumstances:
- When a member is admitted from the emergency room or an urgent care setting
- When a member is referred directly from a physician’s office or skilled nursing facility

Observation care is not payable in the following situations:
- After outpatient surgery. Reimbursement for recovery room care is included in the outpatient surgical fees.
- For routine preparation and recovery for a diagnostic or therapeutic service that requires active monitoring of the member, such as chemotherapy or transfusions
- For monitoring of pregnancy-related conditions, such as preterm labor, hyperemesis gravidarum and gestational diabetes. These services are billable in the outpatient setting using the labor room/delivery room revenue code, since they fall under the member’s maternity benefits.

The **BCN Billing Instructions: Observation Stay** document is updated with this information. Look for these instructions on BCN’s web-DENIS Billing page. To reach that page, log in to Provider Secured Services, click web-DENIS and click BCN Provider Publications and Resources. Finally, click Billing.

**For BCN Advantage**<sup>SM</sup> members. When billing observation stays for BCN Advantage members, additional guidelines apply.

For BCN Advantage claims to be reimbursed at the higher rate associated with an observation ambulatory payment category, or APC, the following conditions must be present:
- The observation code line should be billed with only one service date.
- A qualifying clinic, emergency room or critical care code must be reported in addition to the observation code. Additional payment for the observation stay may be added to the qualifying clinic, emergency room or critical care code.

For more information, refer to the observation billing guidelines in the **CMS Internet Only Manual (IOM)** Publication 100-04, Chapter 4, Section 290.5.

**Additional information**
- Look in the Claims chapter of the **BCN Provider Manual** for more information about billing observation stays. You’ll find the information in the “Billing guidelines for observation stays” section.
- Look in the Care Management chapter of the **BCN Provider Manual** for information about observation criteria and decision-making. Go to the “Guidelines for observations and inpatient hospital admissions” section.
Global referral: What it allows a specialist to do

A global referral allows a specialist contracted with Blue Care Network to perform necessary services to diagnose and treat a member in the office as long as those services do not require prior authorization or benefit review.

The specialist may also order diagnostic tests and schedule elective surgery at a facility as long as those services fall within the date range of the global referral; however, plan notification and prior authorization rules apply. A separate request must be submitted by the specialist, primary care physician or facility for service requiring plan notification or prior authorization. Without plan notification or prior authorization, when applicable, claims for services at facilities will not pay against a global referral.

Please note that only primary care physicians can request global referrals for their patients.

Please see the BCN Referral and Clinical Review Program for additional information about global referrals.

Add correct servicing provider information when submitting requests to eviCore

Be sure to add the correct servicing provider to the case, including name, address, NPI and other information, when submitting authorization requests to eviCore healthcare.

When the correct servicing provider information is in the case, claims will pay. Without that information, the claim will not match the authorization and payment will be delayed.

Blue Care Network has experienced several instances in which the servicing provider’s information was not entered correctly. Payments for the claims connected to those authorizations were delayed.

You’ll find instructions for adding the servicing provider’s information in the e-referral User Guide, which is available on the Training Tools page at ereferrals.bcbsm.com.
Use e-referral for all referrals and authorization requests

Why wait on the phone? Save yourself time and use e-referral exclusively for your Blue Care Network referral and authorization needs. With a couple of clicks you can submit requests or check on the status of requests.

If you don’t have an e-referral user ID sign up today.

If you don’t know how to use e-referral, please go to training tools on the e-referral website.

Remember, you must login at least once every 180 days to keep your user ID active. If your user ID is not working, fax a request on company letterhead to 1-800-495-0812 asking for the ID to be reconnected. Include the user ID, your name and email address, and have it signed by the authorized individual in the office. For additional help, please call the Web Support Help Desk at 1-877-258-3932.

Urgent requests should still be made by phone by calling 1-800-392-2512. To make this number more accessible for urgent requests, BCN will begin asking callers with a standard request to submit the request through e-referral.

We continue to improve the e-referral system. Click on ereferrals.bcbsm.com for announcements about system updates or changes to BCN care management processes.
Changes in eviCore authorization requirements

Effective immediately, the following procedures no longer require authorization by eviCore healthcare:


- Select radiation therapy codes also do not require prior authorization. Click here to see a list of the affected radiation therapy codes.

- The unlisted radiation therapy procedure code *77799 is no longer managed by eviCore. Requests to authorize this procedure should be submitted to BCN Care Management.

Services that require authorization through eviCore

When multiple radiology and cardiology services are to be performed, a separate authorization is needed through eviCore for each procedure code. This occurs when there are both primary and secondary procedures being performed and the secondary codes are not add-on codes. An example is when procedures associated with both the following codes are being performed and both require prior authorization: *78459 and *78491.

Claims information

BCN’s systems are being reconfigured to accommodate these changes retroactive to Oct. 1, 2015. Once our systems have been updated, any claims that were denied for no authorization that were for procedures that no longer require prior authorization will be reprocessed. There is no need to re-bill these claims.

Updated documents are available

Refer to the updated list of Procedures that require clinical review by eviCore healthcare. This list, along with additional information, is available on the Procedures Managed by eviCore for BCN Web page at ereferrals.bcbsm.com.

Reminder

Oct. 1, 2015, was the effective date on which eviCore healthcare (formerly CareCore National) began performing clinical review for select cardiology, radiology and radiation therapy services. This involves select non-emergent outpatient services when performed on or after Oct. 1, 2015, in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices for BCN HMO® (commercial) and BCN Advantage® members.

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