Award recognizes providers’ roles in star-ratings success

Providers who have made outstanding contributions to the BCN Advantage℠ and Blue Cross Medicare Plus Blue℠ PPO plans’ 2015 star ratings were recently honored with Provider Distinction Awards. This is the third year we have recognized Medicare Advantage providers for their contributions to our star quality measures. Our partnership with providers is critical to our star-ratings success.

The Centers for Medicare & Medicaid Services uses a five-star quality rating system to measure Medicare beneficiaries’ experience with their health plans and the health care system. This rating system applies to all Medicare Advantage lines of business.

The award criteria included the following:

- Achieve a quality score (star measure screenings: diabetes care, colorectal cancer screening, breast cancer screening and other measures) of 85 percent or above either with their patients who have Blue Cross Medicare Plus Blue PPO only, BCN Advantage only, or jointly with patients from both plans. If providers achieve greater than 85 percent in any of those categories, then they pass the first eligibility test for the award.

We’ve redesigned BCN Provider News

Welcome to the May-June issue of BCN Provider News and our new look.

We first introduced this electronic newsletter toward the end of 2009. With this issue, we’re unveiling our redesign. We’ve given the newsletter a fresher look and made it more appealing. A more streamlined design allows us to fit more news on the front page. We’ve also made the type size a bit larger to make it easier to read.

You’ll also notice that we removed the Blue Cross Complete section. That product now has its own newsletter.

We kept what works.

Please see Star ratings, continued on Page 3

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Inside this issue...

5 Provider forums coming to a town near you

17 From the medical director: Primary care physicians play a key role in diagnosing sleep apnea

28 Blue Care Network leads the way in embracing innovative program for treatment of first break schizophrenia

33 Best Practices: Lansing practice uses electronic medical record alerts for breast cancer screening
We kept our traditional sections and navigation so you can find all the news you need whether you’re a provider, medical assistant, referral coordinator or biller. We’ve also kept our Best Practices feature and From the Medical Director column. These mainstays of the newsletter help keep you updated on what other providers are doing in the important areas of screening, maintaining HEDIS® and stars measures and following accepted clinical standards in their offices.

We used the results of our BCN Provider News readership survey to help guide our redesign and to make sure the newsletter continues to serve your needs and provide all the information you need to do business with us. The newsletter keeps you abreast of network and billing changes, clinical guidelines, new plan introductions and other important information.

Survey results
The results of our readership survey were overwhelmingly positive. You told us that you can easily find the information you need (89 percent told us this). One-third of respondents read the entire issue, and two thirds look for information in a specific section that pertains to their jobs. Fifty-nine percent of respondents read every issue, while 92 percent read most issues or every issue. Ninety-three percent said the newsletter is easy to read and helpful in keeping up with important network news and updates.

We hope you continue to find our newsletter useful and continue to recommend it to others in your office who can benefit from the articles. We always welcome your feedback and article suggestions. Just send an email to BCNProviderNews@bcbsm.com and type “feedback” in the subject line.

Thank you for being a loyal reader of BCN Provider News.
Star ratings, continued from Page 1

- Providers must have a minimum of five services that count toward the star rating (for example, a diabetes test, colorectal screening.) [The number of services completed divided by the number of eligible services equals the quality score.]
- Providers must be currently credentialed and contracted with Blue Cross Medicare Plus Blue PPO and BCN Advantage, and in good standing.
- Providers may not be in the low quality score rating program. (Those providers with low quality scores will be eligible for future awards once they have completed the QSR program.)

The plaque awarded is a perpetual plaque, and as the physician groups continue to achieve impressive scores, we will continue to put a star on the plaque.

The providers who received plaques also receive gifts for office staff that help do the administrative work. We appreciate their support.

Clockwise, from top left: Dr. Sawka’s office; Dr. Cordoba-Naguit Holy Family clinic; Ann Arbor Family Medicine; IHA Canton Family Medicine; IHA Internal Family Medicine; Dr. Laura Babe’s office.
We’d like to remind providers to submit a Blue Care Network Qualification Form for Healthy Blue Living members in a timely manner. Members have 90 days from their effective eligibility date to submit the form to us. The qualification forms must be submitted through Health e-Blue™. Providers should also give a copy of the form to the member for his or her records.

If you are submitting qualification forms for the first time and do not have access to Health e-Blue, go to Provider Secured Services to sign up for a login ID and password.

BCN reimburses providers $40 for each electronic qualification form submitted through Health e-Blue. Bill *99080 for reimbursement. Report with Z0000 or Z0001. If the form is completed at the time of the member visit for a preventive physical exam, providers should also bill a preventive service or evaluation and management code for the visit. There is no member cost sharing for the annual physical. Additional diagnoses may be billed for specific conditions.

As a reminder, BCN Healthy Blue Living members are permitted to have more than one physical a year. So a member can schedule a physical at any time, regardless of when he or she had a physical in the previous year.

(See sidebar about scheduling physicals.)

Scheduling physical exams

Members and physician offices often ask us how often a member can have a physical examination. BCN does not restrict the timing between yearly physical exams.

Here are some examples where a member may receive a physical exam more often than once per year.

- If a member has a physical in July and then changes to Healthy Blue Living™ coverage in January and contacts your office for another physical examination in order to get the qualification form completed, it is acceptable to provide another exam, even though it has only been six months since the last exam. The physician can also elect to use the lab results from the June physical to complete the qualification form without conducting another physical exam.

- If a member changes primary care physicians, the new primary care physician can conduct a physical exam regardless of when the member’s last physical was conducted.

- If the physician believes there’s a need to conduct a physical exam more often than once per year – for any reason – the physician can ask the member to return for another physical exam.
Provider forums coming to a town near you

Blue Cross Blue Shield of Michigan and Blue Care Network are coming to you this summer. We’ve scheduled a series of forums focusing on our professional providers across the state. The classes will cover such key topics as:
• Telemedicine (p.m. session)
• Claim attachment enhancement (p.m. session)
• Provider Inquiry (p.m. session)
• New products (p.m. session)
• Clinical edit updates (p.m. session)
• Documentation and coding (a.m. session)
• ICD-10 (a.m. session)

Here’s a schedule of events:
• Registration begins at 7:30. The morning session begins at 8 a.m. and includes a continental breakfast. The afternoon session begins at noon and includes lunch.
• You have the option to register for the full day, the a.m.-only session or the p.m.-only session.

To register, click on the link next to the event you’d like to attend. If you have questions, contact your provider consultant.

<table>
<thead>
<tr>
<th>Class location</th>
<th>2016 Date</th>
<th>Registration</th>
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<tbody>
<tr>
<td>Kalamazoo</td>
<td>May 3</td>
<td>Click here for both sessions</td>
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<tr>
<td>Radisson Kalamazoo 100 West Michigan Ave. Kalamazoo 49007</td>
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<tr>
<td>St. Joseph</td>
<td>May 4</td>
<td>Click here for both sessions</td>
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<tr>
<td>The Inn at Harbor Shores 800 Whitwam Dr. St. Joseph 49085</td>
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<tr>
<td>Grand Rapids</td>
<td>May 5</td>
<td>Click here for both sessions</td>
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<tr>
<td>Frederik Meijer Gardens and Sculpture Park 1000 East Beltline Ave., NE Grand Rapids 49525</td>
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<tr>
<td>Southgate</td>
<td>May 10</td>
<td>Click here for both sessions</td>
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<tr>
<td>Holiday Inn Southgate - Banquet &amp; Conference Center 17201 Northline Road Southgate 48195</td>
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For residents: Get an early start with credentialing

Practitioners completing their residency this summer are welcome to submit their Blue Cross Blue Shield of Michigan provider enrollment application 60 days prior to their training completion date. The CAQH ProView applications must be completed in order to begin the credentialing process with Blue Cross and Blue Care Network.

Visit the CAQH ProView website for more information.
Blue Care Network has made some changes to a few of the BCN Provider Publications and Resources Web pages, including the Provider Manual Web page. These changes were made to make information easier to find and easier to use. The changes are a result of advice from providers who participated in provider manual usability testing in 2015 as well as those who participated in the 2015 provider manual survey.

Here are the changes:

• On the left navigation bar of the BCN Provider Publications and Resources pages, the links to billing and authorization / referral information were moved to the top and placed under a new Popular Links heading.

• The Care Management page was renamed Authorizations / Referrals and the information on it was rearranged so things are easier to find.

• On the Provider Manual page, information was placed into boxes and tables for easier reading. The Claims and Care Management chapters were moved to the top of the list of chapters because these are used most often. Also, an explanation was added highlighting what’s in each manual chapter. At the bottom of the page, there is now a link to help providers find other Blue Cross Blue Shield of Michigan provider manuals.

How to find these pages
To access the BCN Provider Publications and Resources Web pages, do the following:


2. Log in to Provider Secured Services.

3. Click BCN Provider Publications and Resources (on the right side of the screen) or click web-DENIS and then click BCN Provider Publications and Resources.

What do you think?
If you have additional thoughts on what would make the BCN Provider Publications and Resources website or the BCN Provider Manual page easier to use, please let us know.

You can contact us at BCNProvComm@bcbsm.com.
How to find Blue Cross and BCN provider manuals, publications and resources

We’re making it easier for you to find the information you need. When you go to bcbsm.com and log in to Provider Secured Services, you will see some new links on the Welcome page to get you quickly to important information.

On the right side of the screen, there’s a blue box with links to the current issues of Blue Cross Blue Shield of Michigan and Blue Care Network provider newsletters. You may already be familiar with these links, but now there are a few new links directly below this blue box that you may find helpful.

These new links are:

- **BCBSM Provider Publications and Resources**
  This website has Blue Cross fee schedules, the Blue Cross provider manuals, pharmacy forms, newsletter archives and many additional resources, such as provider training and clinical criteria.

- **BCN Provider Publications and Resources**
  This website has information on BCN billing, authorizations and referrals, the BCN Provider Manual, forms, learning opportunities and many other resources.

- **Provider Manuals**
  This is a new page that links to all four of the Blue Cross and BCN provider manuals for medical providers. It’s a one-stop shop to find information on guidelines for claims submission, authorization requests, appeals and many other topics. Just select the manual you need according to the patient’s coverage: Blue Cross, BCN, Blue Cross Medicare Plus BlueSM PPO, or Blue Cross Complete.

Please see Provider resources, continued on Page 9
Provider resources, continued from Page 8

These websites are also still available within web-DENIS, but now you can find them on the Provider Secured Services Welcome screen to save you time.

<table>
<thead>
<tr>
<th>Provider manual (click to access)</th>
<th>For patients with the following coverage:</th>
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</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield of Michigan provider manuals</td>
<td>Blue Cross traditional, preferred provider organization (PPO) and exclusive provider organization products (EPO) (See below for Medicare or Medicaid coverage.)</td>
</tr>
<tr>
<td>BCN Provider Manual</td>
<td>Blue Care Network health maintenance organization (HMO) commercial and Medicare products (Includes BCN Advantage™ coverage.)</td>
</tr>
<tr>
<td>Blue Cross Medicare Plus Blue™ PPO Provider Manual</td>
<td>Blue Cross Medicare Advantage preferred provider organization products</td>
</tr>
<tr>
<td>Blue Cross Complete Provider Manual</td>
<td>Blue Cross Medicaid product</td>
</tr>
</tbody>
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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
Blue Care Network offices will be closed on May 30 for Memorial Day. When BCN offices are closed, call the BCN After-Hours Care Manager Hot Line at 1-800-851-3904 and listen to the prompts for help with:

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

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

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

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

As a reminder, when an admission occurs through the emergency room, we ask that you contact the primary care physician to discuss the member’s medical condition and coordinate care before admitting the member.
New winners for BCN’s tobacco cessation office staff contest

Congratulations to the offices of Dr. Hoda Zaki, Flint, and the Oakwood Taylor Clinic in Taylor for winning the last two office staff contests! These two offices won for handing out our tobacco use survey and Quit Guide to BCN commercial members aged 18 to 65. Each office will split $1,000 in Visa gift cards among their staff.

Smoking cessation continues to be a top priority for Blue Care Network in 2016. When smokers receive advice from their health care providers, it can double their chances of successfully quitting smoking. We need you to help us reach out to our members who smoke so they get this important advice from you, their trusted provider. We will send out new surveys and FAQs in the coming weeks, so watch for them.

If you have not previously received the surveys and quit guides and would like copies for patients, please call 248-799-6959 to request them.

We will continue to accept the previous surveys that you have on hand and enter them in the drawing until the new surveys are in the field. Good luck in the monthly drawing.

Blue Cross Complete launches provider newsletter

Blue Cross Complete of Michigan has introduced a separate newsletter for providers starting with the March issue.

The current issue is available on mibluecrosscomplete.com/providers. The new issue features the following topics:

- New process for provider enrollment and change requests
- Newborn coverage for Medicaid members
- Blood lead guidelines

To subscribe, please contact Janise Plata at jplata1@mibluecrosscomplete.com.

New provider representatives for Blue Cross Complete

We have received an increase in calls from providers related to Blue Cross Complete. Blue Cross Complete is being serviced separately from Blue Cross Blue Shield of Michigan and Blue Care Network. Please see the attach PDF for provider representatives to contact. For the areas with no provider representative listed, you may call Pat Embry. Her number is listed on the attached document.

Also please note that enrollment and changes are handled separately from Blue Cross and BCN. See the link to the Blue Cross Complete newsletter in the above article for information.
New information on provider requirements for CMS training about compliance and fraud, waste and abuse

We’ve communicated in the past about the responsibility each provider has to complete annual training related to fraud, waste and abuse and compliance with Medicare requirements. This training is a requirement that BCN AdvantageSM must make sure providers carry out. BCN Advantage is required by the Centers for Medicare & Medicaid Services to ensure that its network providers complete training as part of its compliance program.

What’s new

We’ve recently learned that the only way for providers to generate a certificate of completion for this training is to take the training using the modules available at the Medicare Learning Network.

To fulfill the requirements for compliance training and generate a certificate of completion, you must do the following:

1. Click to open the Medicare Learning Network® (MLN) Learning Management System.
2. Log in. (If you are a first-time user, you must create an account.).
3. Complete the following two training modules:
   - Medicare Parts C and D General Compliance Training
   - Combatting Medicare Parts C and D Fraud, Waste and Abuse
4. Generate a certificate of completion for each module.

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

Your staff must complete the training within 90 days of hire or contract and annually thereafter.

Exception

If you’re enrolled in Medicare Parts A or B, you’re deemed to have satisfied the fraud, waste and abuse training requirement and you are not required to take additional fraud, waste and abuse training. However, you must still complete the general compliance training section and maintain a certificate as evidence of training completion.

Alternative training option

Providers who wish to use their own training program must incorporate the content from both the Medicare Parts C and D Fraud, Waste and Abuse Training and the Medicare Parts C and D General Compliance Training modules into their training materials without modification and keep a record demonstrating completion of the training.

Keep certificates on file

Regardless of the training option you choose, the certificates of completion you generate or other evidence of training completion must be kept on file for 10 years following the expiration of the contract.

Background on requirements

As a reminder, CMS requires BCN Advantage, which receives payment from Medicare, to implement an effective general compliance program.

In order to satisfy CMS guidelines, this program must meet the minimum requirements established by federal statutes that pertain to Medicare Parts C & D (Section 1860D-4(c)(1) (D) of the Act, 42 C.F.R. §§ 422.503(b)(4)(vi), 423.504(b)(4)(vi)).

According to these guidelines, providers are required by CMS to take CMS-specific training about fraud, waste and abuse and compliance.
Blue Cross and BCN retain Mobile Medical Examination Services for home health reviews

Blue Cross Blue Shield of Michigan and Blue Care Network will once again retain an independent company to conduct home health reviews, formerly known as in-home assessments, for eligible Blue Cross and BCN Medicare Advantage members.

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

Licensed health care professionals from Mobile Medical Examination Services Inc., or MedXM, will provide the personalized home health reviews. These reviews will include a medical history review, brief physical exam and documentation of any existing medical conditions.

The health review won’t replace any care members receive from their physicians. Also, the MedXM health professional can’t access a member’s medical history or write prescriptions.

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

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

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

If you have any questions, please contact your provider consultant.
Blue Cross Blue Shield of Michigan and Blue Care Network, in partnership with Data Driven Delivery Systems, will be using CIOX Health, formerly known as Enterprise Consulting Services, or ECS, to perform medical record retrieval for risk adjustment services for Michigan Medicare Advantage members.

This service was previously performed by Inovalon. DDDS, a respected vendor in the health care industry, will manage the partnership. DDDS will review and code medical records at sites that do not permit scanning or copying of records. The retrieval process will start in April 2016.

“We’re working to minimize disruption at hospitals and provider offices,” said Tracy Korczyk, Blue Cross director of performance management and enterprise risk adjustment.

Inovalon will continue to manage in-state Healthcare Effectiveness Data and Information Set, or HEDIS®, medical record retrievals for Blue Cross PPO and Medicare Advantage PPO members from March through May each year.

Verisk Health will continue to manage medical record retrieval for in-state commercial risk adjustment business and continues to partner with other Blue Cross plans for out-of-state risk adjustment and HEDIS chart-retrieval services.

Blue Cross and BCN request medical records every year to meet the Centers for Medicare & Medicaid Services’ standards for data submission and coding accuracy, and CMS’ and Health and Human Services’ regulations and quality standards for patient care. Ensuring office visits take place and diagnoses are appropriately captured and documented can enhance the quality of a member’s care, while lowering premiums.

DDDS and CIOX Health are contractually bound to preserve the confidentiality of members’ protected health information obtained from medical records, in accordance with the Health Insurance Portability and Accountability Act of 1996.

You won’t need to submit patient-authorized information releases to comply with medical records requests when both the provider and health care plan have a relationship with the patient, and the information relates to this relationship [45 CFR 164.506(c)(4)]. For more information about privacy rules, go to hhs.gov/ocr/privacy.

If you have any questions, contact one of the following Blue Cross provider outreach consultants:

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

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Blood pressure control is one focus of the Chronic Care Improvement Program

BCN Advantage’s Chronic Care Improvement Program, designed to prevent cardiovascular disease in BCN AdvantageSM members is entering its final year. The five year program, started in 2012, is designed to prevent cardiovascular disease in BCN Advantage members. The program highlights member self-management strategies and partnership with physicians.

The core of our program are clinical interventions championed by Million Hearts®, a public initiative led by the Centers for Disease Control and the Centers for Medicare & Medicaid Services to prevent 1 million heart attacks and strokes in the United States by 2017. The Million Hearts clinical interventions focus on improved management of the “ABCs” – Aspirin for high-risk patients, Blood pressure control, Cholesterol management and Smoking cessation.

In this issue, we’re focusing on blood pressure control.

We all know that having high blood pressure is a risk factor for heart disease and stroke. According to the Centers for Disease Control, there are many missed opportunities to prevent heart disease and stroke. Here are a few facts from the CDC VitalSigns September 2012 edition about blood pressure:

- Nearly one in three adults (about 67 million) has high blood pressure.
- About 36 million adults with high blood pressure don’t have it under control.
- High blood pressure contributes to nearly 1,000 deaths a day.
- Most people with uncontrolled high blood pressure know they have high blood pressure, see their doctor and take prescribed medicine.

You can visit the CDC website to learn more about how you can improve blood pressure control by following this link: Getting Blood Pressure Under Control | VitalSigns | CDC.

The Million Hearts website is also a good resource for helping you treat your patients with high blood pressure. Follow this link to learn more about The Million Hearts project and to download tools and information that you can share with your patients: B/P Fact Sheets | Million Hearts.

Blood pressure control

At Blue Care Network, we’re committed to support your efforts to control blood pressure in your BCN Advantage patients. The BCN Million Hearts Incentive program allows practitioners to earn a payment for BCN Advantage members whose blood pressure is controlled. You can earn payment for patients who meet the eligibility requirements for the incentive and have blood pressure readings within the following parameters.

The requirements are (members age 40 and over as of Dec. 31, 2016) who meet both the systolic and diastolic blood pressure reading requirements below:

- For members 18 to 59 years of age whose blood pressure was less than 140/90 mm Hg (The incentive applies to members 18 and up and is not specifically part of the Chronic Care Improvement Program.)
- Members 60 to 85 years of age as of Dec. 31, 2016 with a diagnosis of diabetes whose blood pressure was less than 140/90 mm Hg
- Members 60 to 85 years of age as of Dec. 31, 2016 without a diagnosis of diabetes whose blood pressure was less than 150/90 mm Hg
- Systolic blood pressure value: report one of the systolic codes - 3074F—systolic blood pressure less than 130 - 3075F—systolic blood pressure 130-139 - Systolic blood pressure greater than 140 and less than 150 (needs to be documented in the electronic medical record or in Health e-Blue®. No CPT Cat II codes are available.)
- Diastolic blood pressure value report one of the diastolic codes - 3076F—diastolic blood pressure less than 80 - 3079F—diastolic blood pressure between 80-89

The 2016 CMS Million Hearts Incentive Program document that explains this program in detail is available in BCN’s Health e-Blue. The document is located in the Resources section under Incentive Documents. If you have any questions, please contact your medical care group leadership or your BCN provider consultant. We appreciate your continued support of our physician incentive programs.
It’s no secret that American adults have busy lives and are getting less sleep than they did a century ago. Teens also get less sleep due to busy schedules, homework and access to electronic media.

But the increased rates of obesity have also led to increased diagnoses of sleep apnea. One in five Americans has mild sleep apnea. Out of 40 million with apnea, one third have moderate to severe sleep apnea. And many adults go undiagnosed or untreated.

Sleep apnea is the inability to transport air down into the lungs due to an obstructive process with the collapse of the oropharyngeal walls. The National Healthy Sleep Awareness Project cites several new studies that show a correlation between obstructive sleep apnea and the risk of high blood pressure. Obstructive sleep apnea is also seen with an increased correlation or prevalence of Type 2 diabetes, stroke and depression.*

Data from the American Journal of Epidemiology shows the estimated prevalence rate of obstructive sleep apnea has increased over the last two decades.

Key findings from new studies on the negative effects of sleep apnea include the following:

- A study in the journal *Sleep* found that untreated sleep apnea led to a reduction in white matter fiber integrity in multiple brain areas, accompanied by impairments to cognition, mood and daytime alertness. One year of CPAP therapy led to almost complete reversal of these symptoms.

- A Brazilian population study found that nocturnal cardiac arrhythmias occurred in 92 percent of patients with severe sleep apnea, compared with 53 percent of people without sleep apnea.

- A study published in the *Journal of Hypertension* found a favorable reduction of blood pressure with CPAP treatment in patients with resistant hypertension and sleep apnea.

Blue Care Network encourages physicians to initiate discussions with patients about their sleep habits and encourage obese patients to lose weight. Sleep problems can be considered a national health issue because sleep disorders interfere with work, driving and social functioning.

Physicians should educate patients about healthy sleep habits. For example, most adults need seven to eight hours of sleep. Seniors require at least six hours of sleep each night. Young children need 12 hours of sleep or more, and teens need around nine hours.

According to WebMD®, getting fewer than six hours sleep per night is risky. People over 45 who get less than six hours a night doubled their chances for stroke or heart attack and are more likely to have heart failure.
From the medical director, continued from Page 17

It’s especially critical for primary care physicians to discuss potential sleep problems when patients have a diagnosis of hypertension, diabetes mellitus Type 1 or 2, thyroid disease, menopause, heart disease or are obese.

Questionnaires such as the Berlin Questionnaire or the Epworth Sleepiness Scale can help you determine if obstructive sleep apnea is an issue that needs to be addressed.

To meet the criteria for obstructive sleep apnea, the Epworth Sleepiness scale should be at or greater than 10 with a neck circumference of 17 inches or more. The neck measurement can be adjusted by adding 3cm if the patient is a habitual snorer, 4cm if hypertension is present and 3cm if apnea, gasping, choking occurs most nights. If the actual circumference, when adjusted, is greater than 43 cm (17 inches), then this is considered positive for high risk in addition to the ESS > 10.

If your patient is obese and may have obesity hypoventilation syndrome, then a home sleep test is contraindicated. A pulmonary or sleep medicine specialist will be able to determine what kind of test is indicated.

Other contraindications to a home sleep test include:

- Narcolepsy
- Periodic limb disorder during sleep (not restless leg syndrome, which occurs during wakefulness)
- Central sleep disorder
- Pulmonary diseases (pulmonary function test results of an arterial blood gas showing PO2 < 60, or PCO2 >45, documented neuromuscular disease, including Parkinson’s, stroke with residua, active epilepsy (without treatment rendering a stable status), spina bifida, myotonic dystrophy, ALS, moderate to severe congestive heart failure with New York Heart Classification of Heart Failure (III, IV) (see table, page 19), documented pulmonary congestion or left ventricular ejection fraction <45%, or critical illness that would prevent the patient from using the equipment, restless leg syndrome, parasomnias or REM behavior disorder.

Doctors can diagnose patients with a sleep problem by asking patients to keep a diary for one to two weeks. Ask patients to write down what time they went to bed, what time they woke up, how alert and rested they felt in the morning and how sleepy they felt during different times of the day.

Examples of questions which may alert you as a care provider that a sleep disorder is present are as follows:

- Do you snore?
- How often do you snore? (3 to 4 times per week, 1 to 2 times per month. Almost never? (Berlin Questionnaire for OSA)
- Does your snoring bother other people?
- Has anyone noticed that you stop breathing during your sleep? (3 to 4 times per week, 1 to 2 times a week or 1 to 2 times per month. (Berlin Questionnaire for OSA)
- How many hours of sleep are you getting?
- Do you doze and sleep when you are seated and inactive in a public place?
- Do you doze and sleep when you’re a passenger in a motor vehicle for an hour or more?
- Do you doze or nap in the afternoon?
- Do you doze and nap while sitting and talking to someone?
- Do you doze and nap while sitting quietly after lunch without alcohol?
- Have you ever stopped for a few minutes in traffic or at a light and fallen asleep? (Epworth Sleepiness Scale)

Please see From the medical director, continued on Page 19
From the medical director, continued from Page 18

Because patients may not be aware that they snore or choke during sleep, you might ask them to enlist a partner’s help to record symptoms during sleep.

Family history is also important. Be sure to ask if the patient has any family members who have been diagnosed with sleep apnea.

You can tell patients to find information about sleep and a sample sleep diary in the National Heart, Lung and Blood Institute’s Your Guide to Healthy Sleep.

*The National Healthy Sleep Awareness Project addresses the sleep health focus area of Healthy People 2000, which provides science-based, 10-year national objectives for improving the health of all Americans. The sleep health objectives are to increase the medical evaluation of people with symptoms of obstructive sleep apnea, reduce vehicular crashes due to drowsy driving and ensure more Americans get sufficient sleep. projecthealthysleep.org

New York Heart Classification of Heart Failure III & IV

III. Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.

IV. Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

Blue Care Network’s Sleep Management Program

The gold standard for diagnosing obstructive sleep apnea is a polysomnogram. The American Academy of Sleep Medicine also supports the use of a home sleep test in those who are at a high probability of moderate to severe obstructive sleep apnea.

Primary care physicians can refer patients to specialists for sleep studies. Sleep study candidates include habitual snorers with daytime sleepiness or observed apnea (cessation of breathing lasting 10 seconds or more). Daytime sleepiness can be determined by using a common assessment tool available to health care providers, such as the Epworth Sleepiness Scale, Stanford Sleepiness Scale or the STOP-BANG model.

Home sleep studies allow for testing in the comfort of the patient’s own bed and are particularly useful in areas where the nearest sleep center may be hours away. Home sleep studies are covered to diagnose obstructive sleep apnea for patients who fit the following description:

- Are 18 years of age or older
- Have a high pretest probability of moderate to severe obstructive sleep apnea
- Have no comorbid conditions

For more information about sleep studies and treatment for BCN patients, including clinical review requirements, please see information about our Sleep Management Program at ereferrals.bcbsm.com.
Last fall we asked you to complete an online survey to tell us how satisfied you are with Blue Care Network’s Care Management services. The 2015 Physician Satisfaction survey was available electronically on our website during October, November and December 2015. Almost 700 people answered our survey and all were placed in our drawing. Two lucky winners each won a $250 gift card. Your responses help us evaluate our efforts and determine other improvements that we can make to enhance our care management processes.

The questions on our survey were designed to gather information about how you use care management services as well as to measure your satisfaction with each of the functional units within Care Management. A five-point response scale allowed you to rate your satisfaction as very satisfied, satisfied, neutral, dissatisfied or very dissatisfied. We also allowed an “opt out” response of no opinion/don’t know. We didn’t include the no opinion/don’t know responses in the totals. Here’s what we found:

- Satisfaction ratings ranged from 62 percent satisfaction with the provider appeal process to 92 percent satisfaction with our disease management programs. We combined the very satisfied and satisfied responses to determine the satisfaction rating.
- We also offered you the chance to tell us what Blue Care Network could do to improve your satisfaction with its care management programs. Your comments provide valuable information about your experience with us and guide us in our efforts to improve our services.

We’re happy that you’re mostly satisfied with our processes, but this survey and your comments tell us that we still have some things to work on. Here are a few of them:

**Phone wait times**

We’re working to increase the rate of online referral submissions. This will decrease the number of inbound calls to the referral intake unit and decrease the phone wait times for those times when you need to call us.

**Referrals**

We’re conducting further research to determine what works well and what could work better on the site. You may have taken a short survey that we made available on the e-referral home page back in February and March. The results of this survey will give us more direction of what’s needed to improve the e-referral website and your experience with it.

**Clinical review requests that are rejected due to incomplete information**

We’re always working to spread awareness of the tools and resources available on BCN’s e-referral home page. There you’ll find BCN’s referral and clinical review program grid, the medical necessity criteria/benefit review requirements tool, sample questionnaires, clinical review procedures managed by eviCore and much more including behavioral health tools and resources.

**Online questionnaires**

We’re updating some of our questionnaires to bring them up to date with current processes and to streamline use.

We value your opinion and welcome the feedback you give us about our processes and programs at BCN. We appreciate your participation in this survey and we’ll use the information it provides to identify ways to improve the services we provide to you and our members.
Blue Cross Blue Shield of Michigan and Blue Care Network maintain a policy for content of medical records

A clinical record must be maintained for each our members. The clinical record should be:

- Contemporaneous
- Organized in a manner that facilitates easy access for reviewing and reporting purposes
- Stored or electronically secured to ensure compliance with HIPPA regulations

The content of the medical record should include member demographics, health assessment, reason for visit, diagnoses, documentation of discussion about advanced directives, preventive health and health maintenance, patient education, follow-up plan, consultation review and referred services review. Our medical record keeping policies supports the Centers for Medicare & Medicaid Services and National Committee for Quality Assurance standards and contains elements from the Michigan Quality Improvement Consortium Guidelines.

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

Feedback from the 2015 medical record review summary reflects an overall improvement from 2014 except advanced directives. Opportunities for improvement include:

- Documentation regarding advance directives
- Cervical and colorectal cancer screenings

We have medical record forms available to assist practitioners with medical record guidelines.

For further information please contact BCN’s Quality Management department at 248-455-2708.
Providers should provide counseling on childhood BMI

The Michigan Quality Improvement Consortium guidelines recommend that children age 2 or older be assessed at each periodic health exam by measuring and recording weight and height using the CDC BMI-for-age growth chart (for either girls or boys) to obtain a percentile ranking.

A BMI assessment may be a good way to screen children for overweight and obesity, but it is not a diagnostic tool. To determine if excess fat is a problem, a health care provider would need to perform further assessments such as skin fold thickness measurements, evaluations of diet, physical activity and family history, and other appropriate health screenings.

Providers can counsel parents to help children maintain a healthy weight by doing the following:

• Serving five portions of fruits and vegetables a day
• Limiting screen time to two hours a day
• Encouraging at least one hour of physical activity per day
• Offering drinks that have no added sugar

BMI assessment is one method for determining body fat

Evaluating body mass index for adult patients is an inexpensive and easy-to-perform screening method.

Providers looking for other ways to estimate body fat percentage in their adult patients can look into these most common methods:

• **Skinfold measurements.** Percent body fat can be estimated by using calipers to measure skinfold thickness at various sites on the body. The sum of the skinfolds taken at various sites can then be converted to calculate percent body fat (American College of Sports Medicine, 2012). This technique is reasonably quick and can be accurate. If the measurements are not taken correctly or an incorrect formula is applied, invalid values can result.

• **BOD POD body composition assessment measurements.** A more advanced method is the BOD POD. These fiberglass pods are intended to measure body weight and body volume. Because fat is less dense than lean tissue, the “weight-to-volume ratio can be used to predict percent body fat” (ACSM, 2012).

• **Bioelectrical impedance analysis.** Another technique that is frequently used in gyms is bioelectrical impedance analysis, or BIA. The principle behind this technique is that fat contains little water; most of the body’s water is in the lean components of the body. Therefore, when an electrical current goes through fat, there is more resistance. By evaluating how simply a current moves through the body, body fat can be estimated.
Blue Care Network provides continuity of care in certain situations

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

Members can’t see their current physician if he or she was terminated from BCN for quality reasons. The member is required to receive treatment from an in-network provider. BCN notifies members within 15 days after learning of the effective date of the practitioner’s disaffiliation.

BCN permits the member to continue treatment in the situations described below provided that the primary care or specialty physician:

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

### Situation | Length of continuity of care
--- | ---
General care | 90 days after the date of the practitioner notification to the member of the practitioner’s disaffiliation
Pregnancy | Through postpartum care directly related to the pregnancy, if the member is in the second or third trimester of pregnancy at the time of the practitioner’s disaffiliation
Terminal illness | For the remainder of the member’s life for treatment directly related to the terminal illness, if the member was being treated for the terminal illness prior to the practitioner’s disaffiliation

An ongoing course of treatment is one in which a disruption of the current course of treatment could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. Some examples of ongoing course of treatment include:

- Postsurgical care
- An acute episode of a chronic illness
- An acute medical condition
- Behavioral health services for an acute exacerbation of a chronic psychiatric condition

A disaffiliating physician who wants to offer a member continuity of care in accordance with the conditions of payment and BCN policies must notify BCN and the member who seeks continuity of care. Providers may contact BCN’s Care Management department at 1-800-392-2512 to arrange for continuity of care services. Members should contact Customer Service by calling the number on the back of their ID card. The Behavioral Health phone number is 1-800-482-5982.

A nurse will notify the member and practitioners in writing of BCN’s decision. Newly enrolled members must select a primary care physician before requesting continuity of care services and within the first 90 days of their enrollment.
Blue Cross Blue Shield of Michigan and Blue Care Network promote coordination of care

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

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

We collect and analyze data to identify opportunities to improve coordination of care between specialists and primary care physicians. The feedback we’ve received from coordination of care audits reveal an opportunity for improved documented communication from behavioral health providers to primary care physicians.

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

Continuity and coordination of medical care and specialty services are crucial to ensure that members receive the highest quality and safest care possible.

Optum CarePlus home visit program ending May 31

Starting May 31, 2016, Optum™ CarePlus will no longer provide in-home care management visits by a certified nurse practitioner for Blue Care Network and BCN AdvantageSM. Optum™ CarePlus is a nationally recognized program that provides home visits for a small number of members with complex, chronic medical conditions.

Blue Care Network Care Management is contacting members who are in this program to determine future enrollment into our case management programs.
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, BCN provides clarification from McKesson on various topics.

**Question:**
In General Medical, Electrolyte or mineral imbalance, page 559
Hypophosphatemia, Finding, One – Phosphate 1.0 – 1.4 mg/dL and muscle weakness, should we be looking for manual muscle testing or would there be other indicators? Or can we use documentation of muscle weakness in the clinical review? (Note: Muscle weakness is also listed as a finding under hypocalcemia, hypermagnesemia, hypernatremia and hyponatremia.)

**Answer:**
The documentation of muscle weakness doesn’t need to be based on any particular testing method. If muscle weakness is found on physical exam and documented as such in the record or if the patient reported muscle weakness and it’s documented in the record, the criteria point can be applied. This is true of other muscle weakness criteria points as well, as long as the criteria point itself doesn’t require specific testing or results.

**Question:**
Heart Failure, Episode day 1, acute page 231
Finding: Dyspnea at rest and not returned to baseline after two hours of treatment. For a patient to meet the two hours of failed treatment, does the facility have to provide information related to the specific treatment given or can the facility just say the member failed two hours of treatment? If they have to provide the specific treatment, will any treatment suffice such as IV diuretic, oxygen, breathing treatments or sublingual nitroglycerin?

**Answer:**
Document what type of treatments were done. As long as the treatment is given under the direction of the medical practitioner and is above and beyond their normal care regimen, it would be appropriate to apply this criteria point. The treatment itself can be any specific treatment ordered by the physician to help the new episode of dyspnea. That might include, for example, nebulizer, oxygen or oral medications (as long as it is beyond their normal care regimen).
Blue Care Network has adopted additional Local Rules that will be implemented starting May 2, 2016. These additional Local Rules are:

- Infection GI/GU/GYN: Diverticulitis
- Gastrointestinal or biliary: Dehydration or gastroenteritis
- Gastrointestinal or biliary: Jaundice or bilirubin
- Gastrointestinal or biliary: Pancreatitis, chronic
- Genitourinary: Acute kidney injury
- Deep vein thrombosis
- Diabetes
- Syncope
- Infection: General
- Major joint arthroplasty for rehabilitation and skilled nursing facility
- Pain management for skilled nursing facility

Blue Care Network develops Local Rules to address exceptions to the application of McKesson Corporation’s InterQual® criteria that reflect BCN’s accepted practice standards. The Local Rules outlined in the PDF document attached to this article are added to the 2015 InterQual criteria now in use.

The Local Rules apply to all BCN commercial and BCN Advantage™ members statewide whose care is coordinated by BCN’s Care Management department.

Medical policy updates

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

**Noncovered services**
- Genetic testing for pharmacogenetic testing for pain management
- Genetic testing for Noonan Syndrome
- Home monitoring device for age-related macular degeneration
- Genetic testing-fetal RHD genotyping using maternal plasma

**Covered services**
- Tumor treatment fields therapy for glioblastoma
- Balloon ostial dilation for treatment of chronic sinusitis
- Computed tomography perfusion imaging of the brain
- Hyaluronan injections
Referral to BCN not needed for diabetic retinopathy exam

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

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

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

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

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

Procedure codes:
*92002, 92004, 92014, 92226, 92250, S3000, S0620, S0621

There are many more codes for diabetic retinopathy when billing ICD-10 codes. Please use this CMS link to look up the equivalent ICD-10 codes for the following ICD-9 codes that we previously accepted: 249.5x, 250.xx, 648.0x

Another resource for ICD-10 is CDC.gov.

Men’s Health week is June 13 to 19

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

Women are more likely than men to visit the doctor for annual exams and preventive services.

Some tips for your male patients:

- **Eat healthy.** Advise patients to take small steps, such as saying no to supersizing and yes to a healthy breakfast. Eat many different types of foods to get all the vitamins and minerals needed. Add at least one fruit and vegetable to every meal.

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

- **Make prevention a priority.** Many health conditions can be prevented or detected early with regular check-ups. Make sure your patients get regular screenings for blood pressure, cholesterol, glucose and prostate health.
Blue Care Network leads the way in embracing innovative program for treatment of first-break schizophrenia

Blue Care Network contracted providers can now refer members to facilities in Michigan who use innovative treatment protocols to treat first-episode psychosis.

Our relationships with three contracted providers is an outgrowth of a National Institutes of Mental Health initiative called RAISE, or Recovery After an Initial Schizophrenia Episode. (See the box at the end of this article for the provider contacts.)

The National Institutes of Mental Health was awarded $25 million in 2014 to develop an evidence-based program to improve the treatment and outcomes of individuals with first break psychosis. Approximately 100,000 adolescents and young adults experience first episode psychosis in the United States each year.

With peak age of onset occurring between 15 and 25 years old, first-episode psychosis can derail a young individual’s life in areas of school, social, and vocational function. Family relationships also suffer as a result of this disease. Meta analysis of the data suggests strong evidence of early intervention in first-episode psychosis can modify the course of the illness. Several facilities around the country were involved in the initial research and standardization of the protocol. Three of those facilities are in Michigan and listed on the next page. Blue Care Network has contracted with these providers, so these innovative treatment practices are now available for our members.

The program uses routine psychotherapy intervention (cognitive behavioral therapy) on a graduated basis over the first year and then routinely thereafter. The members receive weekly counseling and a series of vocational or school coaching interventions to address how the illness affects their day-to-day lives. The member also gets routine monthly medication review and the primary tool includes long acting injections. They also get school or work coaching to either stay in school or work and increase socialization capability. Members receive the use of a smart phone (loaned) to contact the therapist and use a computer-based application to help them tolerate the hallucinations and delusions between sessions.

The results from this research are very good, especially at preventing the downward social progression of these members. BCN is the first payer in Michigan to embrace this innovative and evidence-based intervention to address the devastating consequences of first episode psychosis. BCN coordinated its efforts with Dr Achtyes, chairman of Department of Psychiatry at MSU-West, who was also recently the president of Michigan Psychiatric Society and a leader in Michigan of NIMH’s effort to mainstream this protocol.

Please see Schizophrenia, continued on Page 29
Schizophrenia, continued from Page 28

This has been an excellent example of innovation and teamwork across departments at BCN, along with researchers and community resources, to facilitate access to tools to improve the well being and health of our members.

To get referrals for your patients who would benefit from these services, have them or your staff contact the behavioral health department at BCN with the 800 number on the back of the member’s BCN insurance card.

Referrals would be appropriate for any member who has had an initial psychotic episode — likely a hospitalization. Due to the timeframe for the diagnosis of schizophrenia (six months) a firm diagnosis of schizophrenia is not imperative.

If a hospital or case manager refers a patient, it’s beneficial for the primary care physician to be informed. The PCP may be asked to assist the team in providing care in an integrated fashion, such as administering monthly injectable medication.

Coordination of care audits show behavioral health providers need to document communication to primary care physicians

Blue Cross Blue Shield of Michigan and Blue Care Network have a process to ensure and promote continuity and coordination of care among medical practitioners.

Our coordination of care audits promote improved documented communication from behavioral health providers to primary care physicians.

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

Continuity and coordination of medical care and specialty services are crucial to ensure that members receive the highest quality and safest care possible.

Our policies align the National Committee for Quality Assurance standards and require evidence of continuity and coordination of care. Provider contracts specify that the specialist’s timely communication to the referring physician is essential to effectively manage the member’s care.
Quality corner: Therapeutic alliance

What is therapeutic alliance?
Therapeutic alliance, sometimes referred to as working alliance or therapeutic bond, is the relationship between the patient and behavioral health provider. According to Edward Bordin, an early researcher of the concept, it should have the following three core components: “agreement on the goals of the treatment, agreement on the tasks, and the development of a personal bond made up of reciprocal positive feelings”1.

Why is it important?
Based on a substantial amount of research, therapeutic alliance is shown to be very helpful for active participation in counseling, as well as better counseling and treatment outcomes. The positive effects of a strong therapeutic alliance are found across many different counseling approaches. Furthermore the severity of the patient’s symptoms does not hinder the development of a strong therapeutic alliance2. Because of its impact and applicability to so many different patients, this alliance is viewed as very important to providers.3

What can behavioral health providers do?
We encourage you to gauge the strength of the therapeutic alliance between you and your patients. The Behavioral Health Incentive Program continues to provide a tool to examine therapeutic alliance, called the BCN Therapeutic Alliance Survey, and we offer incentives when our survey is filled out and submitted to us.

What if I am not participating in BHIP?
You do not have to participate in BHIP to examine and facilitate your alliance with patients. There are numerous questionnaires that measure this bond, which you can use independently. Even something informal such as asking patients if they feel the sessions are making a difference, or if they feel there has been progress, may help facilitate therapeutic alliance.

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

References
1  http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3198542/
Blue Care Network Behavioral Health Incentive Program 2016

We are well into 2016 and excited that so many offices are participating in the incentive program.

To view the 2016 program documents on web-DENIS, please follow these steps:
  • Go to BCN Provider Publications and Resources
  • Click on Behavioral Health under Resources
  • Scroll down to Behavioral Health Incentive Program

Self-reported measures
We are receiving more self-reported submissions than ever before. To accommodate this growth, we have created an electronic method for submissions. Our traditional fax process is still available, but if you submit the information electronically instead, you are eligible for a $10 increase in payment per submission. Instruction documents about the new electronic submission process are available on web-DENIS.

Let us know what you think
We’re continually reviewing our incentive program. We’ve created a survey regarding BHIP that addresses familiarity with the program, understanding of program policies, feedback for program improvement and any barriers to participation. Regardless of whether or not you are participating in BHIP, we would like your feedback. We look forward to your input and partnering with you in designing the 2017 program.
Effective May 1, BCN behavioral health providers must use e-referral to submit initial requests for authorization for nonurgent outpatient services

Starting May 1, 2016, Blue Care Network’s behavioral health providers will be required to submit initial requests for authorization using the e-referral system. This applies only to nonurgent outpatient (clinic or office) services.

What’s changing
Many behavioral health providers are submitting the initial outpatient authorization requests for their BCN patients using the Behavioral Health Initial Outpatient Authorization Request Form, which is available on the Behavioral Health Web page at ereferrals.bcbsm.com.

Starting May 1, that form will no longer be available online and requests for initial outpatient authorizations will be accepted only through the e-referral system. Requests to authorize extensions of outpatient treatment must also be submitted through the e-referral system.

Sign up to use the e-referral system
BCN-contracted providers who have not already signed up for access to the e-referral system should apply immediately. To do that requires signing up for the Blue Cross / BCN Provider Secured Services portal, as follows:

2. Click Sign Up or Change a User.
3. Click to open the appropriate forms for your provider type.
4. Complete the forms. Make sure to check that you want access to the e-referral system.
5. Submit the forms. Follow the instructions on each form.

Learn how to use the e-referral system
Instructions for using the e-referral system are available at ereferrals.bcbsm.com. Click Training Tools. Select the best training option for you.

In the next few weeks, an e-referral user guide geared specifically toward behavioral health providers will be available. Watch for the announcement!

Additional information
You should continue to call in urgent requests to authorize outpatient (clinic or office) services to 1-800-482-5982. Requests to authorize other levels of care should be called into BCN Behavioral Health at the appropriate phone number, as indicated on the Provider Inquiry Contact Information list.

For more information, refer to the Behavioral Health chapter of the BCN Provider Manual.
Best Practices

Lansing practice uses electronic medical record alerts for breast cancer screening

It can be a challenge for busy practices to keep track of annual screenings for their patients. But Barbara Fretwell, M.D. has found that using electronic medical records helps her practice, Capital Internal Medicine Associates, ensure that all eligible patients get breast cancer screening.

“There’s a section in the electronic medical record, called Alerts, where medical assistants can indicate when the last mammogram was done and when the patient is due,” explains Dr. Fretwell. “We keep progress notes at the annual exam, but we also check the alerts at every visit.”

The office has increased emphasis on tracking screenings since it became a certified patient-centered medical home. “There’s definitely an emphasis on making sure we’re doing the screening and documenting when it gets done.”

“The system isn’t foolproof,” admits Dr. Fretwell. “It only works when the assistants take the time to check the alerts in the record. And it’s up to the doctors to order the tests.”

Patient education is also important to making sure women get an annual mammogram.

“I talk to patients about the importance of screening so they buy into it,” says Dr. Fretwell. “I tell them what the American Cancer Society guidelines are. Also, while I’m doing an exam, I tell them to let us know if they feel a lump because it doesn’t always show on a mammogram.”

The office also provides shower hangtags to remind and educate patients about breast self-exams.

Communication with radiologists also helps the office track that patients had their mammograms done. Whether a patient chooses the breast center affiliated with the practice or another imaging center, the results go directly into the electronic medical records. “The technician at our breast center is friendly with patients and will call or email me if they see abnormal results so I can follow-up with the patient,” says Dr. Fretwell.

There are a few challenges to screening. “Some women flat out refuse to go for a mammogram,” says Dr. Fretwell. “I have some patients with breast implants and they don’t want to get a mammogram because they’ve had trouble with their implants. In those cases, I still emphasize what the American Cancer Society guidelines recommend.”

“I’d like to devise a better system for identifying high-risk women,” continues Dr. Fretwell. “I still recommend an annual mammogram for women over 55 with higher risks, even though the guidelines have changed. I recently had a woman in her 70s diagnosed with breast cancer. She has a mother and sister with breast cancer and, thankfully, has been faithfully screening for years.”

Resources for your patients

Providers can help educate patients about breast cancer screening. The Centers for Disease Control & Prevention has information and resources to patients.

[cdc.gov/cancer/breast/index.htm](http://cdc.gov/cancer/breast/index.htm)

Blue Cross Blue Shield of Michigan recognizes 63 Michigan hospitals for high-quality, more affordable maternity care.

Blue Cross Blue Shield of Michigan has announced the first hospitals in the state to receive the Blue Distinction® Center and Blue Distinction® Center+ for Maternity Care designation, a new designation under the Blue Distinction Specialty Care program.

“The Maternity Care designation is a significant achievement, and an indication of quality performance, and safe and effective care for the many thousands of Michigan residents who will add to their families in the future,” said Dr. David Share, senior vice president, Value Partnerships. “We congratulate all the hospitals that have earned the designation for their commitment to providing this high level of care.”

Nearly 115,000 babies are born in Michigan annually. The new designation program for maternity care evaluates hospitals on several quality measures, including the percentage of newborns that fall into the category of early elective delivery, an ongoing concern in the medical community.

Hospitals that receive a Blue Distinction Center for Maternity Care designation must agree to participate in evidence-based practices of care. They also must agree to support programs that promote breastfeeding.

Blue Distinction Centers and Blue Distinction Center+ are health care facilities recognized for their expertise in delivering specialty care.

To see the list of hospitals and learn more, read the news release at bcbsm.com.
Blue Cross Blue Shield of Michigan has designated 17 hospitals across the state as Blue Distinction® Centers+ for Cardiac Care, part of the Blue Distinction Specialty Care program.

“The Blue Distinction Center+ designation lets our members know where they can go in Michigan to receive high-quality, cost-effective care that meets robust clinical standards,” said David Share, M.D., senior vice president, Value Partnerships.

To receive a Blue Distinction Center+ for Cardiac Care designation, a hospital must demonstrate its expertise in delivering safe and effective cardiac care, focusing on cardiac valve surgery, coronary artery bypass graft and percutaneous coronary interventions episodes. A hospital must also have earned national accreditation. In addition to meeting established quality thresholds, these hospitals must also demonstrate better cost efficiency compared to their peers.

Only those facilities that first meet nationally established quality measures for Blue Distinction Centers are considered for designation as a Blue Distinction Center+.

Research shows that facilities designated as Blue Distinction Centers demonstrate better quality and improved outcomes for patients compared with their peers. On average, facilities designated as a Blue Distinction Center+ for Cardiac Care are 20 percent more cost efficient in an episode of care compared to health care facilities that don’t have the Blue Distinction Center+ designation.

Hospitals earning Blue Distinction Center+ for Cardiac Care include:

- Allegiance Health, Jackson
- Borgess Medical Center, Kalamazoo
- Bronson Methodist Hospital, Kalamazoo
- Crittenton Hospital Medical Center, Rochester Hills
- Genesys Regional Medical Center, Grand Blanc
- Henry Ford Macomb Hospital, Clinton Township
- McLaren Bay Regional Medical Center, Bay City
- McLaren Macomb Hospital, Mt. Clemens
- MidMichigan Medical Center, Midland
- Munson Medical Center, Traverse City
- Sparrow Hospital, Lansing
- Spectrum Health Butterworth Hospital, Grand Rapids
- St. John Macomb Oakland Hospital — Macomb Center, Warren
- St. Joseph Mercy Hospital, Ann Arbor
- St. Mary’s of Michigan Medical Center, Saginaw
- University of Michigan Medical Hospital, Ann Arbor
- William Beaumont Hospital, Troy
Healthcare Disparities Report: Poorer households continue to experience worse quality in care

The 2014 National Healthcare Disparities Report concludes that while access to health care has improved, poorer households had less access to care and continue to experience worse quality in care than other households.

Other key findings from the report include the following:

- Several racial and ethnic disparities in rates of childhood immunization rates of adverse events associated with procedures were eliminated
- Rates of uninsured among adults ages 18 to 64 decreased substantially during the first half of 2014. The report attributed this to the Affordable Care Act.
- Between 2002 and 2012, access to health care improved for children but was unchanged or significantly worse for adults.
- Children with only Medicaid or CHIP coverage were less likely to get care as soon as wanted compared with children with any private insurance in almost all years.
- Adults ages 18 to 64 who were uninsured or had only Medicaid coverage were less likely to get care as soon as wanted compared with adults with any private insurance in all years.
- Through 2012, access to care improved across a broad spectrum of measures among children but less so among adults ages 18 to 64.
- In 2012 disparities were observed across a broad spectrum of access measures. People in poor households experienced the largest number of disparities followed by Hispanics and Blacks.
- People in poor households had worse access to care than those in high-income households on all access measures.
- Performance on many measures of quality remains far from optimal, according to report. For example, only half of people with high blood pressure have it controlled. Recommended care is delivered only 70 percent of the time across a broad range of measures.
- Disparities are increasing in the areas of cancer screening and maternal and child health.

The National Healthcare Disparities Reports are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999. The reports provide a comprehensive overview of the quality of health care received by the general U.S. population and disparities in care experienced by different racial, ethnic and socioeconomic groups.

Reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality.

For the full report and Executive Summary, go to the AHRQ website.

Blue Cross and Blue Shield of Michigan and BCN have identified health care disparities among certain ethnic groups, and have a committee to develop actions to address identified health care gaps. We encourage all contracted providers to identify member demographics in Health e-BlueSM.
Quality Improvement program information available upon request

Blue Care Network provides you with ongoing information about our quality improvement programs and clinical practice guidelines through this newsletter. Approved clinical practice guidelines are available to all Blue Care Network primary care physicians, primary care groups and specialists.

Copies of the complete guidelines are available on our secure provider portal. To access the guidelines:

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

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

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

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

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

Some measures that scored as needing improvement included:

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

Please see Quality Improvement, continued on Page 38
Quality Improvement, continued from Page 37

- Postpartum care

In 2015, BCN Advantage received four out of five stars from the Centers for Medicare and Medicaid Services, and the NCQA 90th percentile on the following HEDIS measures that address important health improvement goals:

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

Some measures that scored as needing improvement included:

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

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

To ensure accessibility of care to our members, BCN has access and availability standards for the following types of appointments: preventive care, routine primary care, urgent care and after-hours access. Access monitoring is conducted throughout the year by quality management staff. Physicians who are noncompliant with access standards are given the opportunity to correct their noncompliant status. More information is available in the BCN Provider Manual. Log in to web-DENIS, click on Provider Manual and open the Access to Care chapter.

If you'd like additional information about our programs or guidelines, please contact our Quality Management department via email at BCNQIQuestions@bcbsm.com. You may also call us at 248-455-2714.

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

Clarification: How to meet the HEDIS criteria for medication reconciliation post-discharge

An article in the March-April issue titled, How to meet the HEDIS criteria for medication reconciliation post-discharge neglected to include some important information. Please note that medication reconciliation services may be billed using Transition of Care codes *99495 or *99496.

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Blue Care Network is expanding our medical drug prior authorization program (also called clinical review) for commercial members to encourage proper utilization of high-cost specialty medications administered by a health care provider. Beginning July 1, 2016, BCN will require prior authorization before these drugs will be covered under members’ medical benefits.

<table>
<thead>
<tr>
<th>J code</th>
<th>Brand name</th>
</tr>
</thead>
<tbody>
<tr>
<td>J3262*</td>
<td>Actemra®</td>
</tr>
<tr>
<td>J0129*</td>
<td>Orencia®</td>
</tr>
<tr>
<td>90378</td>
<td>Synagis®</td>
</tr>
<tr>
<td>J2357</td>
<td>Xolair®</td>
</tr>
</tbody>
</table>

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

For Synagis and Xolair requests, this requirement will apply only to BCN commercial members who start the medication on or after July 1, 2016. Members who have a paid claim for one of these medications by June 30, 2016, will not be required to seek initial prior authorization or clinical review.

For Actemra and Orencia, this requirement will apply only to BCN commercial members receiving the medication in an outpatient hospital setting on or after July 1, 2016. All members with a paid claim prior to June 30, 2016 and receiving the medication at a physician’s office or at the member’s home will not require prior authorization or clinical review.

This requirement does not apply to BCN AdvantageSM members.

To request approval for one of these medications, submit a request through BCN’s e-referral system or fax the request to BCN Care Management at 1-800-675-7278. You can also call Care Management at 1-800-392-2512.

For a full 2016 list of all medications and procedure codes subject to the BCN Referral and Clinical Review Program, please visit ereferrals.bcbsm.com and click on **Clinical Review & Criteria Charts**. Medical necessity criteria are posted on the same page and can be viewed by scrolling down to the medical necessity section. The updated criteria charts will be posted to the website by July 1, 2016.

*Criteria requirements include site of care. Please refer to Actemra, Orencia and Simponi Aria added to Site of Care Optimization Program on July 1, below.

### Actemra, Orencia, and Simponi Aria added to Site of Care Optimization Program on July 1

Many injectable or infusible drugs covered under Blue Care Network members’ medical benefit can be safely and effectively administered at sites of care including an outpatient hospital, physician’s office or member’s home. The cost of these drugs varies widely between care settings.

To help manage costs, starting July 1, 2016, BCN will add Actemra®, Orencia® and Simponi Aria® to its site of care optimization program. This program directs patients receiving select infused drugs in the outpatient hospital setting to a lower cost alternate site of care.

Prior authorization review is required for members being treated with one of these medications when administered in an outpatient hospital setting, physician’s office or member’s home. All members receiving these medications in the outpatient hospital setting require additional review for site of care requirements.

As with other drugs in the site of care program, if a member isn’t a candidate to receive the drug at a site other than the outpatient hospital setting, the provider must submit clinical documentation supporting medical necessity to the plan for review.

For a full list of drugs in the program, and how to request authorization go to ereferrals.bcbsm.com and click on the **BCN Referral / Clinical Review Program** document on the Clinical Review and Criteria Charts page.
BCN adds Exjade and Jadenu to the 15-day fill specialty brand drug list

On February 11, 2016, Blue Care Network added both Exjade® and Jadenu® to the 15-day specialty brand drug list. The program includes first fills and refills. This change doesn’t apply to members who were already taking one of these drugs prior to February 11, 2016 or to BCN AdvantageSM members.

Members will pay half of their member cost share for a 15-day supply.

Since the start of this program, approximately 30 percent of BCN members who started one of the medications on this list discontinued using it after the first fill. Members have saved significant amounts on cost-sharing, and the program has also helped to reduce the amount of drugs wasted.

Members can fill prescriptions for specialty drugs at most network retail pharmacies or have their prescriptions delivered by mail.

The 15-day list includes 31 medications and is continuously updated, so please refer to the 15-day Specialty Drug Limitation Program on bcbsm.com for the current list.

The following drugs will be limited to a 15-day supply:

<table>
<thead>
<tr>
<th>Afinitor®</th>
<th>Afinitor Disperz®</th>
<th>Bosulif®</th>
<th>Caprelsa®</th>
<th>Cometrig®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erivedge®</td>
<td>Exjade</td>
<td>GilotrifTM</td>
<td>Gleevec®</td>
<td>IclusigTM</td>
</tr>
<tr>
<td>ImbruvicaTM</td>
<td>Inlyta®</td>
<td>Jadenu</td>
<td>Jakafi®</td>
<td>LenvimaTM</td>
</tr>
<tr>
<td>LynparzaTM</td>
<td>Nexavar®</td>
<td>Odomzo®</td>
<td>Sprycel®</td>
<td>Sutent®</td>
</tr>
<tr>
<td>Tarceva®</td>
<td>Targretin®</td>
<td>Tasigna®</td>
<td>Votrient®</td>
<td>Xalkori®</td>
</tr>
<tr>
<td>Xtandi®</td>
<td>Zelboraf®</td>
<td>Zolinza®</td>
<td>Zydelig®</td>
<td>ZykadiaTM</td>
</tr>
<tr>
<td>Zytiga®</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Blue Cross Blue Shield of Michigan 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.
Are you billing medical drugs with the correct unit of measure?

As of Nov. 1, 2015, Blue Care Network requires a valid National Drug Code and NDC quantity for pricing and reimbursement for medical professional drug claims. The correct unit of measure is also required to ensure the correct quantity is being submitted.

The appropriate NDC billable units for injections can be found by procedure code on the BCN In‑Scope Unit of Measure Crosswalk at ereferrals.bcbsm.com. A claim line will not pay if the unit of measure submitted doesn’t match the unit that is listed on the Unit of Measure Crosswalk schedule for a particular procedure code.

The billing for Prevnar® is a good example. The correct unit of measure is milliliter, according to the crosswalk.

Correct unit: N400005197102ML 5
Incorrect unit: N400005197102UN1

Are you billing the correct quantity?

Check the Blue Cross Injection Fee Schedule to determine the billable units per procedure code used. Remicade®, for example, is billed in 10mg units.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Minimum Fee Amount</th>
<th>Procedure Code Billable Units</th>
<th>NDC Billable Unit</th>
<th>AWP minus / plus x%</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1745</td>
<td>$79.67</td>
<td>10 MG</td>
<td>UN</td>
<td>Minus 35%</td>
</tr>
</tbody>
</table>

For a 400mg dose of Remicade:
• The HCPCS billable unit is equal to 10mg, so the HCPCS quantity submitted should be 40.
• The NDC is billed in units. There are 100mg per unit of Remicade, so the NDC value that should be submitted is UN4.

Correct:

Incorrect:

Commonly mislabeled products

<table>
<thead>
<tr>
<th>Drug</th>
<th>Procedure code</th>
<th>NDC billable units (from crosswalk)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevnar</td>
<td>90670</td>
<td>mL</td>
</tr>
<tr>
<td>Gardisil®</td>
<td>90651/ 90649</td>
<td>mL</td>
</tr>
<tr>
<td>Vaqta®</td>
<td>90633</td>
<td>mL</td>
</tr>
<tr>
<td>Kenalog®</td>
<td>J3301</td>
<td>mL</td>
</tr>
<tr>
<td>Menactra®</td>
<td>90734</td>
<td>mL</td>
</tr>
<tr>
<td>Ketorolac tromethamine</td>
<td>J1885</td>
<td>mL</td>
</tr>
<tr>
<td>Boostrix®/Adacel®</td>
<td>90715</td>
<td>mL</td>
</tr>
<tr>
<td>Flu vaccine injection</td>
<td>varies</td>
<td>mL</td>
</tr>
</tbody>
</table>
Billing medical drugs, continued from Page 41

Other examples of determining the correct HCPCS/CPT and NDC values:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Procedure code</th>
<th>Procedure Code Billable Units*</th>
<th>NDC Billable Unit*</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xolair® 150 mg SOLR</td>
<td>J2357</td>
<td>5mg</td>
<td>UN</td>
<td>300mg of Xolair is 60 billable units. Xolair is 150mg per unit, and the NDC value would be UN2.</td>
</tr>
<tr>
<td>Rituxan® 100 mg/10mL SOLN</td>
<td>J9310</td>
<td>100mg</td>
<td>mL</td>
<td>1000mg of Rituxan is 10 billable units. Rituxan is 100mg/10mL and the NDC billable unit is mL, so the NDC value is 100mL.</td>
</tr>
<tr>
<td>Neulasta® 6 mg/0.6mL SOSY</td>
<td>J2505</td>
<td>6mg</td>
<td>mL</td>
<td>6mg of Neulasta is 1 billable unit. The NDC billable unit is in mL, and there are 0.6mL per unit, the NDC value is 0.6mL.</td>
</tr>
</tbody>
</table>

*Billable units are listed on the Blue Cross injection fee schedule on web-DENIS

In the January-February 2016 issue (Page 35), we told you that a medical drug will be denied if the unit of measure or the NDC quantity is not valid for the NDC and HCPCS/CPT code combination.

- These medical drug claim scenarios will result in the claim being denied BTD. For payment review, the claim has to show the correct NDC unit of measure and quantity for the item used with this code.
- The 835 remittance advice message will have a claim adjustment reason code of 16: Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
- The RARC will be M123: Missing/incomplete/invalid name, strength, or dosage of the drug furnished.

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 drug</th>
<th>Average cost per prescription</th>
<th>Lower-cost generic alternatives</th>
<th>Average cost per prescription for alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naftin® cream</td>
<td>$400</td>
<td>Lotrimin®, Nizoral® cream, Mycostatin® cream</td>
<td>$28</td>
</tr>
<tr>
<td>Nexium®</td>
<td>$412</td>
<td>Prilosec®, Prevacid®, Protonix®, AcipHex®</td>
<td>$35</td>
</tr>
<tr>
<td>Zegerid®</td>
<td>$1,227</td>
<td>Prilosec®, Prevacid®, Protonix®, AcipHex®</td>
<td>$35</td>
</tr>
</tbody>
</table>
BCN launches prior authorization for testosterone products covered under medical benefit

Over the past several years, the market for testosterone products has grown by 90 percent and is projected to reach $5 billion annually by 2017. With no new medical indication for testosterone therapy, this dramatic increase may be linked to overuse and misuse, driven in part by patient demand.

To ensure that our members receive appropriate, safe and cost-effective drug therapies, starting July 1, 2016, prior authorization will be required on most testosterone products covered under the medical benefit for commercial members. The new criteria are in response to the new practice guidelines and potential safety concerns. BCN has required approval for testosterone covered under members’ pharmacy benefit since 2014.

BCN will authorize continued use for 12 months for male members who currently use one of the products covered under the medical benefit. This authorization will allow physicians to evaluate members who currently use the therapy to determine whether the member meets BCN criteria for approval.

Testosterone has not been tested for safety or effectiveness by the U.S. Food and Drug Administration for use by females. BCN does not cover testosterone for our female members.

Testosterone replacement therapy can improve symptoms and quality of life; however, long-term safety remains unknown. Clinical studies have highlighted the potential harm of testosterone overuse in older males. The Testosterone in Older Men with Mobility Limitations trial evaluated males with a high prevalence of comorbidities. The trial was ended early due to increased cardiovascular events in the treatment group.

BCN’s prior authorization criteria align with the Endocrine Society Clinical Practice Guidelines to help promote cost-effective and high-quality drug therapy. Practice guidelines support the use of testosterone replacement only in men who have consistent signs and symptoms of deficiency and unequivocally low serum testosterone levels.

When considering prescribing testosterone products for BCN members, please keep these criteria in mind:

- Males with a diagnosis of androgen deficiency syndrome
  - Two morning testosterone levels below the normal range (free testosterone levels may be required)
  - At least two clinical signs/symptoms specific to androgen deficiency
    - Incomplete or delayed sexual development, eunuchoidism
    - Breast discomfort, gynecomastia
    - Loss of body (axillary and pubic) hair, reduced shaving
    - Height loss, low trauma fracture, low bone mineral density
    - Hot flushes, sweats

- Dose titrations based on clinical response and testosterone levels
- Clinical assessment and monitoring per Endocrine Society Clinical Practice Guidelines
- Requires treatment failure of or intolerance to a preferred agent
- Annual authorization to confirm appropriate use and therapeutic response

These testosterone products will require prior authorization:

<table>
<thead>
<tr>
<th>J code</th>
<th>Generic name</th>
<th>Brand name</th>
<th>Quantity limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1071</td>
<td>testosterone cypionate</td>
<td>Depo®-Testosterone</td>
<td>50mg every 2 weeks</td>
</tr>
<tr>
<td>J3121</td>
<td>testosterone enanthate</td>
<td>Delatestryl®</td>
<td>50mg every 2 weeks</td>
</tr>
<tr>
<td>J3145</td>
<td>testosterone undecanoate</td>
<td>Aveed®</td>
<td>750mg (3mL) every 10 weeks</td>
</tr>
<tr>
<td>S0189</td>
<td>testosterone pellet</td>
<td>Testopel®</td>
<td>450mg (6 pellets) every 3 months</td>
</tr>
</tbody>
</table>
Billing Q&A

**Question:**
I have a question regarding chiropractic X-rays. The example we have is CPT code *72070. We received a rejection stating that the procedure code is inconsistent with modifier used or a required modifier is missing. It was billed without a modifier. Does BCN now require a modifier for X-rays?

**Answer:**
Typically modifiers are only required if the provider is reporting the technical or professional component of the X-ray procedure. Modifiers can be used in certain instances to indicate the anatomic site for a procedure, such as an X-ray being performed on the right wrist.

When several codes are reported on a claim and there is a more comprehensive code that represents those services, an edit may occur which indicates the “procedure code, modifier or place of service is inappropriate for the reported service.” This can occur when cervical, thoracic and lumbar spinal X-rays are reported. The expectation is that the comprehensive code indicating the complete exam of the entire spine would be reported, not the individual codes.

**Question:**
I have received a denial for a mental health claim saying a required modifier is missing. I can’t find a list of the modifiers that apply to mental health. The CPT code was just a *90834. Could you please tell me where else I could look for the modifiers?

**Answer:**
The modifiers can be found on the behavioral health fee schedule on web-DENIS. Go to BCN Provider Publications and Resources and click on Behavioral Health under Resources on the left side of the page. The Behavioral Health Fee Schedule is the second bulleted item under Other Resources.

As a reference the behavioral health modifiers are as follows:
- AH Licensed psychologist (Ph.D., /Ed.D. or Psy.D.)
- AJ Social worker
- AM Adult psychiatrist (M.D. or D.O.)
- HA Child/adolescent psychiatrist (M.D. or D.O.)
- HE Physician assistant
- HO Other master’s or board-certified behavior analyst
- TD Nurse practitioner

**Question:**
I work in a chiropractor’s office and understand massage therapy is covered, but am struggling with how to bill it. Can you provide guidance?

**Answer:**
First, it is important to understand that massage therapy is not a standalone or independent benefit for Blue Care Network members. Massage therapy can only be provided as part of a comprehensive physical medicine program. Reporting massage therapy with an E&M visit code or a manipulation service will result in a denial of the massage therapy.

As with any therapy service, it requires clinical review and approval by our therapy vendor prior to the service being performed for the claim to pay. The massage therapy must also be provided by the chiropractic provider. BCN doesn’t reimburse for these services when performed by noncontracted providers, such as massage therapists.

When reporting any physical medicine service, please make sure the claim contains the appropriate procedure codes and modifier GP. BCN retains the right to audit medical records to support services reported in the claims.

Please see Billing Q&A, continued on Page 45
Billing Q&A, continued from Page 44

**Question:**
Is there a list of approved diagnoses that BCN follows that indicates when you will cover bone density testing?

**Answer:**
For bone density testing, BCN follows the guidelines that are set forth by Medicare. We have added a few additional diagnosis codes that were not included in either the Wisconsin Physician Services or National Government Services listings. Our listing now is updated according to the Wisconsin Physician Services listing, so if you reference that local coverage decision, it will provide you with the most current information. The local coverage decision number is L34639.

**Question:**
Blue Cross Blue Shield of Michigan has been credentialing and recognizing licensed professional counselors for direct reimbursement for behavioral health services as of Jan. 1, 2016. Will BCN also recognize licensed professional counselors in this way, or will they continue to be billed under direct supervision of a licensed PhD psychologist? Will limited licensed psychologists continue to be a supervised entity as well?

**Answer:**
BCN allowed licensed professional counselors to apply to contract as individual providers up until Jan. 31, 2016. Licensed professional counselors who did so would now be able to get a pre-authorization from behavioral health and bill for direct reimbursement. However, if a licensed professional counselor works in an outpatient psychiatric clinic, he or she could also see BCN members since behavioral health authorizations are loaded to the outpatient clinic rather than the individual provider. As of Feb. 1, 2016, further applications for the BCN panel are currently closed because contracting for BCN is based on network need.

Limited licensed psychologists will continue to be supervised and bill under a PhD using the correct modifier, which is HO.

For additional resource information, refer to the behavioral health section of the **BCN Provider Manual** located in **BCN Provider Publications and Resources** on web-DENIS.

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.
Atrial fibrillation, which is defined as a rapid, irregular heart rhythm, affects about 2.3 million adults in the U.S. It’s one of the most common arrhythmias, or abnormal heart rhythms.

Atrial fibrillation is listed as one of the most common chronic conditions among Medicare beneficiaries. It’s generally managed with long-term medication. But the condition has the potential to severely worsen if it’s not treated properly, particularly if the patient is experiencing other acute conditions. It’s one of the Centers for Medicare & Medicaid Services’ hierarchical condition categories in ICD-9 or ICD-10 CM classification systems for both Medicare Advantage and commercial products.

Unlike ICD-9-CM, which only identifies one type of atrial fibrillation, ICD-10-CM identifies the following types:

- Chronic atrial fibrillation
- Permanent atrial fibrillation
- Paroxysmal atrial fibrillation
- Persistent atrial fibrillation
- Unspecified atrial fibrillation

Atrial fibrillation is considered a chronic condition by CMS, and with the specificity now captured within the ICD-10-CM code set, medical record documentation plays a key role for disease validation. When a patient with atrial fibrillation presents symptoms for a different reason, the atrial fibrillation must be addressed in some form within the visit note such as documentation of:

- Any disease- or type-specific symptom
- Specific treatment or management
- Any complication due to the disease process

Another form of validation could be documentation that indicates the effect of atrial fibrillation on other systemic diseases during the visit.

For example, when atrial fibrillation is listed only in the past medical history of a progress note when the reason for the visit is a cough, documentation must include some form of support for atrial fibrillation. The documentation may include physical exam findings, disease-specific medication or any specific complication of atrial fibrillation for validation.

Disease-specific documentation is the key to validating chronic conditions such as atrial fibrillation. Symptoms of the condition may include:

- Rapid and irregular heartbeat
- Fluttering or “thumping” in the chest
- Dizziness
- Chest pain or pressure
- Shortness of breath

Complications may include:

- Stroke
- Heart failure

A patient on a treatment or management program for atrial fibrillation must have documentation included in the progress note. The document may include:

- Medications
- Any nonsurgical procedures
- Any surgical procedures

Please see Coding Corner, continued on Page 47
Coding Corner, continued from Page 46

Documenting congenital heart disease

Heart disease, also referred to as cardiovascular disease, includes conditions that cause any functional, structural or electrical abnormality of the heart.

Heart disease includes structural abnormalities, such as congenital heart defects, that are present at birth. This disease includes:

- **Coarctation of aorta**
- **Congenital subaortic stenosis**
- **Patent ductus arteriosus, or PDA:**
  - Small PDA in infants and children is generally asymptomatic.
  - Infants with a large PDA may display signs of heart failure, such as failure to thrive, poor feeding, tachypnea, dyspnea with feeding or tachycardia.
- **Tetralogy of Fallot:** This condition may be seen in infants, young children and even in adults unrepaired. Patients with this type of heart defect are usually cyanotic, which means their skin has blue or purple coloration.
- **Ostium secundum type atrial septal defect:** Children with atrial septal defect may be asymptomatic but may present with long-term complications after age 20. The symptoms may include:
  - Pulmonary hypertension
  - Heart failure
  - Atrial arrhythmias
  Symptoms in an adult may include:
  - Exercise intolerance
  - Dyspnea
  - Fatigue
  - Atrial arrhythmias

Again, documentation plays a crucial role in validating these conditions if such anomalies are present or have been partially or completely repaired.

For any of the above defects, clinical presentation of the condition — including diagnostic evaluation, disease specific symptoms, disease-specific complications or ongoing care management — is key for a coder to look for evidence of active disease in the documentation.

Physician documentation affects a coder’s accuracy in assigning and validating a code for any condition, especially chronic ones, due to the nature of the condition.

*None of the information included in this article is intended to be legal advice and, as such, it remains the provider’s responsibility to ensure that all coding and documentation are done in accordance with applicable state and federal laws and regulations.*
Referral to BCN not needed for diabetic retinopathy exam

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

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

Procedure codes:

*92002, 92004, 92014, 92226, 92250, S3000, S0620, S0621

There are many more codes applicable for diabetic retinopathy when billing for ICD-10 codes. Please use this CMS link to look up the equivalent ICD-10 codes for the following ICD-9 codes that we previously accepted: 249.5x, 250.xx, 648.0x.

Another resource for ICD-10 is CDC.gov.

The complete article can be found on Page 27.

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

Clinical editing billing tips

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

This issue’s billing tips include the following:

- Transitional care management
- Radiology oncology management update
- When to report a new patient visit

Reporting diagnosis code Z961 and billing for lenses after cataract surgery

The ICD-10 diagnosis code Z961 is used to report a lens replaced by other means. According to the ICD-10 manual, this code should not be reported as a principal diagnosis. BCN’s requirements are different from the ICD-10 manual. Please report it with a principal diagnosis appropriate for the patient’s condition.

Because diagnosis code Z961 is required to identify members receiving lenses or glasses following cataract surgery and to provide coverage when the member has the benefit, Blue Care Network will continue to accept this diagnosis as a secondary diagnosis.

Coding in this manner will provide the required principal and secondary diagnoses, but also allow proper benefit administration post-cataract surgery, when applicable.
Effective May 1, BCN behavioral health providers must use e-referral to submit initial requests for authorization

Starting May 1, 2016, Blue Care Network’s behavioral health providers will be required to submit initial requests for authorization using the e-referral system.

What’s changing
Many behavioral health providers are submitting the initial authorization requests for their BCN patients using the Behavioral Health Initial Outpatient Authorization Request Form, which is available on the Behavioral Health Web page at ereferrals.bcbsm.com.

Starting May 1, that form will no longer be available online and requests for initial authorization requests will be accepted only through the e-referral system.

Please see full article on Page 32.
Clinical review required for excisional breast biopsy

Clinical review is required for excisional breast biopsy for members with Blue Care Network commercial (including self-funded groups) and BCN AdvantageSM products.

BCN provides coverage for excisional biopsy in certain situations in which there is a need for an open surgical procedure as opposed to a minimally invasive diagnostic procedure of needle core biopsy for suspected breast abnormalities.

As an alternative, BCN covers the minimally invasive diagnostic procedure of needle core biopsy for suspected breast abnormalities. Needle core biopsy doesn’t require clinical review.

Needle core biopsy is preferred over excisional biopsy for the diagnosis of breast cancer because it:

- Equals surgical biopsy in accuracy
- Eliminates the need for members with image-detected breast abnormalities to undergo an open surgical procedure
- Improves the cosmetic outcome for the member
- Increases opportunities for multidisciplinary treatment planning
- Lowers morbidity
- Costs less, overall, for diagnosis

Providers should submit requests for clinical review for these procedures to BCN electronically. Users are prompted to complete an appropriateness questionnaire for clinical review consideration. If the criteria are met, the request automatically approves. If the criteria aren’t met, the request requires further clinical review. For urgent requests, health care providers may contact BCN’s Care Management department at 1-800-392-2512 to request clinical review.

The questionnaire was updated and made available in January 2016 on the BCN e-referral Web pages at ereferrals.bcbsm.com. Visit the Clinical Review and Criteria Charts page and look under the “Medical necessity criteria / benefit review requirements” heading. Minor style and grammatical changes were made to the questionnaire but no content changes were made to the criteria.
Changes start May 1 when submitting authorization requests for inpatient acute medical and surgical admissions

The following changes will go into effect related to submitting authorization requests to Blue Care Network for inpatient acute medical and surgical admissions:

- From May 1 through June 30, 2016, you are strongly encouraged to submit these authorization requests via the e-referral system. Faxes will be accepted during certain times, however. (See below.)
- Beginning July 1, 2016, these authorization requests will be accepted only when they are submitted through the e-referral system. Requests submitted by fax will no longer be accepted.

This applies to all BCN lines of business, including for BCN HMOSM (commercial) members and BCN AdvantageSM (BCN Medicare Advantage) members.

In addition, the fax numbers to use in submitting requests are changing.

Here are the details you need to know.

Faxing time frames
From May 1 through June 30, 2016, faxed requests will be accepted starting at midnight each Monday through noon on the following Friday. Faxes will not be accepted during the following times:
- From noon on Friday through midnight on the following Sunday
- Anytime on the day prior to a holiday on which BCN offices are closed. (The holidays observed at BCN are listed in the BCN Provider News issue published prior to the holiday occurring.)

Requests submitted by fax during these time frames will not be processed.

Fax numbers
The fax numbers to submit requests are changing, as shown here. Use these new fax numbers from May 1 through June 30 to submit requests and to provide concurrent reviews and discharge dates:
- For BCN HMO (commercial) members: 1-866-313-8433
- For BCN Advantage members: 1-866-526-1326

The current fax numbers will be eliminated starting on May 1. These fax numbers are 1-866-652-8985 and 1-866-578-5482. Please delete references to these fax numbers in the materials you use.

Submit via e-referral
Requests to authorize inpatient acute medical / surgical admissions can be submitted via the e-referral system right now but beginning July 1, 2016, they must be submitted via e-referral. Requests submitted by fax on or after July 1 will not be accepted.

To access the e-referral system, do the following:
1. Visit ereferrals.bcbsm.com and click Login.
2. Insert your Provider Secured Services user name and password.
3. Click Login.
4. Click BCN e-referral on the page that opens.

Sign up for e-referral. If you haven’t yet signed up for access to the e-referral system, visit ereferrals.bcbsm.com and click Sign Up or Change a User. On the “Sign up for e-referral or change a user” page that opens, follow the instructions to complete the appropriate Provider Secured Services application form.

We encourage you to sign up immediately, since you’ll need access to the e-referral system on July 1.

Additional Information
Refer to the Q&A document for answers to some questions you may have. In addition, an updated user guide for the e-referral system will be available in the next few weeks.
Updated nutrition assessment and follow-up form now available for home infusion providers

An updated Enteral and TPN Nutrition Assessment / Follow-up Form is now available. This form is intended for use only by home infusion providers.

Where to get the form
To find the form, visit ereferrals.bcbsm.com and click to open the Forms page. At the bottom of the page, under the “Transitional care services” heading, click to open the form.

The form is also available on BCN’s web-DENIS Forms page. Log in to Provider Secured Services, click web-DENIS and click BCN Provider Publications and Resources. Finally, click Forms.

What’s changed
The updated Enteral and TPN Nutrition Assessment / Follow-up Form:

- Contains fields into which you can type the information about your agency and the patient. Open the form and save it to your hard drive. Then type the data into the fields.
- Includes information for patients getting total parenteral nutrition feedings as well as enteral feedings
- Shows two different fax numbers — one for BCN HMO℠ (commercial) members and one for BCN Advantage℠ members. Faxing the form back using the appropriate fax number will help facilitate your request.

What’s important to know
Be aware that:

- The home infusion agency’s name, contact person and contact number must be entered into the form. Without that information, BCN cannot complete the authorization process and get the authorization decision back to the home infusion provider in timely fashion.
- You must provide the start-of-care date. That date may be different from the assessment date and the date the form is submitted.
- Enteral and TPN feeding services must be provided by an infusion provider contracted with Blue Care Network. You can search for an infusion provider by visiting bcbsm.com/find-a-doctor.
- BCN, not Northwood, Inc., receives and processes requests to authorize home infusion services. The fax numbers you’ll use to return the completed form go to BCN, not to Northwood.

What about after-hours calls?
If you need discharge planning assistance after hours or on weekends or holidays, contact BCN’s after-hours nurse at 1-800-851-3904.
Changes in clinical review requirements coming in 2016

Several changes in clinical review requirements will occur in 2016. These changes will be reflected in the revised BCN Referral / Clinical Review Program document that will be available online at the end of June. We’ll give you an overview of the changes here.

**0159T and 0190T**
Services associated with procedure codes *0159T and *0190T require clinical review by Blue Care Network even when they are used as add-on codes. These changes apply to both BCN HMO$^\text{SM}$ (commercial) and BCN Advantage$^\text{SM}$ members.

We had communicated earlier that these codes were among several that no longer required clinical review through eviCore healthcare when used as an add-on codes, as long as a valid authorization is on file for the primary code. However, because the *0159T and *0190T codes represent services that are experimental and investigational, they do require clinical review by BCN on their own merits even when they are used as an add-on code and a valid authorization is on file for the primary code. This is effective immediately.

Claims will deny when they show one of these codes used as an add-on code and a valid authorization is not on file for both the primary code and the add-on code.

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**Certain surgeries**
Effective for dates of service on or after Oct. 1, 2016, clinical review is required for the following surgeries:
- Cervical spine surgeries
- Laparoscopic cholecystectomies
- Total joint replacements (hip, knee and shoulder)

These changes apply to BCN HMO (commercial) and BCN Advantage members and to services related to the following procedure codes:

**Medical specialty drugs**
For information on the changes related to the medical specialty drugs, see the articles in the “Pharmacy News” section of this newsletter.

*CPT codes, descriptions and two-digit modifiers only are copyright 2015 American Medical Association. All rights reserved.*
Coordination of care audits show behavioral health providers need e-referral to submit initial requests for authorization for nonurgent treatment of first-break schizophrenia. Effective May 1, BCN behavioral health providers must use e-referral to submit initial requests for authorization for nonurgent outpatient services.

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Billing Q&A
Have a billing question?
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Atrial fibrillation and congenital heart disease
Referral to BCN not needed for diabetic retinopathy exam
Reporting diagnosis code Z961 and billing for lenses after cataract surgery
Clinical editing billing tips

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Blue Care Network is closed May 30
New winners for BCN’s tobacco cessation office staff contest
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Blue Cross Blue Shield of Michigan and Blue Care Network maintain a policy for content of medical records
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Quality Counts
Best Practices: Lansing practice uses electronic medical record alerts for breast cancer screening
Resources for your patients
Blue Cross Blue Shield of Michigan recognizes 63 Michigan hospitals for high-quality, more affordable maternity care
17 Michigan hospitals earn Blue Distinction® honors for cardiac care
Healthcare Disparities Report: Poorer households continue to experience worse quality in care
Quality Improvement program information available upon request
Clarification: How to meet the HEDIS criteria for medication reconciliation post-discharge

Pharmacy News
BCN expanding specialty medical drug approval program on July 1, 2016
Actemra, Orencia, and Simpion Aria added to Site of Care Optimization Program on July 1
BCN adds Exjade and Jadenu to the 15-day fill specialty brand drug list
Blue Cross Blue Shield of Michigan and BCN drug lists updated, available online
Are you billing medical drugs with the correct unit of measure?
Price watch feature helps manage drug costs
BCN launches prior authorization for testosterone products covered under medical benefit

Referral Roundup
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