Physicians can monitor patients to slow prescription medication abuse

Prescription medications are relatively simple for many Americans to obtain. The consequences of illegal possession can be quite severe, but not as risky or severe as possession of illicit substances.

Narcotics usually come to mind when we discuss addiction or misuse, but psychostimulants and other classes of medications can also be addicting. Increasing awareness of the potential for abuse of prescription medications to treat pain, anxiety and attention deficit order, for example, can help physicians monitor patients and slow the growing problem of abuse.

Although 4.6 percent of the world’s population lives in the United States, 80 percent of the opioid supply of the world is consumed here and 99 percent of hydrocodone consumed in the world is used in the United States. Hydrocodone is the most widely prescribed drug in the U.S. Physicians prescribing just one prescription of hydrocodone will triple the risk of opioid addiction in an individual. Chronic use increases that risk to 15 percent and high-dose chronic use to 122 percent over opioid naive populations.

Tolerance and dependence does not automatically mean addiction. Patients who need to use opioids can be tolerant and dependent, allowing them to function and have a good quality of life. It is when people spend an inordinate amount of time planning to use, use in abusive manner, suffer consequences of use such as loss of job or estrangement of relatives that quality of life suffers. The inability to cut down on use, recurrent use in situations that are dangerous, and evidence of withdrawal if the drug is not used are just some of the indicators of abuse outlined in the DSM-5.

Dr. Beecroft is a medical director at Blue Care Network.

Please see Medical director, continued on Page 2
Medical director, continued from Page 1

Treatment of the individual who develops a substance use disorder is quite complex, especially when a chronic pain syndrome is involved. Illicit opioid use in a patient without chronic pain issues would follow a standard substance use disorder protocol. Detoxification, education, peer support and, possibly, medications to address any comorbid psychiatric disorder or decrease likelihood of relapse is a general standard of care. Medications such as Revia® or Vivitrol® (injectable naltrexone) are very helpful in this regard.

In patients with chronic pain, maximizing the other pharmacologic and psychological interventions along with gradual detoxification to the lowest dose of opioid as possible are the biologic interventions. Addressing issues such as support from like peers, education, and assistance in maintaining as normal as function as possible are interventions that help individuals get off the addiction path.

Treating patients with anxiety disorder

Benzodiazepines are very effective medications to alleviate the common symptom of anxiety. Anxiety is usually perceived as a very uncomfortable sensation and the immediacy of its relief is a strong psychologically addicting reward.

Using classic behavior modifying interventions, the alleviation of the discomfort is the operant and it does not take very long for humans to learn that taking the medication gives almost immediate relief. Some of the more rapidly acting agents such as Xanax are extremely rapid in their absorption (30 to 90 seconds from mouth to brain) so this association is reinforced; consequently it is highly addicting. The offset of certain agents also can be very rapid and the anxiety can return, along with actual withdrawal symptoms of shakiness, sweating, rapid heart rate and tremulousness. These symptoms can be addressed by taking another dose of the drug.

Longer acting medications have less of this effect, but still can have addicting properties. Tolerance and dependence can occur within two weeks on most medications in this class so treating a patient with an anxiety disorder can be problematic.

BCN Provider News publishes “From the medical director” in each issue in the Patient care section. BCN medical directors address timely patient care topics. To suggest a future topic, send an email to BCNProviderNews@bcbsm.com with “medical director” in the subject line.

Please see Medical director, continued on Page 3
Medical director, continued from Page 2

There are other alternatives such as SSRI antidepressants, atypical antidepressants (trazodone, nefazodone or mirtazepine) or even some anticonvulsants that may be of help. Use of beta blockers in low doses can be of help with the peripheral symptoms of anxiety in some individuals.

Psychostimulants
Psychostimulants are another class of medications that can be abused. Tolerance can develop as well as dependence, but the dependence is a little different than with opioids or sedative hypnotics. The dependence becomes not being able to function as well without the medications. Addiction comes into play when the individual starts down the path of escalation and focusing on use in lieu of other more positive and productive areas of their life.

Monitoring the use of the medication closely and reevaluating the benefit that is being gained with its use is critical especially in ADHD/ADD management. Paying attention to the natural history of the patient seeking these medications is also important. New onset of ADHD/ADD in late adolescents or adults can happen but is not the rule. In those circumstances carefully diagnosing using the criteria in the DSM-5 and a standard rating scale such as the Vanderbilt will help you be more certain of the disorder you are treating along with monitoring the efficacy of the treatment. Usually once a dose is identified that addresses the attention symptoms there is no further escalation. Diversion and sharing of psychostimulants is common so a dramatic increase of the patient’s use pattern or significant decline in function may signal trouble that needs further investigation.

Cannabis
Cannabis even when used for medical purposes shares some of the same addictive properties of sedatives/hypnotic medications. It is a long half-life drug and is highly fat soluble, so it stays in the body and is psychoactive for a long time. There are few acute withdrawal symptoms, but dependence can develop as can addiction. Detoxification is relatively simple most of the time but some individuals need assistance through this transition.

Ultimately the goal would be for total abstinence if at all possible as there are other medicinal agents that have fewer adverse side effects that usually address the underlying disorder that was being treated. These other medications and interventions may be less problematic for the individual in terms of abuse.

This has been a very high-level discussion of prescription substance use disorders. This problem is very common in the United States. Medications readily available are being diverted from family members or relatives and friends. They are also relatively easy to obtain through illegal means. These medications generally have fewer stigmas than abuse of illicit drugs and are easier to hide. Identifying this disorder and instituting a treatment plan to address the entirety of the members needs is the primary focus we as physicians need to maintain.

Checking the Michigan Automated Prescription Service for all patients periodically, and especially those on Schedule 2 controlled substances, may be very helpful to you in identifying issues of abuse. Developing a relationship with an addictionologist, psychiatrist or substance use disorders specialty center may be of significant help to you in your practice to help these individuals get back on track.

See also Abuse-deterrent formulations help, but don’t stop controlled substance use in the Sept.-Oct. 2015 issue.

References
Diagnostic and Statistical Manual of Mental Disorders Fifth Edition; American Psychiatric Association ©2013
What BCN expects of its contracted physicians

Blue Care Network expects its contracted physicians to comply with the American Medical Association Code of Medical Ethics, which encourages physicians to select a personal physician for their regular health care and refrain from treating themselves or their immediate family members.

As part of that expectation, BCN prohibits physicians and other prescribers from prescribing controlled substances for themselves or for their immediate family members.

Here are some definitions that may make this expectation clearer:

- Immediate family members are first-degree relatives such as parents, siblings, spouse and children.
- Controlled substances are drugs, substances or chemicals used to make drugs that are classified as Schedule II or Schedule III on the drug schedules published by the U.S. Drug Enforcement Administration.

In line with its overall expectations that physicians comply with the AMA Code of Medical Ethics, BCN’s contracted practitioners shall not bill BCN for covered services provided to themselves or to their immediate family members.

You’ll find an outline of the responsibilities of physicians contracted with BCN and information on related BCN policies and procedures in the BCN System of Managed Care chapter of the Blue Care Network Provider Manual. To locate that information:

1. Log in to Provider Secured Services.
2. Click web-DENIS.
3. Click BCN Provider Publications and Resources.
5. Click BCN System of Managed Care. Look in the section titled “General responsibilities of all contracted providers.”

New policy allows providers to bill certain telemedicine visits

Blue Care Network has developed a new medical policy to provide coverage for certain telemedicine services, effective Jan. 1, 2016. The telemedicine policy applies to both and commercial members and BCN Advantage.

Telemedicine visits include voice-only or audio-visual communication. However, the visit must take place at an originating site, for example, a doctor’s office. An example of a telemedicine visit would be a patient using his or her PCP’s office equipment to communicate with a specialist at another location.

To bill a telemedicine visit, providers should add a GT modifier to the normal code for that visit. The member copayment still applies to the visit.

For more details, including definitions, exclusions and codes, log in to web-DENIS to view the medical policy. You can also see Medical policy updates on Page 24 of this issue.
BCN clarifies coverage when a newborn is born to a dependent

When a dependent child has a baby, is that newborn covered under the dependent child’s coverage? The simple answer is no.

The state of Michigan mandates that HMOs provide coverage for the newly born child of a subscriber (contract holder) who is enrolled in a standard insured product. Coverage is to be in place for 31 days whether or not the subscriber adds the child to their contract. Coverage guidelines vary for other types of products, such as Medicare, self-funded groups and Federal employees.

For example, Medicare does not provide any coverage for newborn care, while ERISA (self-funded) plans have the ability to establish eligibility rules in their benefit plan, which may or may not provide coverage for a newborn child.

For care of the newly born child of a dependent, though, all Blue Care Network standard HMO plans are consistent. If the mother is a dependent (not the subscriber or the spouse) on a contract and there is no information to indicate that another BCN subscriber is the father, then claims for the newborn will be denied. BCN does not provide coverage to the child of a dependent unless the child is adopted by the subscriber. Coverage for the newborn may be available through other sources, like Medicaid.

Copayments and the 50 percent rule

Effective Jan. 1, 2016, the 50 percent rule will no longer be applied to Blue Care Network members with individual coverage (coverage that is not through a group plan). In the past BCN applied a 50 percent rule to certain claims — mostly office visits — which made it challenging to determine a member’s cost-sharing at the time of service. We hope this change will make collecting copayments easier for you for these members.

As a reminder, here’s how the 50 percent rule works:

If a member’s copayment is more than 50 percent of the approved amount for the service, BCN adjusts the copayment to be 50 percent of that approved amount. That reduced copayment amount is then reflected in your payment and on your remittance advice. This would create an overpayment on that member’s account if you collected the member’s full copayment at the time of service.

Here’s an example: If the member’s standard office visit copayment is $25 and BCN reimburses the provider $47 for that service, the member’s copayment for the service would be adjusted to be 50 percent of $47, or $23.50.

We will continue to apply the 50 percent rule to many BCN members, including those with group coverage and all BCN AdvantageSM members. The 50 percent rule does not apply to pharmacy services.

Please remember to always check the BCN remittance advice to determine what the member’s cost-sharing should have been. If you charged more at the time of service than the remittance advice shows as member liability you need to refund the member within 60 days of receiving payment from BCN. See the related article, Refund member overpayments within 60 days, Page 6.
Refund member overpayments within 60 days

If you collected money from a Blue Care Network member that turns out to be more than you should have, BCN expects you to refund that member within 60 days.

This might occur for several reasons.

- In some situations you are allowed to bill a member who has coverage through the Health Insurance Marketplace, but whose premium payment is over 30 days delinquent. If BCN later pays for that service because the member pays the premium, you will have an overpayment.
- You may also have collected too much cost sharing from a member at the time of service.

Remember to always check the BCN remittance advice to ensure that you collected the correct cost-sharing amount (copay, deductible and coinsurance) from your BCN patients. If you determine that the patient was overcharged, make sure you refund the overpaid amount within 60 days of receiving BCN’s payment.

For a refresher on how to find a BCN remittance advice, view the Locating a remittance advice online document attached here.

Don’t forget to check member eligibility and benefits for your BCN patients at each visit. You can do this through one of the following methods:

- Online through web-DENIS
- Through the PARS (Provider Automated Response System) phone lines
- Through a HIPAA-compliant 270/271 electronic standard transaction
- By calling BCN Provider Inquiry

For more information, view the Member Eligibility chapter of the BCN Provider Manual. Here’s how:

1. Log into Provider Secured Services at bcbsm.com.
2. Click on web-DENIS.
3. Click on BCN Provider Publications and Resources.

Information about new provider directory rule and CAQH initiative

The Centers for Medicare & Medicaid Services announced that, beginning Jan. 1, 2016, Medicare Advantage organizations and Medicare-Medicaid insurance plans must contact participating health care providers on a regular basis to review, update and confirm their information in provider directories.

For complete details, see the article on Page 20.
Blue Care Network to maintain increased office staff reward for tobacco cessation contest

Blue Care Network’s tobacco cessation office staff contest will maintain the higher office staff reward begun in July 2015 for the Tobacco Cessation Office Staff Contest. Each monthly winning office will share $1,000 in Visa gift cards among their staff. We will also continue to offer the reward to a charity in the event an office staff cannot accept a financial reward from a health care plan.

While we saw a large increase in submissions during the second half of 2015, the contest ultimately fell short of our goal to receive 5,000 new survey submissions between July and December, 2015. As a result, 2015’s winning offices will not receive the additional $500 reward. This additional incentive will be discontinued in 2016. However, BCN maintains tobacco cessation as a top priority in 2016 as we aim to help our members get the information to help them successfully quit tobacco.

Please continue to hand out our survey and Quit Guide to all BCN commercial members aged 18 to 65 years old. If you need additional supplies, please call 248-799-6959 to request them.

Reminder: 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.

See the article in the Jan-Feb. 2016 issue for details.
Landmark Healthcare is now eviCore healthcare

Our physical therapy benefits management service, Landmark Healthcare, has a new name — eviCore healthcare. If you receive emails or letters from eviCore, be assured that it’s from the same Landmark Healthcare people who review physical therapy treatment plans for our groups and providers throughout Michigan.

eviCore healthcare oversees outpatient physical, occupational and speech services for BCN members delivered by independent physical therapists, outpatient therapy providers and physician practices. eviCore also oversees physical medicine services for BCN members delivered by chiropractors.

See Tips about eviCore Authorizations for BCN Members onereferrals.bcbsm.com for helpful information about authorizations. Click Outpatient PT, OT, ST.

If you have questions about this change, contact eviCore’s Customer Service department at 1-877-531-9139.

We’ve made a change to provider payment process for members with health savings accounts

Blue Care Network and Blue Cross Blue Shield of Michigan no longer uses the V-Card, or virtual card, provider payment process for our members with health savings accounts. Instead, HealthEquity has begun using paper checks, effective Feb. 1. Paper checks will be issued to providers when a member initiates a provider payment through the HealthEquity member portal.

This policy change does not affect the payment process for members with BCN’s health reimbursement arrangement.

For more information about how the change affects Blue Cross, see the article in the February issue of The Record.

BCN clarifies that expansion in chiropractic benefits does not include BCN Advantage members

Blue Care Network announced in the Jan.-Feb issue of this newsletter that chiropractors contracted with BCN may provide some physical medicine services for BCN HMO® commercial members with coverage through groups that offer standard chiropractic benefits. We’d like to clarify that this expansion in physical medicine services does not apply to BCN Advantage® members. Medicare does not cover physical medicine services from a chiropractor.

Another article in the same issue announced online learning available for chiropractors to learn about the expansion of services. The e-Learning includes the expanded list of payable procedures, new process change requirements and how to check a member’s eligibility and benefits.
Do you offer lactation counseling?  
Put it in our online provider directory

Practitioners who offer lactation counseling can now add this service to our online provider directory. To get started, click here and follow the normal process for updating your information.

Tell us what you think about **BCN Provider News** – You could win a prize!

Can you spare five minutes to take an online survey? Your input will help us make *BCN Provider News* more useful to you. We look forward to your suggestions for improvement.

Please complete the online survey by March 31. You could win one of two $25 gift certificates.

Participation in the survey is not necessary to win. The drawing is open to all active BCN providers. Enter by completing the survey no later than March 31, 2016, or by sending an email with your name, phone number and “Survey drawing” in the subject line to BCNProviderNews@bcbsm.com by March 31.

All entries must be received by March 31. Two winners will be selected in a random drawing from among all eligible entries. Each winner will receive a $25 gift card. The drawing will take place the first two weeks of April. Winners will be notified by telephone or email following the drawing.
How to bill for BCN Advantage members’ services using NOC codes

When a specific HCPCS code is not available for a service provided to a BCN AdvantageSM member, you must bill with a not-otherwise-classified code. Here are some guidelines for billing services using an NOC code.

Billing drugs and biologicals
When a specific HCPCS code is not available for a particular drug, follow the Centers for Medicare & Medicaid Services guidelines for billing the J3490, J3590 or J9999 code. Here’s what to do:

- Submit NOC codes in the 2400/SV101-2 data element in the 5010 professional claim transaction (837P). When billing an NOC code, you are required to provide a description in the 2400/SV101-7 data element. The SV101-7 data element allows for 80 bytes (that is, 80 characters, including spaces).
- Include all of the following information in the SV101-7 data element:
  - Name of the drug
  - National Drug Code
  - Total dosage plus strength of dosage, as appropriate
  - Method of administration

Pricing and payment
BCN Advantage payments for drugs and biologicals billed with NOC codes follow CMS guidelines. Pricing information for most unlisted drugs may be found on the CMS website. Look under Medicare Part B Drug Average Sales Price.

Billing medical services
For medical services for which no CPT or HCPCS is available other than a HCPCS “S” code, bill using an unlisted NOC code. BCN Advantage does not recognize the HCPCS “S” codes except in certain circumstances, so you should not submit the HCPCS “S” codes in place of NOC codes unless otherwise advised by the health plan. When the health plan has approved the use of an NOC code for the medical services you’re billing, you must include a description of the service on the claim.

Authorization requirements
All drugs/biologicals and medical services with NOC codes require authorization by the plan. When the request for authorization is made, the service is reviewed for clinical appropriateness. Services with NOC codes that are not authorized will be denied.

Important! For BCN Advantage members, providers must not submit the HCPCS “S” codes for drugs and biologicals in place of NOC codes unless otherwise advised by the health care plan.
Blue Cross Blue Shield of Michigan and Blue Care Network mailed a Medicare Advantage health assessment to new Medicare Advantage members in late January. The Affordable Care Act and the Centers for Medicare & Medicaid Services require providers to review results of a health assessment and other medical information to create a personalized prevention plan for all Medicare beneficiaries. The ACA and CMS require that health assessments, customized for older adults, must be completed before or during a member’s annual wellness visit.

The Medicare Advantage Health Assessment is a key opportunity for you and your patients to discuss their past and current health status, including potential health risks, medical conditions, medications, activities of daily living and suggested services.

This assessment is for new Blue Cross and BCN members with Medicare Plus Blue℠ PPO, BCN Advantage℠ HMO-POS, BCN Advantage℠ HMO ConnectedCare and BCN Advantage℠ MyChoice Wellness coverage.

Members are offered the health assessment by mail, online and may also get it at your office. Physicians may help members complete the assessment by accessing a blank copy through web-DENIS. On the BCN Provider Publications and Resources website, click to open the BCN Advantage page. Then click Health Assessment form for preventive visits.

Members who complete and return the assessment will receive a personalized letter identifying health topics they are encouraged to discuss with their physicians.

BCN Advantage providers with access to BCN Health e-Blue℠ can retrieve completed Medicare Advantage health assessment responses for their BCN Advantage patients on BCN Health e-Blue.
New BCN Advantage incentive encourages Basic plan members to visit their doctors

BCN Advantage mailed attestation forms for BCN Advantage℠ HMO-POS Basic plan members in January to use for the new incentive for 2016.

Members will receive a $50 gift card choice — Meijer, Walmart, CVS or Amazon — if they visit the doctor and receive an initial preventive physical examination (G0402), annual wellness visit (G0438 or G0439) or a comprehensive physical examination (9938x or 9939x).

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 including information about the procedures in the incentive program materials.

If members have misplaced their forms, they can call the Customer Service number on their ID cards to get new forms.

Providers can identify BCN Advantage Basic members by their ID cards, which are pictured below. The ID cards feature the CMS plan benefit package number, which is 004 for the Basic plan.
How to bill advance care planning services for BCN Advantage members

Effective with dates of service on or after Jan. 1, 2016, practitioners can bill advance care planning services for BCN AdvantageSM members. To bill correctly, here’s what you need to know.

What is advance care planning?
An advance care planning service provides the opportunity for an open dialogue to occur between the practitioner and patient, family member or surrogate about the type of care the patient wants if he or she becomes incapable of making decisions.

What procedure codes should I use to bill this service?
Practitioners should use CPT codes *99497 and *99498 to report the face-to-face advance care planning service. These are the two new codes CMS published in 2015 for end-of-life discussions; fees for reimbursement were assigned effective Jan. 1, 2016.

What about modifiers?
The member’s copayment and deductible are waived if the discussion is performed in conjunction with the member’s annual wellness visit or an initial preventive physical examination. For this situation, practitioners must append modifier 33 to codes *99497 and *99498 and report the annual wellness visit or initial preventive physical examination on the same claim. If modifier 33 is not present, both the copayment and deductible apply. In addition, if the advance care planning service is reported with modifier 33 and the annual wellness visit or initial preventive physical examination is not reported, the claim line may be subject to denial.

How often can these services be billed?
Advance care planning services are payable once every 12 months, on the first claim, regardless of who submits it. The member gets the most benefit from the service when it is done in conjunction with the annual wellness visit or an initial preventive physical examination.

Can I bill these services for BCN HMOSM (commercial) members?
Practitioners can bill advance care planning services only for BCN AdvantageSM members.

Additional information is available in CMS Transmittal 216, dated Dec. 22, 2015.

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

The risk of falling and sustaining an injury as the result of a fall increases with age. Among older adults, falls are the leading cause of both fatal and nonfatal injuries. According to the Centers for Disease Control and Prevention, one in three adults age 65 and older fall each year, but less than half talk to their health care providers about it. It’s an important conversation to have and since fall risk prevention is a Healthcare Effectiveness Data Information Set® measure, please be sure to document your discussions and interventions related to fall risk and prevention in the patient’s medical record.

Falls aren’t only associated with morbidity and mortality in the older population, but are also linked to poorer overall functioning and early admission to long-term care facilities. For the older population, effective fall prevention initiatives have the potential to reduce serious fall-related injuries, emergency department visits, hospitalizations, nursing home placements and functional decline.

Health care providers can lower a person’s risk for falling by reducing or minimizing an individual’s modifiable risk factors in the following ways:

• Be proactive. Ask all patients 65 and older if they have fallen in the past year.
• Identify and address fall risk factors, such as:
  - Lower body weakness
  - Gait and balance problems
  - Chronic medical conditions such as diabetes, stroke, urinary incontinence and dementia
  - Psychotropic medication use and polypharmacy
  - Postural dizziness
  - Poor vision
  - Problems with feet or shoes
  - Home safety
• Refer, as needed, to specialist or community programs.
• Follow up with the patient within 30 days.

Please see Fall prevention, continued on Page 15
Fall prevention, continued from Page 14

Key fall prevention interventions may include one or more of the following:

- Providing patient education and information on fall prevention
- Enhancing strength and balance through a customized exercise program
- Minimizing medications, if appropriate, to include reduction or discontinuation of any psychotropic medications
- Managing postural hypotension
- Supplementing vitamin D and calcium, as needed
- Managing foot and footwear problems
- Treating visual impairment
- Optimizing home safety by discussing safety measures with the patient such as reducing clutter in the home, installation of handrails on stairways, grab bars in the bathroom and improving lighting in the bedroom and hallways

Staying active and participating in an exercise program is a good way for your elderly patients to prevent falls. Your BCN AdvantageSM members may have access to basic fitness services at gyms and fitness centers located around the state. SilverSneakers® is a fitness program available to some BCN Advantage members. SilverSneakers offers amenities such as exercise equipment and fitness classes designed specifically for older adults and taught by certified instructors. Personal advisors assist members to create a plan designed to meet their needs.

BCN Advantage members can check to see if they have access to the SilverSneakers program by calling 1-866-584-7352.

Managing risk of fracture

While you may not be able to prevent all falls, you can reduce the risk of fracture in some patients by screening for and managing osteoporosis effectively. Osteoporosis increases the risk for fractures from falls and bumps that wouldn’t hurt a person with healthy bones. Osteoporotic fractures (fragility fractures) occur as a result of a fall from a standing height or less without major trauma.1

BCN endorses Michigan Quality Improvement Consortium’s evidence based clinical practice guidelines for the management and prevention of osteoporosis. For more information on the MQIC guidelines for assessment and management of your patients to reduce fracture risk due to osteoporosis, please go to the MQIC website.

For more information on fall risk prevention and additional tools you can use to assess your patient’s risk for falls, please refer to the Stopping Elderly Accidents, Deaths and Injury (STEADI) toolkit, designed specifically for health care providers,

References: American Academy of Orthopedic Surgeons; American Geriatric Society; Centers for Disease Control and Prevention

Aspirin use prevents heart attacks and strokes

Our Chronic Care Improvement program, designed to prevent cardiovascular disease in BCN Advantage℠ members, is in its fourth year. Prevention or reduction of cardiovascular disease will help us to meet our goals to decrease heart attacks, strokes and related deaths in those members.

We’re using the clinical interventions championed by Million Hearts™, 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 United States by 2017. The Million Hearts clinical interventions focus on improved management of the “ABCS” – Aspirin for high-risk patients, Blood pressure control, Cholesterol management and Smoking cessation. Million Hearts recommends prioritizing the ABCS because high performance on these measures leads to fewer disabling and deadly cardiovascular events.

**Aspirin for high-risk patients**

Our medical record review conducted last year revealed that 52 percent of the member records contained documentation that aspirin was ordered when appropriate. Our goal for this measure was 56 percent. Aspirin use for high-risk patients, unless contraindicated, is one of the preventive actions recommended by the Million Hearts initiative and also is a recommendation found in the Michigan Quality Improvement Consortium Guideline for the Management of Diabetes Mellitus.

We know that daily aspirin use isn’t for everyone. However, we’re committed to the Million Hearts goal of increasing aspirin use when appropriate. You can join us by talking to your patients about aspirin use, and prescribing it when indicated.

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. Information about these programs is available on BCN Health e-Blue in the Resources section under Incentive Documents.

Documenting these discussions in the patient’s medical record will help us measure improvements in aspirin use rates. Our 2016 BCN Advantage Million Hearts Incentive program rewards you for having and documenting this discussion. If your BCN Advantage patient is prescribed or currently taking aspirin or antiplatelet therapy, report CPT II code 4086F for all patients meeting the criteria.

Preventing 1 million heart attacks and strokes by 2017 will require the work and commitment to change from all of us.

If you would like more information about the Million Hearts initiative, please go to the Million Hearts website.
Changes for place of service codes

The Centers for Medicare & Medicaid Services published Transmittal R3315CP notifying providers of one new place of service code (19) and a revision in the description of a current place of service code (22), both affecting physician billing for outpatient services. Effective Jan. 1, 2016, the new and revised POS codes and nomenclature are:

<table>
<thead>
<tr>
<th>POS code</th>
<th>Description</th>
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<tbody>
<tr>
<td>19</td>
<td>A portion of an off-campus hospital-provider-based department that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization</td>
</tr>
<tr>
<td>22</td>
<td>A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization</td>
</tr>
</tbody>
</table>

The following is a summary of how these code changes will affect BCN AdvantageSM claim submissions:

- POS codes 19 and 22 are to be reported by physicians in the outpatient department of a hospital.
- Providers must make certain that all coding and billing personnel understand the new definition.
- Fees and policies that currently apply to POS 22 will also apply to POS 19 (facility rate).
- POS codes are applicable to the CMS 1500 form, not the UB-04.
- Effective Jan. 1, 2016, the hospital will report modifier PO (services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) on every procedure code for services performed in an off-campus department.
- It is critical that the hospital’s use of modifier PO and the physician’s reporting of POS 19 coincide for the same patient services.

In addition, CMS included a reminder that services performed in a physician office wholly owned or wholly operated by a hospital are included in the hospital admission if performed within the three-day period prior to admission. The complete text of this document is located in the CMS publication Change Request 7502. We have summarized the main points in the following tables:

### CMS differentiation between “on campus” and “off campus”

<table>
<thead>
<tr>
<th>POS 19: Off-campus outpatient hospital</th>
<th>POS 22: On-campus outpatient hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>A portion of an off-campus hospital-provider-based department that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization</td>
<td>A portion of a hospital’s main campus that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization</td>
</tr>
</tbody>
</table>

### Terms and definitions

- **Campus**: The physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider’s campus
- **On campus**: A facility located on the campus of the potential main hospital
- **Off campus**: A facility that is not located on the campus but is within 35 miles of the potential main hospital
- **Department of a provider**: A facility or organization or a physician office that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership and financial and administrative control of the main provider. This may not be licensed to provide health care services in its own right and may not by itself be qualified to participate in Medicare as a provider. Medicare conditions of participation do not apply to a department as an independent entity. This does not include a rural health center or, except as specified in these regulations, a federally qualified health center.
Medicare Advantage Diagnosis Closure Incentive program continues in 2016

Blue Care Network and Blue Cross Blue Shield of Michigan will continue the Medicare Advantage Diagnosis Closure Incentive program in 2016.

The incentive program again applies to Medicare Advantage patients, including those with Medicare Plus BlueSM PPO or Medicare Plus BlueSM Group PPO coverage from Blue Cross, or BCN Advantage HMO-POS™ and BCN Advantage HMO™ coverage.

Diagnosis Closure Incentive program

The incentive program rewards participating primary care doctors for having annual, face-to-face visits with Medicare Advantage patients to evaluate, document and code diagnoses according to standards set by the Centers for Medicare & Medicaid Services. Doctors will receive a financial incentive for closing diagnosis gaps identified by BCN and Blue Cross.

A gap is a suspected or past condition that hasn’t been documented and coded in the current year.

The Diagnosis Evaluation Panel on BCN Health e-Blue™ or BCBSM Medicare Advantage Health e-Blue™ lists patients who are suspected of having a condition based on:

- Pharmacy claims
- Medical claims
- Other supplemental data sources
- Prior-year diagnoses

But the diagnoses for patients listed on the Diagnosis Evaluation panel haven’t been submitted to BCN or Blue Cross in the current year. Reports are refreshed monthly so doctors can track their progress in closing these identified diagnosis gaps.

BCN and Blue Cross will pay doctors $100 for each Medicare Advantage member with one or more gaps identified between Jan. 1, 2016, and Sept. 30, 2016, and for whom all gaps are closed during a face-to-face encounter by Dec. 31, 2016.

An identified gap can be closed following a face-to-face visit with the patient in 2016. During this visit, the doctor should manage, evaluate, assess or treat the condition, and the diagnosis should be documented in the patient’s medical record following CMS guidelines. The gap can then be closed through one of the following methods:

- Confirm the diagnosis code:
  - By submitting a claim with the diagnosis code
  - Through Health e-Blue
  - By submitting a patient medical record

- Notify Blue Cross that the patient does not have the suspected condition:
  - Through Health e-Blue

A gap should not be closed solely for the reason that you are not actively treating the condition. A diagnosis gap should only be closed if you have conducted an office visit, addressed the condition and determined that the patient no longer has the condition or the suspected condition does not exist.

More information about this incentive program will be posted on Health e-Blue for Medicare Advantage primary care doctors in the first quarter 2016. If you don’t have access to Health e-Blue, sign up today on bcbsm.com/providers. Contact your provider consultant if you need assistance.

Please see Diagnosis closure, continued on Page 19
Diagnosis closure, continued from Page 18

Web-DENIS member care alerts
When checking patient eligibility and benefits on web-DENIS, be sure to check your member care alerts, which have been updated to include 2016 patient gaps in care.

These alerts are color-coded to help you identify patient needs quickly, and they display a printable list of diagnosis gaps and treatment opportunities for patients.

2015 incentive payment
If you participated in the 2015 Diagnosis Closure Incentive program, your incentive payment will be mailed to you by the end of the third quarter in 2016.

Training available
BCN and Blue Cross can provide training to doctors and their office staff on proper documentation and coding guidelines and the importance of closing gaps for Medicare Advantage patients.

You can access online training resources and ICD-10 tip cards:
1. Log in to web-DENIS
2. Click on BCN Provider Publications and Resources
3. Click on Patient Care Reporting for Risk Adjustment and in the Training Resources section look for:
   - Online training for risk adjustment, documentation and coding
   - E-learning module: Best Practices for Medical Record Documentation
   - Documentation and ICD-10 Coding Tips for Professional Offices

The 30-minute, e-learning module includes a 10-question assessment. If you score 80 percent or better, you’ll receive one continuing education credit from the American Academy of Professional Coders.

These presentations are also available in BCBSM Provider Publications and Resources under Patient Care Reporting. Contact your provider consultant for assistance.

Address chronic conditions, past diagnoses
The Diagnosis Closure Incentive program is in effect again this year for dates of service on or after Jan. 1, 2016.

As you conduct face-to-face, annual wellness visits with Blue Cross and BCN Medicare Advantage patients, make sure you address every chronic condition or past diagnosis that still applies to the patient. Then document this information in the patient’s medical record following ICD-10 coding guidelines. Include all of the diagnoses in your claim submission.
Here’s information on new provider directory rule and CAQH initiative

The Centers for Medicare & Medicaid Services announced that, beginning Jan. 1, 2016, Medicare Advantage organizations and Medicare-Medicaid insurance plans must contact participating health care providers on a regular basis to review, update and confirm their information in provider directories.

While the original regulation called for monthly updates, it’s recently changed to require that health care plans communicate with providers at least quarterly to obtain updated directory information. Health care plans that fail to do this may be fined.

Provider directory information must include:
• Provider location
• Contact information
• Specialty
• Medical group
• Institutional affiliation
• Accepting new patient status

Additionally, requirements for qualified health plans participating in the federal Health Insurance Marketplace went into effect on Nov. 1, 2015.

The National Committee for Quality Assurance will also put directory audit process rules in place for health care plans accredited by that organization beginning July 1, 2016. Health plans that fail to follow these regulations may be fined; there are no penalties for health care providers.

What we’re doing
At Blue Cross Blue Shield of Michigan and Blue Care Network, we want to avoid the frequent outreach that’ll cause considerable disruption among providers and their staff, as each health care plan seeks to regularly update directory information.

That’s why Blue Cross and BCN are partnering with other health plans in a new initiative of the nonprofit alliance CAQH to enable health care providers to more easily update and confirm their directory data. We’ve long been participants in CAQH ProView, which dramatically streamlined the credentialing process. Now, we’re working together to use that same self-reported information to also simplify the process of updating provider directories.

What providers need to do
In the CAQH Provider Directory Data Confirmation initiative, providers designated by participating health care plans will be contacted by CAQH and asked to review, edit and confirm specific information for use in provider directories. Through this one-to-many approach, providers need only update and confirm their information in one place; that data is then made available to participating plans designated by the provider.

Once we receive this information from CAQH, we’ll encourage the use of self reporting by professional groups to manage their information. As a reminder, we require all practitioners to attest to the accuracy of their CAQH application information. If you don’t attest every three months, your enrollment with Blue Cross and BCN may be terminated for inactivity and removed from our provider directories.

CAQH worked closely with us and other health care plans to develop an initiative that would meet the requirements of CMS and other regulatory agencies. We ask that all providers in our network respond promptly to CAQH email requests to update the information required for provider directories.

With Blue Cross’ participation in this initiative, we hope to reduce the administrative burden on health care providers, increase the accuracy of our directories and enable patients to make more informed choices about their care.
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 Change Health (formerly Emdeon) website.

If you have not already enrolled with Change Health, visit emdeon.com/epayment. If you are already enrolled with Change Health through another health care plan, you can access Change Health 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 Change Health website and select BCBSM as your receiver.

Emdeon is now Change Healthcare

Emdeon has changed its name to Change Healthcare. Providers will continue to have access to the important information you need. Here is some helpful information:

- Change Healthcare has not closed the existing Emdeon website. All existing Emdeon bookmarks will continue to work.
- The login button on the new (Change Healthcare) website will redirect you to the Emdeon sites and product lists.
- Contact Change Healthcare (Emdeon) at 1-877-363-3666 or visit changehealthcare.com and select Resources for:
  - Enrollment
  - Product support
  - Payer lists
  - EFT/e-payment
  - Payer ERA

Change Healthcare will continue to update the provider community about its new identity. For more information, please visit the Emdeon website.

If you have questions about this communication, please contact your account executive or the Blue Cross Complete Provider Call Center at 1-888-312-5713.
Blue Cross Complete provides the following communications services for members and practitioners:

- Staff is available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding utilization management issues.
- Staff can receive inbound communication regarding utilization management issues after normal business hours.
- We offer TDD/TTY services for members who need them.
- Language assistance is available for members to discuss utilization management issues.

Providers can contact Blue Cross Complete’s Utilization Management department for plan notification or clinical review at 1-888-312-5713 (press 1) during normal business hours, 8:30 a.m. to 5 p.m., Monday through Friday.

For urgent or emergent requests after business hours, a physician and nurse are available 24 hours on weekends and holidays to review requests and authorize medically appropriate services. Providers should call 1-888-312-5713 (press 1). The call will be forwarded to the reviewer on call.

Certified translation services are available to all Blue Cross Complete providers and to eligible Blue Cross Complete members whose primary language is not English or those who have limited English proficiency. Providers are encouraged to use these services to ensure all information is accurately communicated to members.

Members who access care in any setting (ambulatory, outpatient or inpatient) can call Blue Cross Complete Customer Service at 1-800-228-3354 for assistance with the following:

- Translating health care plan documents
- Obtaining health care plan documents in alternative formats

Translation and interpretive services are available in more than 200 languages. Providers and members can call 1-800-228-3354 to:

- Obtain these services immediately over the telephone
- Schedule an appointment for services to be delivered either by telephone or in person

TTY and TTD services are also available for both providers and members who are sensory impaired. To obtain these services, providers and members should call 1-800-987-5832.

Blue Cross Complete awarded additional Michigan counties

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

The new contract expands Blue Cross Complete of Michigan’s service area from its current counties of Livingston, Wayne, Washtenaw into new 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 counties.
New process for provider enrollment and change requests

Blue Cross Complete of Michigan announced changes to its provider enrollment and change processes last October. Blue Cross Complete provider data will no longer be managed through the Provider Enrollment and Change process managed by Blue Cross Blue Shield of Michigan.

How to enroll in the Blue Cross Complete provider network

Providers who wish to enroll in the Blue Cross Complete Provider Network should complete the “Blue Cross Complete Enrollment Form” located at mibluemcrosscomplete.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.

Submit changes on the “Blue Cross Complete Provider Change Form” located on the Blue Cross Complete website at mibluemcrosscomplete.com/providers in the Provider Forms section.

Forms submission

Completed enrollment or change forms must be submitted by one of the following methods:

- Email: bccproviderdata@mibluemcrosscomplete.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.

Blue Cross Complete to launch newsletter in March

Blue Cross Complete will soon publish its own newsletter, called Blue Cross Complete Connection. The first issue is expected to be ready in March and will be posted to mibluemcrosscomplete.com/providers.

Please check the Blue Cross Complete website regularly for updated information.
BCN’s Adult Kidney Health Management program offers support to members

Blue Care Network’s Adult Kidney Health Management program offers support to members diagnosed with chronic kidney disease. The program emphasizes screening members at risk for developing CKD (including those with hypertension or diabetes), monitoring and treatment to prevent or delay disease progression, and to facilitate referral of patients to nephrologists when indicated for treatment of progressive or advanced disease.

The program is based on the Michigan Quality Improvement Consortium’s *Guideline for the Diagnosis and Treatment of Adults with Chronic Kidney Disease*.

Program goals include:

- Increase annual assessments of glomerular filtration rate in members at risk for kidney disease or with kidney disease (identified as having hypertension or diabetes or GFR < 45 ml/min/1.73²)
- Annual assessment of urine albumin or protein in members with diabetes not filling prescriptions for ACE-1 or ARB medications
- Increase use of ACE inhibitors or angiotensin receptor blockers to slow progression of CKD in members with GFR between 44-15 ml/min/1.73m²
- Increase referrals to nephrologists for members with advanced disease GFR <30 ml/min/1.73m² who aren’t receiving renal replacement

We identify members for the program by medical and pharmacy claims related to hypertension, diabetes, CKD, by laboratory results for serum creatinine tests and from claims for urine albumin-protein tests. We also accept referrals to the program from physicians, other BCN departments, member health assessments and member self-referral. Members identified are automatically enrolled in the program. They may opt out of the program by notifying BCN’s Chronic Condition Management department.

Please see Kidney health, continued on Page 25

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*. A recent update to the medical policies includes telemedicine.
Kidney health, continued from Page 24

Members are staged and interventions are implemented based on MQIC’s criteria:

- **Members with diabetes and hypertension at risk for developing stage 1 and 2 CKD with a GFR >60ml/min/1.73²** should be encouraged by their primary care physician to have an annual GFR and work with their physician to keep their blood pressure under control. You should also encourage your members to avoid nonsteroidal anti-inflammatory drugs.

- **Members with stage 3A CKD and a GFR 45-59ml/min/1.73m²** receive self care educational booklet about kidney health management, a personal health card and a CKD management plan. They also receive reminders about available services, such as annual assessment of GFR, urinary and albumin excretion (if not on ACE-I or ARB) as well as program newsletters.

- **Members with stage 3B CKD and GFR between 30-44ml/min/1.73m²** and members with stage 4 CKD with GFR between 15-29ml/min/1.73m² receive a program introductory letter and packet, reminders for needed services including ACE-I or ARB treatment, blood pressure control, lipid management, smoking cessation and glycemic control (if diabetic). They also receive information about avoiding nephrotoxic drugs, including nonsteroidal anti-inflammatory drugs and iodine contrast.

BCN’s Kidney Health program, in accordance with MQIC guidelines, recommends that members with stage 4 or unstable stage 3B CKD be referred to a nephrologist for counseling and management including assessment of calcium and phosphate balance, bone health, anemia, vaccinations, end stage renal disease planning and advance directives.

A reminder letter is sent to the primary care physician about referring the member to a nephrologist. These members may also be enrolled in BCN’s case management program.

- **Members identified with stage 5 CKD (GFR <15 ml/min/1.73m²) on dialysis** are referred to a BCN specialty case management program for dialysis management.

When your member is enrolled in the adult Kidney Health program, you receive the following support from BCN:

- Notification of your individual patients meeting the above criteria on Health e-BlueSM reports
- Notification of members overdue for testing and medication refill on Health e-Blue reports
- Program assistance from a registered nurse chronic condition management specialist at 1-800-392-4247, Monday through Friday, 8:30 a.m. to 5 p.m. (holidays excluded)
- Case management nurse assistance at 1-800-392-2512, Monday through Friday, 8 a.m. to 5 p.m. (holidays excluded)
- Customer service assistance at 1-800-662-6667, Monday through Friday, 8:30 a.m. to 5 p.m. (holidays excluded)
- Chronic condition management information for members at bcbsm.com
- BCN’s pharmacy benefit manager performs concurrent evaluation to identify potential drug-related interactions

To learn more about BCN’s Kidney Health Management program or to refer a member, call the Chronic Condition Management department at 1-800-392-4247 Monday through Friday, 8:30 a.m. to 5 p.m. (holidays excluded).
Choosing Wisely – low back pain campaign

Low back pain is a common problem for many adults. In fact, as many as 80 percent of all adults will have low back pain at some point in their lifetime, according to the National Institute of Neurological Disorders and Stroke.

Causes of low back pain
The most common causes of low back pain are muscle strains and sprains. These injuries often happen from improper lifting, twisting or overstretching.

In many cases, low back pain will get better on its own after a few days or weeks. In most cases, your patients won’t need any imaging tests, such as an X-ray, MRI or CT scan, unless they’ve had:

- Back pain for longer than six weeks
- Weight loss
- Fever
- Loss of bladder or bowel control
- Loss of feeling or strength in your legs
- Problems with reflexes
- History of cancer

Treatments for low back pain
In most cases, starting with self-care and medicines is all that’s required to treat low back pain. If these treatments don’t relieve your patient’s pain, he or she may need another type of treatment.

- **Heat or ice**. Hot or cold packs can help reduce swelling and relieve pain.
- **Rest**. A day or two of rest may be good for back pain, but more than this may cause more harm than good. Instruct your patients to try lying on their backs with pillows propped up under their knees to relieve the pressure on their backs.

- **Exercises or physical therapy**. Prescribing specific exercises to help stretch and strengthen the back muscles may be also helpful as well as a physical therapy program.

- **Pain relievers**. You may want to suggest starting with over-the-counter medicines to help relieve the pain and inflammation of low back pain. These include nonsteroidal anti-inflammatory drugs like ibuprofen, naproxen sodium and ketoprofen. If NSAIDs don’t help, stronger pain relievers may be necessary.

- **Surgery**. This may be an option if other treatments don’t work. In most cases, surgery is only used to repair serious injuries or relieve a compressed nerve.

As we’ve discussed in previous issues of BCN Provider News, Choosing Wisely is a great place to look for information on health topics. The organization has valuable information about treating low back pain and imaging tests for low back pain. Please visit choosingwisely.org for low back treatment and imaging tests for low back pain information.

Choosing Wisely is an initiative of the American Board of Internal Medicine Foundation that aims to promote conversations between physicians and patients to think and talk about medical tests and procedures that may be unnecessary and, in some instances, can cause harm.

To assist in these conversations, several specialty societies have created lists of Things Physicians and Patients Should Question — evidence-based recommendations that should be discussed to help make wise decisions about the most appropriate care based on an individual’s situation.
BCN chronic condition management is here to help

Blue Care Network automatically enrolls members identified with select chronic illnesses in one or more of the following BCN Chronic Condition Management programs:

- Asthma (adult and child)
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Ischemic heart disease
- Heart failure
- Kidney health management

Chronic condition management helps members to understand and manage their conditions and to identify gaps in care. We mail educational materials to members on the following topics: self-management, preventive health issues, relevant medical tests, lifestyle issues and medication compliance. As part of the program, registered nurse chronic condition managers make outreach calls to identified members.

We welcome referrals to our programs from providers and can help improve your patients’ health by working as part of your team. Membership is voluntary and your patients can opt out of the program at any time. Call 1-800-392-4247 for more information.

For information on the Depression program call Behavioral Health at 1-800-482-5982.

BCN commercial and BCN AdvantageSM members can also get help to quit tobacco use by calling our tobacco cessation program powered by WebMD® at 1-855-326-5102.

March is colorectal cancer screening month

Blue Care Network encourages providers to remind their patients of the importance of colorectal cancer screening.

Both BCN and BCN AdvantageSM members are included in National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set® colorectal cancer screening measure. The description of the measure is the percentage of members 50 to 75 years old who had appropriate screening for colorectal cancer. The appropriate screenings for colorectal cancer include:

- High intensity fecal occult blood test annually
- Flexible sigmoidoscopy during the measurement year or four years prior to the measurement year
- Colonoscopy during the measurement year or the nine years prior to the measurement year

Digital rectal exam doesn’t count as evidence of a colorectal screening because it isn’t specific or comprehensive enough to screen for colorectal cancer.

For 2016, colorectal cancer screening is included in the Performance Recognition Program for BCN Advantage members.

There are opportunities to provide education and support to members to obtain colorectal cancer screening. Resources include:

- **Clinical practice guideline** for colorectal screening, which is available on the Michigan Quality Improvement Consortium website.
- The Centers for Disease Control and Prevention **Screen for Life** campaign, which has printed educational materials available. These include fact sheets, brochures for patients and posters for your office, available in English and Spanish.

Primary care practitioners are valued partners in educating and promoting health care for members.
Criteria corner

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:

If a patient is admitted with a primary condition such as heart failure, COPD or any other diagnosis where there is a specific subset dedicated to that disease or finding, would it be appropriate to perform the review under the general medical subset?

Answer:

If the patient has a condition, symptom, or finding that is included in a condition-specific subset, it is not appropriate to apply criteria within a general subset. Therefore, the general medical subset is not appropriate for a primary diagnosis of heart failure, COPD or any other diagnosis or findings where there is a disease specific subset.

The information on Page RP-8 How to Conduct a Review states:

The reviewer should select the most appropriate subset based on the primary condition or working diagnosis. The primary condition should drive subset selection. If a condition-specific subset exists for the primary condition or diagnosis, it should be used to perform the review. If there is no condition-specific subset, select a general subset based on the patient’s clinical symptoms or findings.

March is National Kidney Month

To raise awareness and promote kidney health, the National Kidney Foundation has designated March as National Kidney Month. We’re taking this opportunity to share a few reminders with you.

People with diabetes, high blood pressure and family history of kidney disease are at risk of developing chronic kidney disease. African-Americans, Hispanics and senior citizens have a much higher risk of developing CKD.

As a Blue Care Network physician you can do your part by monitoring the blood pressure of diabetic and hypertensive members and evaluating their kidney function annually by performing tests such as urine albumin and glomerular filtration rate. You also can encourage healthy lifestyle changes pertaining to diet, exercise and symptom management, such as a stable hemoglobin A1C and cholesterol level.

BCN has registered nurses available to support your treatment plan for members with CKD and to answer member questions. You and your patients may contact a chronic condition management specialist by calling 1-800-392-4247. For more information regarding kidney disease you may also want to check out the National Kidney Foundation website.

We want to stress the importance of educating your at-risk patients about CKD. Early detection of CKD and member education can help slow the progression of CKD and minimize other medical conditions associated with CKD, such as heart disease and stroke. For additional information, refer to the CKD guidelines at mqic.org.
Clinical review decisions are based solely on appropriateness of care

Utilization decisions regarding care and service are based solely on the appropriateness of care prescribed in relation to each member’s medical or behavioral health condition. Blue Care Network’s clinical review staff doesn’t have financial arrangements that encourage denial of coverage or service. BCN-employed clinical staff and physicians don’t receive bonuses or incentives based on their review decisions. Review decisions are based strictly on medical necessity within the limits of a member’s plan coverage.

Providers may discuss decisions with BCN physician reviewers

BCN demonstrates its commitment to a fair and thorough process of determining utilization by working collaboratively with its participating physicians.

BCN’s plan medical directors may attempt to contact the treating health care practitioner for additional information in regard to any review as deemed necessary. When BCN doesn’t approve a request, we send written notification to the appropriate practitioners and providers, as well as the member. The notification includes the reason the service wasn’t approved as well as the phone number to contact BCN’s plan medical directors to discuss the decision. Practitioners may discuss any decision with a plan medical director.

If you’re a practitioner and would like to discuss your patient’s condition or treatment with one of our plan medical directors, call Care Management at 248‑799‑6312 between 8 a.m. and 4:30 p.m. Monday through Friday. To discuss an urgent case with one of our plan medical directors after normal business hours, please call 1‑800‑851‑3904.

How to obtain a copy of Care Management criteria

Upon request, Blue Care Network provides the criteria used in the decision making process. Call Care Management at 248‑799‑6312, from 8 a.m. to 4:30 p.m. weekdays for further information.

Due to licensing restrictions, BCN can’t distribute complete copies of the InterQual® criteria to all practitioners and providers. However, all contracted hospitals have copies of the criteria as part of BCN’s licensing agreement.

If you wish to obtain further information about purchasing copies of InterQual criteria, call McKesson Health Solutions, InterQual Support, at 1‑800‑274‑8374.
Member compliance in cardiac disease treatment: Physicians are the key

Heart disease is the leading cause of death in the United States, according to the Centers for Disease Control and Prevention. Patient compliance in managing their cardiac disease is an important factor in reducing hospitalization.

Blue Care Network offers the following tips for providers to help patients manage their care.

• Reinforce to members who have had an acute myocardial infarction that beta blocker medication therapy is for life unless contraindicated. Consider writing the prescription for 90 days, for continued medication compliance and decreased cost for the member.

• Instruct members not to discontinue any medication without discussing with you first.

• To keep the member on the prescribed therapy, try lowering dosage or using a different beta blocker if the member isn’t tolerating his or her current medication. Please note that BCN requires treatment with two cardioselective agents prior to providing coverage for nebivolol.

• Order cardiac rehabilitation and encourage the member to attend. This increases the likelihood the prescribed medication regimen will be followed.

• Discuss adherence to cardiac medications and smoking cessation as an essential part of every outpatient visit. BCN’s new wellness platform powered by WebMD allows members to log into bcbsm.com and click the wellness tab to access WebMD for information on tobacco cessation program and digital health assistant.

• Use of a highly effective statin can help reduce member’s risk of a subsequent myocardial infarction. Please note that BCN requires a trial of atorvastatin prior to providing coverage for rosuvastatin.

• Use our Health e-Blue℠ website reports to help you identify the screenings your patients need. Ask your provider consultant for details. (To obtain access to the website, you must be registered for Provider Secured Services at bcbsm.com.)

BCN case managers work with you, your office staff and our members to help ensure that members comply with treatment plans. To reach a BCN case manager call 1-800-392-2512.
Behavioral health providers may discuss decisions with BCN physician reviewers

Blue Care Network is committed to a fair and thorough process of determining utilization by working collaboratively with its participating behavioral health practitioners. BCN’s behavioral health physician reviewers may request additional information about members during their review of all levels of care, patient admissions, additional hospital days and requests for services that require medical policy and benefit interpretations.

When BCN doesn’t approve a service request, we send written notification to the requesting practitioner. The notification includes the reason the service wasn’t approved as well as the phone number to call BCN’s behavioral health physician reviewers to discuss the decision. Practitioners may discuss any decision with a BCN behavioral health physician reviewer.

If you are a practitioner and would like to discuss your patient’s condition or treatment with one of our physician reviewers, call Behavioral Health at 734‑332‑2567 between 8 a.m. and 5 p.m. Monday through Friday. To discuss an urgent case after normal business hours with one of our behavioral health physician reviewers, please call 1‑800‑482‑5982.

How to obtain a copy of Behavioral Health criteria

Upon practitioner request, Blue Care Network provides the behavioral health criteria used in the decision-making process. Call Behavioral Health at 734‑332‑2567 between 8 a.m. and 5 p.m weekdays to request a copy of the criteria.

Clinical review decisions are based solely on appropriateness of care

Utilization decisions regarding care and service are based solely on the appropriateness of care prescribed in relation to each member’s medical or behavioral health condition. BCN’s clinical review staff doesn’t have financial arrangements that encourage denial of coverage or service. BCN-employed clinical staff and physicians don’t receive bonuses or incentives based on their review decisions. Review decisions are based strictly on medical necessity within the limits of a member’s plan coverage.
Blue Care Network Behavioral Health Incentive Program 2015 and 2016

As some of you are already aware, we have entered the third year of the Behavioral Health Incentive Program. Please go to web-DENIS to view the 2016 program documents.

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

Although the measures have remained the same, we have increased many of the incentive amounts. Below is the snapshot of the payment schedule.

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<th>Measure</th>
<th>Payment</th>
<th>Intake Period</th>
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<td>Therapeutic alliance electronic submission</td>
<td>$30</td>
<td>1/1/16-12/31/16</td>
<td>Submit Excel data</td>
</tr>
<tr>
<td>Bonus: additional payment after first 10 Therapeutic Alliance forms are submitted (limited to one bonus per office, per year)</td>
<td>$300</td>
<td>1/1/16-12/31/16</td>
<td>Submit Excel data, Submit forms</td>
</tr>
<tr>
<td>Primary care physician Contact manual submission</td>
<td>$35</td>
<td>1/1/16-12/31/16</td>
<td>Submit forms</td>
</tr>
<tr>
<td>Primary care physician Contact electronic submission</td>
<td>$45</td>
<td>1/1/16-12/31/16</td>
<td>Submit Excel data</td>
</tr>
<tr>
<td>Bonus: additional payment after first 10 PCP contact forms are submitted (limited to one bonus per office, per year)</td>
<td>$300</td>
<td>1/1/16-12/31/16</td>
<td>Submit Excel data, Submit forms</td>
</tr>
</tbody>
</table>

Please take note of the split payment schedule for the self-reported measures. If you submit the information electronically, you are eligible for an additional $10 payment per submission for either measure. The electronic submission method is faster and easier for providers. It also reduces administrative work for Blue Care Network and expedites the process of reviewing self-reported submissions.

Both the electronic submission instructions and the tip sheet are available on web-DENIS, along with the other 2016 program documents.

Lastly, for those providers who submitted forms in 2015, we expect to release the payment for the second six months self-reported measures in April.

Again, thank you to all the behavioral health providers who participated. We appreciate your efforts to improve members’ health.
Quality corner: Primary care physician contact

What and when?
Primary care physician contact happens when the behavioral health provider and the PCP reach out to one another to discuss the patient’s health. This may occur when the patient begins therapy, starts a new medication, has a significant change in condition or experiences a comorbidity issue.

Unfortunately, contact between behavioral health providers and primary doctors is not widespread1, especially when compared with other specialties.

Why is it important?
Contact and collaboration is imperative. As many as 70 percent of visits to primary care physicians may be due to psychological issues, such as stress or anxiety.2 Underlying psychological problems can also complicate and contribute to physical problems, such as obesity, hypertension and chronic pain.3 When regular contact occurs, providers can ensure greatest impact and value for patient health.

What can behavioral health providers do?
We encourage you to reach out to primary doctors. To reward behavioral health providers who do so, Blue Care Network is offering an incentive as part of its Behavioral Health Incentive Program. Each time an office completes the measure according to the details provided in the program’s booklet, the provider is qualified to receive $35 when submitting by fax or $45 when submitting electronically.

What does it mean to reach out?
For the purposes of the program, contact should be “meaningful contact”. This includes a behavioral health assessment, rudimentary treatment plan and member-specific recommendations. More details are in the program’s booklet on web-DENIS.

What if I am not participating in Behavioral Health Incentive Program?
We still highly encourage those behavioral health providers not submitting documentation for incentives to keep primary doctors updated in order to enhance quality of care. The primary care physician contact form used for this program’s incentives is a great tool that can be used by offices, regardless of BHIP participation.

Have questions?
Contact your provider consultant about the Behavioral Health Incentive Program by going to bcbsm.com/providers.

Sources/References
2 http://www.bhintegration.org/services/primary-care.aspx
3 http://www.bhintegration.org/services/primary-care.aspx
Appropriate treatment for upper respiratory infections in children and adults

Antimicrobial resistance remains one of the most important public health concerns according to the Centers of Disease Control and Prevention and the Michigan Antibiotic Resistance Reduction Coalition. Healthcare Effectiveness Data and Information Set® has three measures which focus on reducing antibiotic use:

- Appropriate testing for children with pharyngitis
- Appropriate treatment for children with upper respiratory infection
- Avoidance of antibiotic treatment in adults with acute bronchitis

To support success in these three measures, Blue Care Network has two clinical guidelines for antibiotic use which are available at Michigan Quality Improvement Consortium website.

The guidelines address the following:

- Acute Pharyngitis in Children 2-18 Years Old
- Management of Uncomplicated Acute Bronchitis in Adults

It’s challenging to work with a patient who is requesting an antibiotic when it isn’t appropriate for them or their child. Both the CDC and MARR websites provide resources to help with these discussions.

The CDC program Get Smart lists communication strategies that can improve patient satisfaction and understanding when prescribing antibiotics isn’t necessary for their condition. The site offers:

- Brochures and posters for the office to assist in educating patients when antibiotics are to be used and why it’s important to use them correctly
- A list of the top 18 drug resistant threats to the United States

A complete menu of what is available at Get Smart, is found at the CDC website. Enter “Get Smart Home” in the search box. There you will find a category titled “Interventions that Work”. It discusses evidenced based interventions that reduce inappropriate outpatient prescribing of antibiotics.

The MARR website also has a program called PEARLS. This program details actions the health practitioner can use when working with patients that request antibiotic therapy that isn’t needed. It also lists common scenarios where these strategies would be helpful.

Choosing Wisely also has downloadable materials available on 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 offers the 5 Questions to ask your doctor before you take antibiotics flyer that you can print and give to your patients as well as posters that you can use in your office.

For additional information on Choosing Wisely, you can visit choosingwisely.org.
**Best Practices**

## Treating high blood pressure

Dr. Diane Parrett, a family practitioner in Fruitport, Michigan believes it’s important to treat her patients with high blood pressure as individuals. “In medicine, we always want to standardize protocols,” she says. “But it’s important to look at patients as individuals and take into account other health issues they may have.”

“When I choose medications for their blood pressure, for example, I consider what will work for them and which side effects might be beneficial for that patient,” she explains. If a patient has a family history of diabetes, Dr. Parrett might prescribe an ACE inhibitor because they can delay the onset of diabetes, she says. Or she can prescribe beta blockers, which can decrease the risk of a heart attack for those with a family history of heart disease.

In that same vein, her protocols for follow-up with patients depend on individual circumstances, namely how well the patient’s blood pressure is controlled. “I follow up with patients every three months if their blood pressure is under control,” says Dr. Parrett. “Otherwise, I follow up every month.”

The office makes sure patients schedule their follow-up appointments when they leave the office to increase the chances the doctor will see them according to schedule. At follow-up visits, Dr. Parrett checks blood pressure readings and adjusts medications if necessary.

Dr. Parrett also believes it’s important to discuss lifestyle changes with patients, such as exercise and diet, including reducing sodium.

“We talk about what happens when you let blood pressure get too high,” she says. “We discuss the risk factors for heart attacks and strokes. When it comes to smoking, I tell my patients they’ll either quit or find a new doctor because they’ll get tired of me nagging them.”

You can’t emphasize lifestyle enough, in Dr. Parrett’s view. She doesn’t shy away from difficult discussions. “We talk honestly about what happens if you have a heart attack or stroke,” she says. She warns patients of quality of life issues if they do have a stroke and lose the use of their hands or are left unable to walk.

One challenge to treating patients with high blood pressure is medication compliance. “No one wants to take medicine. But it’s more important to decrease the risks of heart attacks and stroke. I had a patient who didn’t come in for a while and stopped taking her medications,” relates Dr. Parrett. “When she finally came in for a follow-up visit, she couldn’t lift her arm and she said to me, ‘I think I had a stroke.’” She has since recovered and now takes her medication regularly.

Dr. Parrett keeps patients in control of managing their own health by emphasizing medication compliance and lifestyle. “We talk about medication compliance, and how much better patients can feel with a good diet and exercise.”

Making lifestyle changes can sometimes be a turning point for patients.

“It happens all the time,” said Dr. Parrett. “I saw a young lady this week and I discontinued her blood pressure medications because she lost 60 pounds and runs three miles every day. I’ve taken her from three blood pressure medications down to none. She is doing great.”
How to meet the HEDIS criteria for medication reconciliation post-discharge

Medication errors are common and often occur when patients are moved between health care settings, especially in the elderly population. The National Committee for Quality Assurance has a HEDIS® measure for the Medicare population to assess this concern, Medication Reconciliation Post – Discharge.

This measure looks at the percentage of discharges from Jan. 1 – Dec. 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

A prescribing practitioner, clinical pharmacist or registered nurse may conduct the medication reconciliation.

Documentation in the medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meets criteria for this measure:

- Documentation that the provider reconciled the current and discharge medications
- Documentation of the current medications with a notation that references the discharge medications (for example, no changes in medications since discharge, same medications at discharge, discontinue all discharge medications)
- Documentation of the member’s current medications with a notation that the discharge medications were reviewed
- Documentation of a current medication list, a discharged medication list and notation that both lists were reviewed on the same date of service
- Notation that no medications were prescribed or ordered upon discharge

If you would like more information about HEDIS®, or would like a copy of the HEDIS® specifications, contact Blue Care Network STARS & HEDIS Operations and Data Management department at 248-350-7405.
New HEDIS® measures were added for NCQA accreditation in 2017. These are based on the 2016 measurement year. The measurements are described below.

**Asthma Medication ratio (commercial)**
Members 5 to 85 years old who are identified as having persistent asthma and had a ratio of controller medications to total asthma medication of 0.50 or greater during the measurement year. Note: For Medicaid, report only members 5 to 64 years of age. For Medicare, report only members 18 to 85 years of age.

**Childhood Immunization Status – Combo 10 (commercial)**
Children who have had the following immunization DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV and Influenza by the age of 2.

**HbA1c below 8 (commercial and Medicare)**
Members 18 to 75 years of age with diabetes with a A1c less than 8.0 percent

**HPV (commercial)**
Female adolescents 13 years of age who had three doses of human papillomavirus vaccine by their 13th birthday

**Initiation and engagement of alcohol – Engagement only (commercial and Medicare)**
Percentage of adolescent and adult members who initiated treatment and who had two or more additional services with a diagnosis of alcohol or other drug dependence within 30 days of the initiation visit (within 14 days of initial treatment for AOD)

**Medication management for people with asthma – Medication compliance (75 percent) (commercial)**
Percentage of members who remained on an asthma controller medication for at least 75 percent of their treatment period

**Plan all-cause readmissions (commercial and Medicare)**
Members 18 years and older: The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data is reported in three categories:
- Count of index hospital stays (HIS)
- Count of 30-day readmissions
- Average adjusted probability of readmission

**Potentially harmful drug-disease interactions in the elderly (Medicare)**
Percentage of Medicare members 65 years and older who had evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Each below are reported separately and as a total rate:
- History of falls and a prescription for anticonvulsants, nonbenzodiazepine hypnotics, SSRIs, antiemetic, antipsychotics, benzodiazepines or tricyclic antidepressants.
- Dementia and a prescription for antiemetic, antipsychotics, benzodiazepines, tricyclic antidepressants, H2 receptor antagonists, nonbenzodiazepine hypnotics or anticholinergic agents
- Chronic kidney disease and prescription for Cox-2 selective NSAIDs

If you would like more information about HEDIS, contact Blue Care Network STARS & HEDIS Operations and Data Management department at 248-350-7405.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Reminder for billing injectables: Use drug codes on original package

When billing for injectable medications, make sure to use the NDC found on the original exterior package. Do not use the NDC found on the individual syringes or vials within the package, as these do not necessarily match the NDC on the exterior package. Individual vial or syringe NDCs are not acceptable for billing.

The Tdap vaccine Boostrix is one example:

- The vaccine comes in a package of 10 single-dose vials. The NDC that is on the package should be submitted on the claim form, not the NDC on the vial. The submitted NDC in this case should be 58160-0842-11.

Help members manage their diabetes and medication costs

Blue Care Network moved certain insulin products to our generic copayment tier (Tier 1/1a), effective July 1, 2015, to make it easier for commercial members to save on out-of-pocket costs and manage their diabetes. We published an article in the July-Aug. 2015 issue of BCN Provider News to inform BCN providers about this initiative. We also wrote to members we identified who could benefit from this change and encouraged them to discuss insulin alternatives with their doctor.

We would like to remind physicians to help their BCN patients save money by prescribing insulin products that are on BCN’s generic copayment tier.

If you have any questions about this program, call the Pharmacy Services Clinical help desk at 1-800-437-3803.

Blue Cross and BCN drug lists updated, available online

Blue Cross Blue Shield of Michigan and Blue Care Network regularly update their drug lists. For the most recent updates, go to bcbsm.com.rxinfo.

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 Care Network adds new drugs for intra-articular hyaluronan injections

Intra-articular hyaluronan injections are approved by the U.S. Food and Drug Administration as devices for relief of pain in patients 21 and older with osteoarthritis of the knee who fail treatment with non-pharmacologic and conservative therapies (for example, acetaminophen or NSAIDs).

Two additional intra-articular hyaluronan injections have been approved. Blue Care Network is updating the list at right to include the two new IA-HA products. These two products are being added to the list of six IA-HA products available for treatment today.

Based on current clinical evidence, differences in efficacy and safety between IA-HA preparations have not been demonstrated.

Please use the guidelines shown in the next column when billing for these products to ensure consistent reimbursement. Detailed reimbursement information is available by logging in to web-DENIS.

BCN does not require prior authorization for these drugs. Clinical claims editing will apply to ensure appropriate use including, but not limited to, diagnosis, dosing limits and frequency of administration. This does not apply to BCN AdvantageSM members.

Price Watch feature helps manage drug costs

Blue Care Network strongly encourages the use of low-cost drugs. Prices for some drugs are increasing rapidly, which can increase costs for patients. BCN continues to monitor changes in the market and highlight alternatives to high-priced medications. Look for this Price Watch feature in upcoming issues of BCN Provider News. We’ll identify drugs that have experienced price jumps and offer lower-cost alternatives for consideration.

<table>
<thead>
<tr>
<th>High-cost generic</th>
<th>Average cost</th>
<th>Lower-cost alternatives</th>
<th>Average cost for alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clindagel® 1%</td>
<td>$1,800/Rx</td>
<td>Cleocin T® (g)</td>
<td>$96/Rx</td>
</tr>
<tr>
<td>Cuprimine®</td>
<td>$56,600/Rx</td>
<td>Depen®</td>
<td>$11,700/Rx</td>
</tr>
<tr>
<td>Daraprim®</td>
<td>$900/tablet</td>
<td>Compounded pyrimethamine tablets</td>
<td>$1/tablet</td>
</tr>
<tr>
<td>Retin-A Micro® Pump 0.08%</td>
<td>$1,100/Rx</td>
<td>Retin-A 0.1% cream (g)</td>
<td>$240/Rx</td>
</tr>
</tbody>
</table>
Question:
Can immunizations, such as Prevnar®, be given and billed on the same date as an office visit?

Answer:
Yes, it is appropriate to provide immunizations on the same date of service when office visits or even other procedures are performed. It is important to remember, though, that the services must be consistent with Advisory Committee on Immunization Practices guidelines and appropriately coded on the claim form to ensure proper processing.

This begins with the documentation in the record. Make sure the office record or clinical documentation supports that the office visit reported is separate and distinct from the immunization. Even the administration of the immunization includes a minor evaluation and management service to ensure the patient can safely receive the immunization.

Therefore, if the patient is in the office only for the immunization, only the immunization and the administration code should be reported. If the patient is in there to see the provider for a preventive exam or another issue, and an immunization is administered, both services can be reported. The appropriate modifier needs to be on the office visit, indicating it is a separate and distinct service.

Note: For patients between the ages of 6 and 64, there may be diagnostic restrictions on Prevnar®, as the standard pneumococcal polysaccharide vaccine, 23 valent, can typically be used in this population. Please refer to ACIP guidelines.

Question:
One of our physicians saw a patient for a medical problem shortly after he had a procedure done in our office. The visit was denied, noting that the patient was in a global period. A different doctor did the procedure, so why are we not getting paid and why do we need to appeal?

Answer:
Global surgery periods or packages can be as complex or as simple as you make them. You just need to remember some key points.

Most surgical procedures have global surgical period of 0, 10, or 90 days. This information can be found in the Medicare Physician Fee Schedule (MPFS) on the Centers for Medicare & Medicaid Services website.

The global surgery period applies in any setting, whether it is office, outpatient, inpatient or ambulatory surgery center.

Practitioners of the same specialty in the same group/tax ID are viewed as the same provider.

For services performed during the post-operative period not related to the original procedure, the appropriate modifier must be reported. Changing the diagnosis will not override an edit.

- Documentation maintained in the office must support the use of the reported modifier, but does not need to be submitted with the claim.

- Examples of modifiers commonly used in the global surgical period include 24, 58, 78 or 79. The type of service performed, as well as the reason for the service, provides direction as to the correct procedure code and modifier to report. For example, an office visit conducted during the global period that was not related to the original procedure should be reported with modifier 24.
Billing Q&A, continued from Page 40

**Question:**
What is the correct date of service when billing for pathology interpretation (professional billing)?
Example: 88305 technical is billed with the date the specimen was collected. We now bill the professional 88305-26 using the date the pathologist makes the interpretation.

**Answer:**
The professional and technical components of a pathology or laboratory procedure should match. Therefore, if the date the pathologist makes his or her interpretation is different than when the specimen is obtained, the collection date should be used. This billing guideline from Blue Care Network facilitates correct claims processing and is in line with the CMS general guidelines.

Medicare has limited exceptions to this guideline, including a specimen that is maintained in storage for greater than 30 days. In that situation, then the date of service would be the date the specimen was removed from storage and the test run.

**Question:**
Regarding home health, for Medicare Advantage plans, are you observing the new skilled nursing codes of G0299 and G0300 or are you continuing with the old code of G0154?

**Answer:**
G0154 is no longer a valid code and has not been accepted since Jan. 1, 2016. The rules and guidelines in place for G0154 were transferred to G0299 and G0300. However, BCN AdvantageSM reimbursement is based on commercial rules and methodology, not Original Medicare.

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. Do not include any personal health information, such as patient names or contract numbers, in your question to us.

For urgent or complex questions, contact Provider Inquiry or your provider consultant. Additional information may be required to answer your question accurately.

How to bill for BCN Advantage members’ services using NOC codes

When a specific HCPCS code is not available for a service provided to a BCN AdvantageSM member, you must bill with a not-otherwise-classified code. Please see the article on Page 10 for guidelines for billing services using an NOC code.
How to bill advance care planning services for BCN Advantage members

Effective with dates of service on or after Jan. 1, 2016, practitioners can bill advance care planning services for BCN Advantage™ members. To bill correctly, see full article on Page 13.

Changes for place of service codes

The Centers for Medicare & Medicaid Services published Transmittal R3315CP notifying providers of one new place of service code (19) and a revision in the description of a current place of service code (22), both affecting physician billing for outpatient services.

Please see Page 17 for the full article and detailed descriptions of the revised place of service codes and nomenclature.

Reminder: Reporting multi-line claims

When reporting services on multi-line claims, the reporting requirements are different for surgical multi-line claims and other multi-line services. This is an important distinction as reimbursement may be affected if services aren’t reported correctly.

Surgical claims/lines (for example, revenue codes 0360, 0361, 0369): List each outpatient surgical procedure performed on the same date on a separate line.

Total the charges for all listed surgical procedures. Enter the total charges on the line for the procedure that has the highest RVU. (Note: Whenever possible, this code should be the first surgical procedure listed on the claim. This will facilitate claims processing.)

Subsequent surgery lines are to be reported with a zero charge amount.

Nonsurgical claims/lines (for example, 0480, 0481, 0489): List each outpatient procedure performed on the same date on separate line.

Report the charges for each nonsurgical procedure on the corresponding line. Do not total the charges.
Care management requirements change for members with low back pain, effective March 1

Effective March 1, 2016, the following two changes go into effect for members with low back pain:

- These members are no longer required to see a physical medicine and rehabilitation provider for evaluation prior to a referral to a neurosurgeon or orthopedic surgeon. The requirement for a referral to a physical medicine and rehabilitation provider had been part of Blue Care Network’s Spine Care Referral program.

- Clinical review is no longer required for the initial visit to a neurosurgeon or orthopedic surgeon and for office visits and procedures. These visits may require a referral from the member’s primary care physician, depending on the region.

These changes apply to BCN HMO℠ (commercial) and BCN Advantage℠ members who have a low back pain condition defined by the select ICD-10 diagnosis codes that were previously subject to these requirements as part of BCN’s Spine Care Referral program.

As a result of these changes, references to the Spine Care Referral program are being deleted from the BCN Provider Manual, the BCN Referral / Clinical Review program and other documents. The Spine Care Referral program Web page is being removed from the ereferrals.bcbsm.com website.

For additional information on BCN’s referral requirements, which vary by region, refer to the BCN Referral / Clinical Review Program, available on the Clinical Review & Criteria Charts page at ereferrals.bcbsm.com. Information on requirements for clinical review is also available in that document.

Reminder: 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.
eviCore authorization requirements changed for pediatric members and for select procedure codes

The authorization requirements have changed for some procedures managed for BCN by eviCore healthcare.

Requirements for pediatric members
Effective immediately, cardiology and radiation therapy procedures no longer require prior authorization for pediatric members younger than 18 (through 17 years of age) who have BCN HMOSM (commercial) and BCN AdvantageSM coverage.

Radiology services for pediatric members continue to require prior authorization for those procedure codes included on the list of Procedures that require clinical review by eviCore healthcare. Cardiology, radiation therapy and radiology services for adult members (18 years of age and older) that are included on the list continue to require prior authorization by eviCore.

BCN’s referral requirements still apply and vary by region. Refer to the BCN Referral/Clinical Review Program for information on the referral requirements for your region.

Other requirements
Effective Jan. 1, 2016, services associated with the following procedure codes require prior authorization by eviCore healthcare:

- Radiology: CPT codes *74712, *78265 and *78266

These are 2016 codes with the annual code updates for the American Medical Association and Healthcare Common Procedure Coding System. They are within the range of services currently managed by eviCore; they either replace 2015 codes or represent new or expanded codes that were made more specific for reporting purposes.

In addition, effective Oct. 1, 2015, services associated with the following procedure codes also require prior authorization by eviCore healthcare:

- Radiology: CPT codes *75635 and 77022
- Radiation therapy: CPT code *77014

These codes were included in the program implemented on Oct. 1, 2015, but were inadvertently not reflected on the list of procedures that require authorization by eviCore.

Documents to be updated
The following documents have been updated with these changes and are available on referfals.bcbsm.com.

- Procedures that require clinical review by eviCore healthcare. Click eviCore-Managed Procedures to find this document.
- BCN Referral/Clinical Review Program. Click Clinical Review & Criteria Charts to find this document.

Reminder
October 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.

*CPT codes, descriptions and two-digit modifiers only are copyright 2015 American Medical Association. All rights reserved.
AMC Health to manage members with CHF and COPD, effective April 1

Effective April 1, 2016, BCN will use AMC Health as the vendor for managing high-risk BCN HMO℠ (commercial) and BCN Advantage℠ members with congestive heart failure and BCN Advantage members with chronic obstructive pulmonary disease. Previously, BCN used Alere™ Health to manage these members.

What you need to know

In anticipation of this change, here’s what you need to know about members moving to AMC Health from Alere Health:

- These members will receive letters in March 2016 letting them know about the transfer.
- The primary care physicians for these members will also receive letters in March.
- AMC Health will contact members who require monitoring to introduce themselves and set up monitoring in early April.
- Members who no longer require telemonitoring will be contacted about enrolling in BCN’s Case Management programs.

How telemonitoring works

The key features of the monitoring program include:

- Home biometric monitoring for blood pressure, weight and oxygen saturation of the blood, using telemonitoring technology
- Nurse review of symptom information 365 days a year and comparison of this information to preset parameters for each member
- Notification to the member’s practitioner by fax when the member’s symptoms exceed the pre-set parameters

The member’s biometric information is communicated to AMC Health through a telemonitoring device. If AMC Health does not receive any alerts about changes in the member’s symptoms, AMC Health simply sets up a regular schedule of educational sessions with the member. When AMC Health receives an alert, AMC Health calls and engages the member in a one-on-one assessment discussion about what’s going on. AMC Health lets the member’s primary care physician know about any concerning changes in the member’s condition that are being transmitted.

In addition, if the member is admitted for inpatient care, AMC Health follows up with the member after discharge.

Benefits of telemonitoring

AMC Health’s biometric monitoring provides the treating practitioner with timely alerts about changes in the member’s symptoms while the members are at home. Through their monitoring activities, AMC Health also gathers data from individual members’ responses to tailored questions that are based on each member’s specific plan of care.

The goals for these high-risk populations are to promote optimal health status and quality of life, reduce the number of avoidable admissions, readmissions and emergency room visits related to their conditions.

How eligible members are identified

BCN identifies members eligible for in-home biometric monitoring through a predictive model database using claims and demographic data. Once a member is identified, AMC Health contacts the member directly. AMC Health notifies the member’s primary care physician when the member agrees to enroll in the program.

For members with CHF and COPD who are not currently being monitored, practitioners can contact BCN Care Management at 1-800-392-2512 to refer them for monitoring through AMC Health.
Call Northwood at new number to identify a contracted supplier

If you need assistance identifying a supplier contracted with Northwood, Inc., call Northwood’s Customer Service department at 1-800-393-6432.

As a Blue Care Network provider (primary care practitioner or specialist), you must refer BCN HMO℠ (commercial) and BCN Advantage℠ members to a supplier contracted with Northwood for outpatient durable medical equipment, prosthetics or orthotics and nondiabetic medical supplies. The supplier will submit the request to Northwood for review.

We are updating the BCN Provider Manual and related documents to reflect this information.

Landmark Healthcare is now eviCore healthcare

Our physical therapy benefits management service, Landmark Healthcare, has a new name — eviCore healthcare.

eviCore healthcare oversees outpatient physical, occupational and speech services for BCN members delivered by independent physical therapists, outpatient therapy providers and physician practices. eviCore also oversees physical medicine services for BCN members delivered by chiropractors.

See Tips about eviCore Authorizations for BCN Members at ereferrals.bcbsm.com for helpful information about authorizations. Click Outpatient PT, OT, ST.

If you have questions about this change, contact eviCore’s Customer Service Department at 1‑877‑531‑9139.

Take a short survey on the e-referral support website and you could win a prize!

The e-referral resource site at ereferrals.bcbsm.com has recent news and updates your staff needs to get your patients their referrals electronically, using the e-referral system.

We’re planning some improvements to the website later this year and would like to know what you think. If you can spare five minutes to take an online survey, your input can help us understand what works well and what could work better on the site.

Please complete the online survey by March 15.

You could win one of two $25 gift certificates.

Participation in the survey is not necessary to win. The drawing is open to all active Blue Cross or BCN providers. Enter by completing the survey no later than March 15, 2016, or by sending an email with your name, phone number and “Survey drawing” in the subject line to ProviderOutreach@bcbsm.com by March 15, 2016.

All entries must be received by March 15, 2016. Two winners will be selected in a random drawing from among all eligible entries. Each winner will receive a $25 gift card. The drawing will take place by the end of March. Winners will be notified by telephone or email following the drawing.
# BCN Advantage

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