

CONSULTANT MODEL

LONG-TERM BENEFITS



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

Blue Cross and BCN consultant model will bring long-term benefits to providers

In the last issue, we told you that the Blue Cross Blue Shield of Michigan and Blue Care Network professional provider consultant servicing model is changing. Here's what's changing and why we believe these changes will bring long-term benefits to our providers.

What's changing

- We are encouraging professional providers to always use the standard methods first when contacting us for information or assistance. These are outlined in our resource guides for **Blue Cross** and **BCN**.
- We are improving our processes to better answer your questions and direct you to helpful tips and online information the first time you contact us.
- We'll soon be assigning professional consultants to serve specific Blue Cross Physician Group Incentive Program physician organizations, known as POs, and Blue Care Network medical care groups, or MCGs, to provide education and training on Blue Cross and BCN policies and programs.

Please see [Consultant model](#), continued on Page 2

Blue Care Network won't accept late claims, effective July 1

Blue Care Network has filing limits for submitting claims. In the past, we've allowed providers to submit claims after our filing limits. Effective July 1, we'll no longer accept claims that we receive after the filing limit.

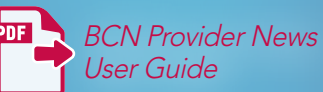
We strongly encourage you to submit your claims within the limits to avoid rejection. We've outlined the information you need to know about filing limits here, for your reference.

BCN claims filing limit policy

The filing limit for claims is 12 months from the date of service or discharge date, for both initial submissions and replacement (corrected or adjusted) claims, unless the claim qualifies as an eligible exception as identified by the Centers for Medicare & Medicaid Services. This applies to both BCN HMOSM (commercial) and BCN AdvantageSM.

Previously, the filing limit for replacement claims for BCN HMO was six months from the date of the initial rejection.

We're making changes to the provider manual to reflect this policy.



Inside this issue...

03 BCN covers digital breast tomosynthesis

14 Communicating screening and treatment options for prostate cancer

26 Follow-up for ADHD focuses on medication effectiveness and compliance

33 MAPS improvements help providers make decisions about substance use disorders

Feedback | [Subscribe](#)

Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Consultant model, continued from Page 1

Why this will help you

- By directing issues through standard methods such as Provider Inquiry, we can better identify problems, prioritize efforts and fix problems impacting many providers simultaneously versus one practice at a time.
- By investing in our standard processes, we expect you will see incremental improvements resulting in higher satisfaction over time when you reach out to us for information or assistance.
- By partnering more closely with POs and MCGs, group administrators can help us focus our educational efforts where they can be the most useful to you.

What you need to know

Here are some important points we want you to keep in mind:

- **Contact Provider Inquiry for claims issues** – All professional claims inquiries must be directed to Provider Inquiry (1-800-344-8525 for medical providers; 1-800-482-4047 for vision and hearing providers), even complex claims issues. If your issue is not satisfactorily resolved, ask the representative to escalate your inquiry to their leadership.
- **Consider joining a physician organization or a medical care group** – if you're not already part of one. With the evolution of value-based reimbursement programs, physicians aligned with an effective organization can receive support they need to best transition to a

population management-based health care delivery system. Take a look at the groups that are available and see which one is a good fit for your practice.

- Learn how to join a **Blue Cross Physician Group Incentive Program** physician organization Scroll down to find a list of physician organizations.
- Learn how to join a **BCN medical care group**.
- **Hospital and facility consultants haven't changed**
Most provider consultant assignments for hospitals and facilities have not changed and the assistance they provide remains the same. If you're with a hospital or facility, here's how you can check your assigned provider consultant.
 - Go to **bcbsm.com/providers**
 - Click on **Contact Us** in the right corner of the page
 - Under *Hospitals and facilities* click on either *Blue Cross Blue Shield of Michigan provider contacts* or *Blue Care Network provider contacts*
 - Click on *Provider consultants*

We know it will take some time to transition to this new service model and perfect it. We ask for your patience over the next few months as we embrace these changes. We value your input. If you have specific comments or suggestions about these changes, please contact us at provideroutreach@bcbsm.com.

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Network Operations



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

Provider forums coming to a town near you

Blue Cross Blue Shield of Michigan and Blue Care Network provider forums begin in May. The morning sessions will include understanding and improving the patient experience, 2018 CPT updates and HEDIS measures. Afternoon sessions will include the new provider service model, eviCore prior authorizations, e-referral, the opioid epidemic, behavioral health, provider enrollment and provider inquiry.

See the flyer for upcoming dates and [registration](#).



Blue Care Network now covers digital breast tomosynthesis

Blue Care Network now covers digital breast tomosynthesis, or 3-D mammography, as a screening or diagnostic modality to assess and manage breast cancer for individuals meeting certain criteria, effective March 1.

Digital breast tomosynthesis may be considered when used in combination with digital screening mammography in high risk individuals, or a qualified healthcare provider (ordering provider or radiologist) determines that it should be the primary mammographic study.

See Medical policy updates, [Page 22](#).



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45

Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



Blue Cross designates centers of distinction for expectant parents

Blue Cross is giving expectant parents in Michigan a tool to find a hospital with high- quality and cost-effective maternity care.

Expectant parents can now choose from 47 hospitals across Michigan that are designated as a Blue Distinction® Center or Blue Distinction® Center+ for Maternity Care.

Maternal health is one of the specialty care areas designated under the Blue Distinction Specialty Care program. Since 2006, the Blue distinction Specialty Care Program has helped patients find high-quality providers in the areas of bariatric surgery, cardiac care, cancer care, knee and hip replacements, spine surgery and transplants. Research shows that designated facilities have better quality and improved outcomes for patients and are 20 percent more cost efficient than facilities without the designation.

“Blue Distinction Center for Maternity Care designation is an indication of quality performance and safe and effective

care for the many thousands of Michigan residents who add to their families,” said Dr. Amy McKenzie, medical director, Value Partnerships at Blue Cross.

“About 113,000 babies are born in Michigan every year, and when parents choose a Blue Distinction hospital, they can be confident they are giving their baby the best start in life.”

Hospitals nationwide throughout the Blue Cross Blue Shield network can earn the designation from their local Blue Cross plan. They must meet quality measures for vaginal and cesarean delivery, based on objective measures developed with input from the medical community. The facilities also must demonstrate family-centered care, such as allowing mothers and infants to remain together 24 hours a day. They may also be designated as a Baby-Friendly Hospital by Baby-Friendly USA.

Blue Distinction Center+ facilities also must demonstrate superior cost-efficiency compared with their peers.

These Michigan hospitals have earned Blue Distinction Center+ for Maternity Care designation

Beaumont Hospital – Dearborn	Hurley Medical Center	Spectrum Health Butterworth Campus
Beaumont Hospital – Farmington Hills	Huron Valley Sinai Hospital	Spectrum Health Gerber Memorial
Beaumont Hospital – Grosse Pointe	McLaren Bay Regional Medical Center	Spectrum Health Ludington Hospital
Beaumont Hospital – Royal Oak	McLaren Flint	Spectrum Health Pennock
Beaumont Hospital – Troy	McLaren Greater Lansing	Spectrum Health United Hospital
Beaumont Hospital – Wayne	McLaren Northern Michigan	Spectrum Health Zeeland Community Hospital
Bronson Battle Creek	Mercy Health Saint Mary’s	Spectrum Health Big Rapids Hospital
Bronson Methodist Hospital	Metro Health Hospital	St. John Hospital & Medical Center
Covenant Medical Center	MidMichigan Medical Center – Alpena	St. Joseph Mercy Hospital Ann Arbor
Garden City Hospital	Munson Healthcare Grayling Hospital	St. Joseph Mercy Oakland
Henry Ford Allegiance Health	Munson Medical Center	St. Mary Mercy Hospital – Livonia campus
Henry Ford Hospital	Promedica Bixby Hospital	University of Michigan Hospital – Main Campus
Henry Ford Macomb Hospital	Promedica Monroe Regional Hospital	
Henry Ford West Bloomfield	Sinai-Grace Hospital	
Henry Ford Wyandotte Hospital	Sparrow Carson City Hospital	

These Michigan hospitals have earned the Blue Distinction Center for Maternity Care

Harper University Hospital & Hutzel Women’s Hospital	Lakeland Community Hospital Niles	Mercy Health Muskegon
	Lakeland Hospital at Niles & St. Joseph	

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



Blue Cross designates top bariatric treatment centers

Blue Cross recently announced its list of bariatric treatment centers that have earned Blue Distinction® Center or Blue Distinction® Center+ for Bariatric Care designation. Bariatric surgery is a treatment for morbid obesity.

Research shows that designated facilities have better quality and improved outcomes for patients, and are 20 percent more cost-efficient than facilities without the designation. Specialty Care includes two levels of designation, both quality-only, Blue Distinction Center and quality and cost, Blue Distinction Center+ designations.

A member can tell if a center is designated by checking the Blue Cross Blue Shield [website](#).

“The Blue Distinction Center designation is an indication of quality performance, safe and effective care for Michigan residents who receive bariatric surgery each year,” said Dr. Amy McKenzie, medical director, Value Partnerships. “We congratulate all the designated hospitals for their commitment to providing this high level of care.”

To earn a Blue Distinction Center for Bariatric Surgery designation, Michigan health care facilities must participate in the longstanding Michigan Bariatric Surgery Collaborative

Quality Initiative, and meet patient safety measures as well as bariatric-specific quality measures. Those include complication and readmission rate for laparoscopic procedures in sleeve gastrectomy, gastric bypass and adjustable gastric band. A health care facility must also be nationally accredited at both the facility and program-specific levels.

“Michigan’s approach of leveraging our internationally recognized bariatric Collaborative Quality Initiative coupled with the Blue Cross Blue Shield Association’s Blue Distinction Specialty Care designation program builds on the strengths of two extremely robust programs,” said Tom Leyden, director, Value Partnerships. “Michigan has an incredibly strong bariatric surgery community that continues to push to deliver the highest quality care for our customers and members. The Michigan Bariatric Surgery Collaborative has had notable impact above and beyond reducing complications for our Michigan membership. This Michigan program has had an impact nationally on the delivery of high-quality bariatric care through the sharing of our state’s best practices to a national audience.”

The following Michigan hospitals have earned designation as Blue Distinction Center+ for bariatric surgery:

Beaumont Hospital – Dearborn
Beaumont Hospital – Royal Oak
Beaumont Hospital – Troy
Borgess Medical Center
Covenant Medical Center
Henry Ford Hospital

Marquette General Hospital
UP Health Systems
McLaren Flint
McLaren Macomb Hospital
Mercy Health Saint Mary’s
MidMichigan Medical Center – Gratiot

Munson Medical Center
Spectrum Health Blodgett Hospital
St Mary Mercy Hospital Livonia Campus
University of Michigan Hospital
Main Campus

The following Michigan hospitals have earned designation as a Blue Distinction Center for bariatric surgery:

Beaumont Hospital – Grosse Pointe
Harper University Hospital & Hutzell
Women’s Hospital
Henry Ford Wyandotte Hospital

Hurley Medical Center
Lake Huron Medical Center
Mercy Health Muskegon
MidMichigan Medical Center – Midland

North Ottawa Community Hospital
Providence Hospital
John Hospital & Medical Center

Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

CAQH ProView application reminders

Here are some tips to help you respond to some CAQH ProView questions that'll ensure that Blue Care Network and Blue Cross Blue Shield of Michigan process your credentialing and recredentialing applications efficiently and without delay.

Retired status

- *Are you retired?* Select "Yes" if you've completely retired from providing medical or behavioral health services to members. This signifies that you're retired from practicing.
- If you move to a new location, practice group or provider organization, share this in your demographics responses where indicated. **Don't** answer "Yes", which would indicate that you're retired from practicing.

Health plan authorization

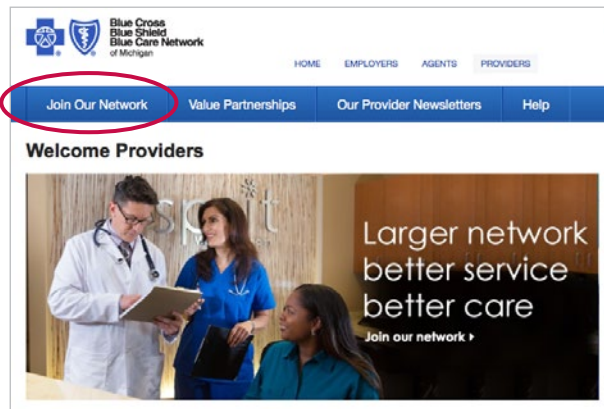
We use CAQH for physicians during recredentialing verification cycles. It's essential that you list Blue Cross, or BCBSM, as one of the health plans authorized to receive your information from CAQH. If we aren't listed as an authorized plan, your credentialing will be delayed until you grant authorization.

Update your practice information

We'd also like you to review the demographic information for your practices to ensure it's up to date this quarter. Here are some helpful tips:

- If you are an individual practitioner, review all your practice locations and make sure they're updated in CAQH Proview, including address suite numbers and phone numbers.
- If you are a practice group, make sure all your practice locations are updated including suite numbers and phone numbers through our Provider Self-Service tool on bcbsm.com. Locations and providers that do not see patients for appointments should be suppressed so they are not displayed for our members in the online directory. Emergency room physicians and administrative addresses are examples of information that should not be displayed in the directory.

Find resources to help you and your practice managers use **CAQH ProView**, or contact CAQH at 1-888-599-1771.



Resources to help you use the Blue Cross Provider Self-Service tool are available at bcbsm.com/providers.

To sign up for self-service:

- Go to Join our Network and click on *Enrollment and Changes*
- Click on *self-service FAQs*
- Click on *How do I sign up?*

You can also call Blue Cross Provider Enrollment at 1-800-822-2761.

Network Operations

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Medical residents: Here's how you can join our network

Are you completing your medical residency training this summer?

If you are, please remember to submit your Blue Cross Blue Shield of Michigan or Blue Care Network provider enrollment application **up to 60 days** before the date you complete your training.

It's important to apply within the required time frame, because if you apply **after** 60 days, your application will be denied and you'll have to reapply.

Before you can begin the credentialing process with Blue Cross and BCN, you must complete the CAQH ProView application.

Visit the **CAQH ProView™** website for more information on application requirements.



Blue Cross and BCN's newborn coverage policy changes

Blue Cross Blue Shield of Michigan and Blue Care Network's newborn coverage policy has changed, retroactive to Jan. 1, 2017, for insured business.

Here's how the new policy works:

Subscribers are still required to add newborns within the time frames allowed in their contracts to obtain coverage for new dependents. However, Blue Cross and BCN have changed our newborn coverage policy so that even if a newborn is not added to the subscriber's contract within the required time frames, we'll cover both facility and professional inpatient claims for the newborn during the first 48 hours for a vaginal delivery and the first 96 hours for a cesarean delivery, as an extension of the mother's maternity benefit.

This coverage only applies if the mother has Blue Cross or BCN coverage on the newborn's date of birth as a subscriber, spouse or dependent.

Blue Cross and BCN will not pay a newborn claim if we determine that the newborn had other coverage on the date of birth or if the subscriber contacts customer service to indicate they don't want us to pay the claim.

You'll want to encourage subscribers to add newborns within the time frames allowed under their contracts to obtain coverage for their newborns beyond the 48 or 96 hours.

This change is being applied retroactively to Jan. 1, 2017. As a result, some newborn claims have been reprocessed to pay for facility and professional inpatient services within the 48-hour and 96-hour thresholds where the mother had our coverage on the newborn's date of birth and the newborn didn't have other coverage.

BCN Advantage

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



Most BCN Advantage services do not require referrals

We want to make coordinating patient care as simple as possible. Therefore, most BCN Advantage services don't require the primary care physician to submit a referral to Blue Care Network when using in-network providers. There are exceptions for members in local networks. (See sidebar.)

When a referral is required, the primary care physician can make it in a manner that is convenient for the office staff, member and specialist. We require only that the member and specialty physician know they have approval for the services and that proof of this referral can be produced if requested by BCN.

Here are some examples of acceptable BCN Advantage referral formats for services requiring a referral:

- Handwritten prescription signed by the primary care physician (can be carried to the specialist by the member)
- Fax on primary care physician office letterhead or emailed from the primary care physician to the specialist (a copy can be given to the member)
- Telephone call from primary care physician to specialist, provided both offices note the date, time and specifics of the call in the patient record and the member is given the specialist's contact information in writing

When BCN receives claims for services that don't require a referral submission to BCN, claims automatically pay.

Some services require authorization from BCN. Providers can access the BCN Advantage referral and authorization requirements on the ***BCN Referral and Authorization Requirements*** document. This document contains a list of procedure codes associated with many of the services that require authorization.

BCN Advantage has special rules for local networks

BCN Advantage has four local networks that are subsets of our larger network. There are special referral and authorization rules associated with these networks.

Care provided by a physician or specialist outside the local network (even if the provider is in the larger BCN Advantage network) requires a referral from the primary care physician and authorization from the plan.

Here are the local networks that are subject to these referral rules:

BCN AdvantageSM HMO ConnectedCare: A subset of the BCN Advantage network involving providers affiliated with the Together Health Network. The Together Health Network is an integrated network of the Ascension Health Michigan and Trinity Health Systems of Saint Joseph Mercy, St. John Providence, Borgess and Ascension Crittenton hospitals, and Genesys Regional Medical Center. This network is for Medicare beneficiaries who reside in Arenac, Genesee, Iosco, Kalamazoo, Livingston, Macomb, Oakland Saginaw, St. Clair, Washtenaw and Wayne counties.

BCN AdvantageSM HMO MyChoice Wellness: A subset of the BCN Advantage network involving providers affiliated with Mercy Health in west Michigan. This network is for Medicare beneficiaries who reside in Kent, Muskegon, Oceana and Ottawa counties

BCN AdvantageSM HMO HealthySaver and BCN AdvantageSM HMO HealthyValue: These two networks are a combination of the ConnectedCare and MyChoice Wellness networks. They are for Medicare beneficiaries who reside in Arenac, Genesee, Iosco, Kalamazoo, Kent, Livingston, Macomb, Muskegon, Oakland, Oceana, Ottawa, Saginaw, St. Clair, Washtenaw and Wayne counties



Medicare Advantage Diagnosis Closure Incentive program continues in 2018

Blue Cross Blue Shield of Michigan and Blue Care Network are continuing the Medicare Advantage Diagnosis Closure Incentive program this year for dates of service on or after Jan. 1, 2018.

The program applies to Medicare Advantage patients, including those covered by:

- Blue Cross Medicare Plus BlueSM PPO
- Medicare Plus BlueSM Group PPO
- BCN AdvantageSM HMO-POS
- BCN AdvantageSM HMO

The program rewards participating primary care doctors for having annual, face-to-face visits with Blue Cross and BCN Medicare Advantage patients to evaluate, document and code diagnoses according to standards set by the Centers for Medicare & Medicaid Services.

Doctors will receive a financial incentive for closing diagnosis gaps identified by Blue Cross and BCN. A gap is a suspected or previous condition that hasn't been documented and coded in the current year.

Diagnosis Evaluation Panel

The *Diagnosis Evaluation Panel* on Medicare Advantage Health e-BlueSM or BCN Health e-BlueSM — found in the Provider Secured Services area of bcbsm.com — lists patients who are suspected of having a condition, based on one of the following, but whose diagnoses haven't been submitted to Blue Cross or BCN in the current year:

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

An identified gap can be closed after a face-to-face visit with the patient in 2018. During this visit, the doctor should manage, evaluate, assess or treat the condition and document the diagnosis in the patient's medical record following CMS guidelines. Then, he or she can close the gap through one of the following methods:

- Confirm the diagnosis code:
 - By submitting a claim with the diagnosis code
 - Through Health e-Blue
 - By submitting the patient's medical record
- Check Health e-Blue to confirm that the patient doesn't have the suspected condition.

You shouldn't close a gap simply because you're not actively treating the condition. Only close a diagnosis gap if you've:

- Conducted an office visit
- Addressed the condition
- Determined that the patient no longer has the condition or the suspected condition doesn't exist

Information on Health e-Blue is refreshed monthly so doctors can track their progress in closing identified diagnosis gaps.

Rewards for closing gaps

Blue Cross and BCN will pay doctors \$100 for each Medicare Advantage member with one or more gaps identified between Jan. 1 and Sept. 30, 2018, and for whom all gaps are closed during a face-to-face visit by Dec. 31, 2018.

More information about this incentive program will be posted on Health e-Blue for Medicare Advantage primary care doctors in the first quarter of 2018.

BCN Advantage

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Diagnosis Closure Incentive, *continued from Page 9*

If you don't have access to Health e-Blue, you can request it on the application for Provider Secured Services and complete the section for Health e-Blue. For more information, go to [How do I get access to Provider Secured Services?](#)

If you already have access to Provider Secured Services and Health e-Blue and just need to update users, fill out this [authorization form](#) and fax it to the number on the form.

web-DENIS member care alerts

When checking patient eligibility and benefits on web-DENIS, check your member care alerts. The alerts have been updated to include 2018 patient gaps in care.

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

2017 incentive payment

If you participated in the 2017 Diagnosis Closure Incentive program, your incentive payment will be mailed to you by the end of the third quarter in 2018.

BCN Advantage encourages members to speak to their physicians about exercise, mental health

Providers should be prepared to discuss exercise and sound mental health with their BCN AdvantageSM patients.

We've mailed three postcards to members to heighten their awareness of the impact of exercise, sound mental health and peak physical health on their overall well-being. Each postcard encourages members to speak to their doctors.

Training available

We can provide training to doctors and their office staff about proper documentation, coding guidelines and the importance of closing gaps for Medicare Advantage patients.

Follow these steps to access online training resources:

1. Log in to web-DENIS.
2. Click *BCBSM Provider Publications and Resources*.
3. Click *Newsletters & Resources*.
4. Click *Patient Care Reporting*; in the *Training Resources* section select any of these training links:
 - *Online training for risk adjustment, documentation and coding*
 - *eLearning module: Online training: Best Practices for Medical Record Documentation*
 - *Documentation and ICD-10 coding tips for professional offices*

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

These presentations are also available in *BCN Provider Publications and Resources* under the *Other Resources* menu. Click on *Patient Care Reporting for Risk Adjustment*.



The first postcard mailing in February dealt with exercise.

The second mailing in early March prompted people to examine their mental health and to get help if needed.

The third mailing in late March speaks to members' physical health and reminds them to call their doctor if they're not feeling well.



How health care providers are helping Blue Cross reach for the stars



By Dr. Marc Keshishian

Marc Keshishian is vice president of Health and Clinical Affairs for Blue Cross Blue Shield of Michigan and senior vice president and chief medical officer for Blue Care Network

The Centers for Medicare & Medicaid Services releases its Medicare star ratings for health plans each October. Star ratings are to health insurers what the Academy Awards are to the film industry but without the gala event and speeches.

For five consecutive years, our health care providers on the front lines have consistently provided the good patient care that's helped Blue Cross Blue Shield of Michigan and its HMO, Blue Care Network, perform at the 4-star level or above. While that's a track record to be proud of, we're continually striving for even higher ratings.

Ratings range from 1 star (lowest) to 5 stars (highest). A large segment of Medicare plans — about 50 percent — didn't reach the 4 level when the current ratings were announced last year.

Why are star ratings important to our providers, our members and the plan?

CMS began its star rating program more than 10 years ago as a strategy to encourage insurance companies to provide the highest quality care to Medicare beneficiaries. There are multiple measures involved in determining the final composite score. The more stars, the better the plan and the more members want to join the plan.

CMS makes it harder each year to perform well on various measures. This makes it more challenging for us but also helps to identify low performers.

Plans that earn at least 4 stars can receive a 5 percent boost to their monthly per-member payments from Medicare, while those with lower scores receive nothing. These bonuses allow us to offer additional benefits for our members. In a nutshell, higher star ratings equal a stronger organization.

The list of composite measures that we're scored on include initiatives related to the following areas:

- **Staying healthy** — Preventive care, including health screenings, tests and vaccines
- **Managing chronic (long-term) conditions** — How we help members with one or multiple chronic conditions to better manage their conditions
- **Member experience with the health plan** — Our members are asked to complete a survey on their level of satisfaction with the plan. (See article titled "**Annual CAHPS survey goes out**," which appeared in Hospital & Physician Update.)
- **Member complaints and changes in the health plan's performance** — How often Medicare and our members had problems with the plan
- **Health plan customer service** — How well we handle our members' grievances and appeal

Please see [Star ratings](#), continued on Page 12



Star ratings, *continued from Page 11*

There are clinical measures associated with two of these areas — staying healthy and managing chronic conditions. See table below for a look at some of the Medicare star measures, which are also HEDIS® measures.

Measures weighted “1” are important process-related measures, while those weighted “3” are tied to outcomes and have a higher level of importance. The numbers associated with each measure are combined to determine our annual star ratings.

Weight allotted to measure	Physician-focused measures
Staying healthy	
1	Adult BMI assessment
1	Breast cancer screening
1	Colorectal cancer screening
Managing chronic conditions	
3	Controlling high blood pressure
1	Statin therapy for patients with cardiovascular disease
1	Statin use in persons with diabetes (Part D pharmacy measure)
3	Comprehensive diabetes care – blood sugar controlled
1	Comprehensive diabetes care – eye examination
1	Comprehensive diabetes care – medical attention for nephropathy
1	Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis
1	Osteoporosis management in women who had a fracture

The hospital-focused measures are included in the table below.

Weight allotted to measure	Coordination of care measures
1	Medication reconciliation post-discharge
3	Plan all-cause readmissions (observed rate; lower is better)
1	Hospitalization for preventable complications

We have teams dedicated to improving our performance on these measures and providing meaningful, actionable data to our provider network. In addition, we have an array of member programs and provider incentive programs aligned with improving our CMS star ratings.

We’ll share highlights of these initiatives in future columns and articles.

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Reminder: Medicare patients at risk for Type 2 diabetes eligible for new diabetes prevention program

As we recently informed you, your Medicare patients who have Part B coverage and are at risk for Type 2 diabetes are eligible to participate in the new Medicare Diabetes Prevention Program, which started on April 1. It's offered at no cost to Blue Cross Blue Shield of Michigan and Blue Care Network members.

In a random controlled trial, the program was proven by the National Institutes of Health to greatly reduce the progression of prediabetes to Type 2 diabetes. Program services are delivered in community settings by lifestyle coaches. The coaches are trained by organizations that are recognized by the Centers for Disease Control and Prevention. To learn more about the program, visit the [Centers for Medicare & Medicaid Services](#) website.

Medicare criteria for eligibility are:

- Enrollment in Medicare Part B
- Blood value (one of the following):
 - Fasting plasma glucose of 100-125 mg/dL
 - A1c value between 5.7 and 6.4
 - Oral glucose tolerance test between 140 mg/dL and 199 mg/dL
- Body mass index greater than 25 (If Asian, greater than 23)
- No diagnosis of end-stage renal disease, Type 1 or Type 2 diabetes; previous gestational diabetes is not an exclusion to participation.

For details on how eligible members can enroll in the program, call the program administrator, Solera Health, at 1-866-653-3837 or visit bcbsm.com/prevent-diabetes.

Patient
CareCommunicating screening and treatment
options for prostate cancer

By Denice Logan, D.O.



J. Adams M.D., a surgeon at The London Hospital described the first case of prostate cancer in 1853 as a “very rare disease.” Today, prostate cancer is the second most common cancer and the second leading cause of death. Skin cancer is most common; lung cancer leads in deaths.

The American Cancer Society estimates that in 2018, there will be 164,690 newly diagnosed cases of prostate cancer. Prostate cancer will

kill 29,430 men. The most recent data from the Michigan Department of Health and Human Services supports a decline in the incidence and numbers affected by death. It’s been estimated that 5,350 new cases of prostate cancer were diagnosed in Michigan in 2017 and that 830 men in Michigan would die from prostate cancer in 2017.

With the continued early diagnosis, prostate cancer is no longer seen as a death sentence. With early diagnosis, about 90 percent of the prostate cancers are found and localized, according to 2016 statistics. Survival rate for five years was at 100 percent. When prostate cancer was diagnosed at the distant stage, there was only a 30 percent five-year survival rate (2013 data). Data from 2014, reviewed in 2017, from the Centers for Disease Control and Prevention, supports an incidence of prostate cancer in Michigan at 99.9 per 100,000 men. The CDC Michigan prostate cancer death rate was 19.9 per 100,000.

Why has there been a decline? The U.S. Preventive Services Task Force issued a recommendation against routine PSA screening in 2012. Could this infer that there are cases that are not being diagnosed at all, early or late, or just not recorded, because they had the diagnosis but died of another cause?

Today, the PSA test remains the most common screening test for prostate cancer. (Current research includes a more definitive PSA, but it’s still investigational and not covered by insurers.) The PSA screening is somewhat controversial and the consensus is that screening should be a matter of informed decision-making between the physician and patient.

Physicians should be aware of and communicate risk factors to patients when discussing screening options.

The Michigan Department of Health and Human Services has published recommendations about when to discuss screening with men by level of risk. They’re highlighted below:

- Average risk:
 - No risk factors
 - Screening discussion starts at age 50
- High risk:
 - African-American race; having one close family member diagnosed before age 65
 - Screening discussion starts at age 45
- Highest risk:
 - Multiple close family members diagnosed with prostate cancer before age 65
 - Screening discussion starts at age 40

Please see [From the medical director](#), continued on Page 15

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

*Dr. Denice Logan is a medical director
at Blue Care Network.*

Patient Care

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

From the medical director, continued from Page 14

The Annals of Family Medicine (July 2013) published a study, "Physician Communication Regarding Prostate Cancer Screening: Analysis of Unannounced Standardized Patient Visits." From this article, we can glean some talking points for physicians engaging in shared decision-making with their male patients.

- Discuss potential harms and benefits of screening.
- Discuss risk factors (race and family history) for prostate cancer.
- Assess a patient's desire to be actively involved in the decision-making process.
- Provide information (web site, brochures) to educate patient and help him make an informed decision.
- Check the patient's understanding of the information.
- Give opportunities for the patient to ask questions about the information, risks of screening and potential adverse effects or other concerns.
- Provide guidance without being overly directive.
- Confirm the patient's decision.



Diagnosis and treatment of cancer

Aside from screening advances, there are options for treatment of prostate cancer. Providers should review staging and the Gleason scoring. Find information on Gleason scoring at the [Cancer Center](#) website.

Determining the stage of prostate cancer plays a role in presenting treatment options.

The staging system helps to describe how far cancer has spread. The American Joint Committee on Cancer's **TNM** system was updated in January 2018.

This system is based on five key pieces of information*:

- The extent of the main (primary) **tumor (T category)**
- Whether the cancer has spread to nearby lymph **nodes (N category)**
- Whether the cancer has spread (**metastasized**) to other parts of the body (**M category**)
- The **PSA level** at the time of diagnosis
- The **Grade Group** (based on the **Gleason score**).

*Source: American Cancer Society

Newer methods of detecting prostate cancer are being studied, including a new type of PET scan that uses radioactive carbon acetate instead of labeled glucose (sugar); multiparametric MRI; and a newer method called the enhanced MRI.

Find more information about diagnosing and staging at the [American Cancer Society](#) website.

Patient Care

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



Blue Care Network promotes continuity of care in some situations

Continuity of care services are available for the following members:

- Existing Blue Care Network members whose primary care physician, specialist or behavioral health provider voluntarily or involuntarily disaffiliates from BCN
- New Blue Care Network members who require an ongoing course of treatment

Members can't see their current physician if that physician was terminated from BCN for quality reasons. In this instance, the member is required to receive treatment from an in-network provider.

BCN provides notification to 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 practitioner:

- 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

Primary care physicians may offer continuity of care for a member in the situations described in the table below. Specialty providers may offer continuity of care for a member receiving an ongoing course of treatment in the situations described in this table.

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 active course of treatment is defined as:

- An ongoing course of treatment for a life-threatening condition: A disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted
- An ongoing course of treatment for serious acute condition: A disease or condition requiring complex ongoing care, which the covered person is currently receiving, such as chemotherapy, postoperative visits or radiation therapy
- An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes
- The second or third trimester of pregnancy, through the postpartum period

A disaffiliating physician who desires to offer a member continuity of care in accordance with the conditions of payment and BCN policies must notify BCN and the member who desires approval of 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 member ID card.

A nurse provides written notification of the decision to the member and practitioners. Newly-enrolled members must select a primary care physician before requesting continuity of care services and within the first 90 days of their enrollment.

Patient Care

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Blue Care Network promotes coordination of care with specialists

Blue Care Network has a process to promote continuity and coordination of care among specialists and primary care physicians.

We collect and analyze data each year to assess the exchange of information between specialists and primary doctors following both inpatient and outpatient consultations. Many studies have identified fragmentation of care as a problem in the medical system. The information we collect is important as we work to improve continuity and coordination of care within our network.

Patient care that isn't coordinated between providers and across settings results in confusion for members, increased

risks to patient safety due to errors and unnecessary costs due to duplicate testing. The collaboration between practitioners can greatly improve both member satisfaction and health outcomes.

Our goal for exchange of information between the specialist and the primary doctor is 100 percent. This goal can be accomplished by ensuring that the specialist has the correct PCP information at the time of the visit and by forwarding the post visit information to the primary care provider.

We encourage all providers to continue to take steps to enhance the information exchange across the continuum of care.

Medical record guidelines policies require providers to maintain member records

Blue Cross Blue Shield of Michigan and Blue Care Network have a policy for content of medical records to ensure clinical records are maintained for each of our members and organized in a manner that facilitates easy access for reviewing and reporting purposes.

The medical record should be stored or electronically secured to comply with HIPPA regulations. Content of the medical record should include:

- Member demographics
- Health assessment
- Reason for visit
- Diagnosis
- Documentation of discussion about the following: advanced directives, preventive health and health maintenance, patient education, follow-up plan, consultation review and referred services review

Our medical record-keeping policies support Centers for Medicare & Medicaid Services and National Committee for Quality Assurance standards and contain elements from the Michigan Quality Improvement Consortium Guidelines.

Quality Management Coordinators in our Quality and Population Health Department conduct medical record random reviews of our contracted primary care, internal medicine, OB/GYN and behavioral health provider offices to monitor compliance with our policies.

We also conduct reviews for providers who are seeking credentialing or recredentialing, or providers with three or more substantiated complaints. The performance expectation is an overall score of at least 80 percent.

Feedback from the 2017 medical record review summary reflects an overall improvement from 2016. All providers reviewed achieved an overall score of 80 percent or higher.

Opportunities for improvement for individual clinical elements that did not meet the 80 percent standard compliance threshold in 2017 include:

- Documentation regarding advance directives
- Intimate partner violence screening
- Hepatitis C screening
- Lung cancer screening

Information regarding these screening guidelines can be found on the **MQIC** website.

Patient Care



Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Hypertension is Michigan's top health problem

Michigan residents are only slightly less healthy than people in the rest of the country, a new study from the Blue Cross Blue Shield Association finds.

We also share the same top five health conditions with the rest of the country, with hypertension in the lead.

The Blue Cross Blue Shield Health Index is a unique measurement tool that contains health statistics for nearly every county in America. The report is created using data from more than 41 million commercially insured members of Blue plans, including Blue Cross Blue Shield of Michigan and Blue Care Network.

The Blue Cross Blue Shield Health Index measures the impact of more than 200 common diseases and conditions on overall health and wellness by assigning each county in the United States a health metric between 0 and 1, designating the proportion of optimal health reached by the county's population.

For example, a measurement of 0.9 shows that, on average, the population of a county is living at 90 percent of its optimal health. In other words, the county population could improve its health up to 10 percent in a healthy lifespan by addressing the top health conditions affecting their area.

Michigan's health index score is 0.91, compared with the national score of 0.915.

According to the Health Index, the healthiest states include California, Colorado, Montana and Utah at 0.94. States with the lowest health score include Alabama at 0.88 and Rhode Island, Florida and Maryland at 0.89.

For more information, go to the [main page](#) of the Health Index.



Michigan's top 10 health concerns

- | | |
|----------------------------|--|
| 1. Hypertension | 6. Chronic Obstructive Pulmonary Disease |
| 2. Major depression | 7. Alcohol use disorder |
| 3. High cholesterol | 8. Other substance use disorder |
| 4. Coronary artery disease | 9. Psychotic disorder |
| 5. Type 2 diabetes | 10. Crohn's disease/ulcerative colitis |

Patient Care

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Men's health is being celebrated internationally June 11-17, 2018

Men's Health Week is being celebrated June 11 through 17 to honor the importance of the health and wellness of boys and men.

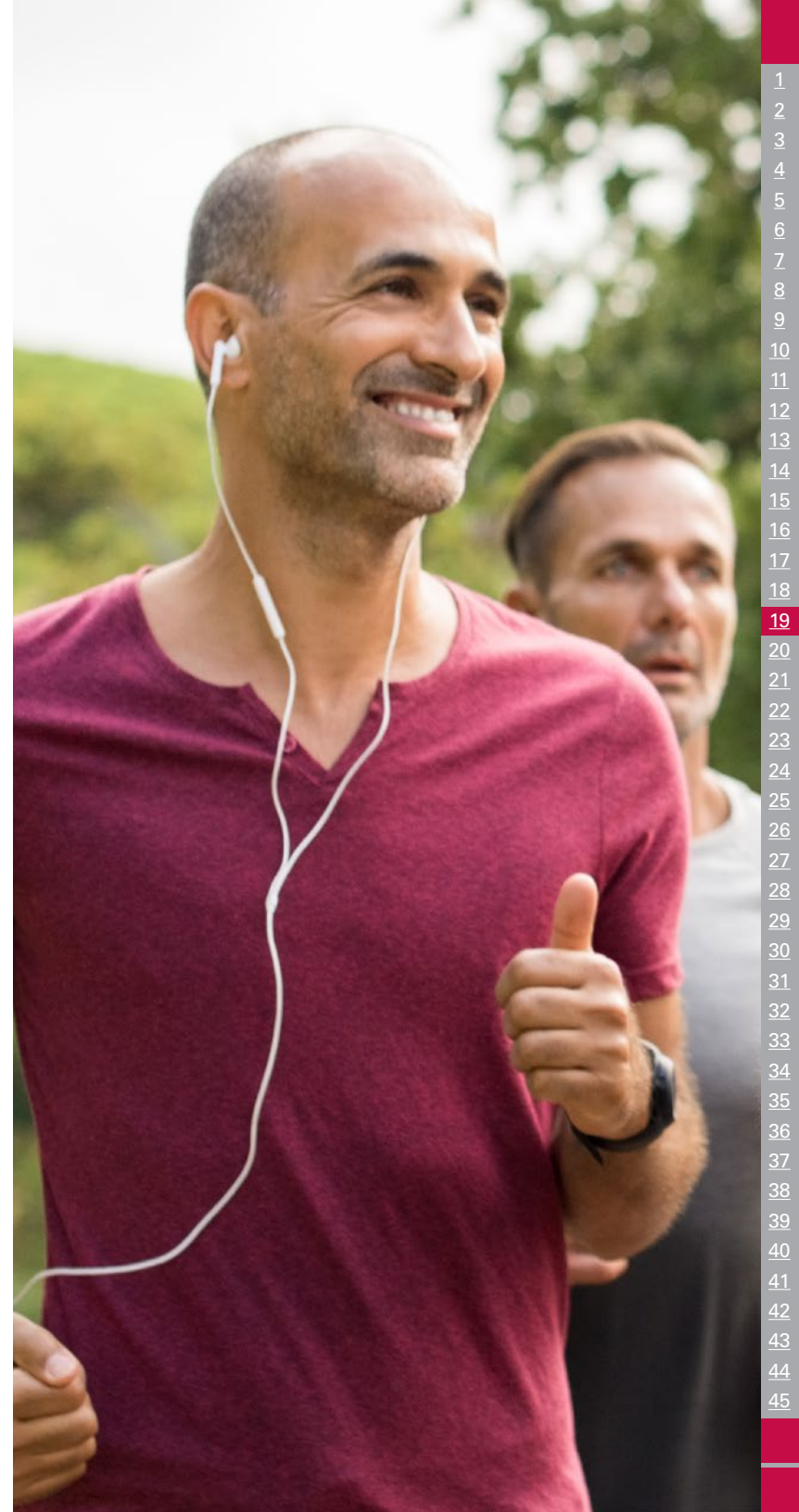
Blue Care Network encourages all men to get their recommended screenings to maintain good health.

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

Here are some tips you can give your male patients:

- **Eat healthy.** Say no to supersizing and yes to 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.** 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. To stay motivated, choose activities that you enjoy.
- **Make prevention a priority.** Many health conditions can be prevented or detected early with regular checkups. Regular screenings may include blood pressure, cholesterol, glucose and prostate health.

For information about prostate cancer, see the Medical director column on [Page 14](#).





Do your patients have unused pills sitting at home? What you should tell them

Patient Care

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



Many people have had leftover pills at one time or another. This can be especially true if a patient has received prescription painkillers. It can be tempting for people to keep unused pills, but they can easily get into the wrong hands of a curious teen or someone already addicted.

More than three out of four people who misuse prescriptions use drugs that are prescribed to friends and family. When it comes to opioids, these powerful medications can be dangerous and even deadly when taken by someone other than for whom they are prescribed. Do your part to protect your patients and others by informing patients about take-back programs.

Medication take-back programs

Take-back programs are the ideal way to properly dispose of expired, unwanted or unused medications in your home. The Drug Enforcement Administration sponsors a **National Prescription Drug Take Back Day** every year in April and October. However, patients don't need to wait. The DEA and Michigan Opioid Prescribing Engagement Network (Michigan-OPEN) both have websites that allow people to enter their ZIP code to find a safe, convenient and anonymous drop-off location in their community that takes back medications year-round.

If no medication take-back program or facility is available in a specific area, there are simple steps patients can take to dispose of most medications in their household trash. However, most powerful opioids should be flushed down the toilet due to safety reasons. Visit the Food and Drug Administration website for a complete **list** of medications that should be flushed.

Help patients find a local opioid drop-off location

- **DEA**
- **Michigan-OPEN**



How to dispose of medicines in the household trash

- Mix medications (don't crush tablets or capsules) with an unpalatable substance, such as dirt, kitty litter or used coffee grounds.
- Place the mixture in a container, such as a sealed plastic bag.
- Throw the container in the household trash.
- Scratch out all personal information on the prescription label of your empty pill bottle or medicine packaging to make it unreadable, then dispose of in the container.



Mi-CCSI offers basic and advanced pain management training



The Michigan Center for Clinical Systems Improvement, or Mi-CCSI, in collaboration with its members and community organizations, has developed a comprehensive training program to address patients with acute and chronic pain. The curriculum includes the foundations of pain management, which addresses:

- Basics of pain management mechanisms
- Pathophysiology
- Biopsychosocial aspects of pain
- Pharmacotherapy
- Non-pharmacy treatment approaches

The advanced practical workshops include:

- Approaches for medication tapering
- Conducting difficult conversations with patients
- Comprehensive assessment of biopsychosocial aspects of pain
- Basics of addiction
- Referral and communications strategies with specialty providers
- Using the new automated prescription system

The intended audience includes primary care practice teams or individual providers, clinical and non-clinical staff, including care managers, social workers, medical assistants, office managers and staff, pharmacists, and behavioral health specialists.

The dates and locations are on the table below.

To register, go to **Mi-CCSI website**.

Date	Location & Venue
June 21	Traverse City Park Place Hotel
October 12	Grand Rapids Masonic Center
October 13	Muskegon Holiday Inn-Harbor
October 30	Wixom/New Hudson BCBSM Lyon Meadows Conference Center
November 20	Wixom/New Hudson BCBSM Lyon Meadows Conference Center



Provider resources available for CDC opioid prescribing guideline

In a previous issue of *BCN Provider News*, we told you about the **CDC Guideline for Prescribing Opioids for Chronic Pain**, published in March 2016. It includes recommendations about the appropriate prescribing of prescription opioids and other treatment options to improve pain management and patient safety.

The Centers for Disease Control and Prevention has **resources** for the prescribing guideline to help improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain. The website includes clinical tools, videos and materials for patients.





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.

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](#).

*CPT codes, descriptions and two-digit modifiers only are copyright 2017 American Medical Association. All rights reserved.

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

- Composite tissue allotransplantation
- Endovenous ablation for the treatment of varicose veins (example: ClariVein®, VenaSeal™ closure system)
- Genetic testing for statin-induced myopathy
- Measurement of serum antibodies to infliximab, adalimumab and vedolizumab
- Optical coherence tomography of the middle ear (for example, PhotoniCare ClearView® system)

Covered services

- Accelerated breast irradiation after breast-conserving surgery for early stage breast cancer and breast brachytherapy as boost with whole-breast irradiation
- Artificial pancreas device systems
- Coverage of routine services associated with clinical trials
- Genetic testing for KRAS, NRAS, and BRAF mutation analysis in metastatic colorectal cancer
- Genetic testing-analysis of MGMT promoter methylation in malignant gliomas
- Genetic testing of CADASIL syndrome
- Photodynamic therapy for dermatologic applications
- Cryosurgical ablation of miscellaneous solid tumors other than liver, prostate, or dermatologic tumors
- Skin and tissue substitutes
- Digital breast tomosynthesis



Behavioral Health



Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Blue Care Network pilots substance abuse treatment protocol with two hospital partners

Blue Care Network is piloting a substance abuse disorder treatment protocol with two hospital partners to improve the way opioid use disorder is treated. The protocol assumes that the key to treating opioid use disorder is allowing time for the natural healing process to occur with the use of medications, therapy and intensive social support.

The two hospital partners are Maplegrove Center (part of Henry Ford Behavioral Health Services) and Pine Rest Christian Mental Health Services. As part of the pilot, the hospitals have agreed to a specific treatment protocol for all patients with opioid use disorders during the cohort year.

“This is a novel approach combining several evidence-based interventions. Working with our pilot partners, Blue Cross and BCN are striving to innovate health care for our members and community,” said Dr. William Beecroft, medical director of behavioral health at Blue Care Network. “Opioid use treatment can significantly reduce health care costs,” he adds. Johns Hopkins Healthcare has reported a return on investment of \$3.65 for every dollar spent on intervention.

“There’s substantial evidence in the literature to support better outcomes by treating substance abuse disorders as chronic illness,” continues Dr. Beecroft. The current system of episodic care for opioid or any substance use disorder doesn’t reflect the current evidence base or biologic

realities, he says. The American Psychiatric Association has recommended this type of comprehensive care since 2000. And the American Society of Addiction Medicine has promoted this type of treatment intervention.

The treatment protocol consists of key phases:

- Detoxification (includes medically-assisted treatment)
- Domiciliary (supervised residential) level of care (includes education and assessing a patient’s motivation to change)
- Intensive outpatient program (includes family support)
- Outpatient care

The protocol developed for this pilot program would include the following:

- Extended time spent in 24-hour, supervised level of care
- Expanded intensive outpatient and outpatient services (This would allow for continued treatment of prolonged withdrawal symptoms in a lower level of care and presents an opportunity to reduce the time in the sub-acute detoxification phase.)
- Intensive outpatient and traditional outpatient services might include home care and sober coaches. The patient would ideally be back to work or school while attending 12-step programming.

Please see [substance abuse treatment protocol](#), continued on Page 24

Behavioral Health

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

substance abuse treatment protocol, continued from Page 23

Medically-assisted treatment is an important part of the protocol. (For more information on medically-assisted treatment, see the Medical director column in the March-April issue of *BCN Provider News*.)

It's also critical to coordinate with other providers responsible for the next level of care.

BCN is using the acronym CLIMB for the program. It stands for:

- C**ommunity-based
- L**ife-changing
- I**ndividualized
- M**edically-assisted
- e**vidence-
- B**ased treatment

The goals of the pilot include the following:

- Use more intensive and prolonged lower level of care resources to promote lower readmission rates
- Educate and engage members to enter opioid and substance abuse treatment
- Decrease medical and behavioral health costs by decreasing costs on co-occurring disorders and relapses
- Improve the use of medically-assisted treatment using various medications
- Improve overall health and quality of life of Blue Cross and BCN members

The pilot will run for one year beginning May 2018. BCN and Blue Cross will analyze data from the pilot to determine whether to make changes to current treatment protocols. In the meantime, providers can refer patients who may benefit from this treatment protocol to these two partner facilities.

Starting July 1, we'll only accept electronic submissions for the 2018 Behavioral Health Incentive Program

As we've communicated in the past, we're phasing out manual submissions for the Behavioral Health Incentive Program for the 2018 program year.

Beginning July 1, we'll only accept electronic submissions for self-reported measures. We won't accept any manual submissions after June 30, even if the submission is regarding a measure completed before June 30.

As part of the phase-out process, we've decreased incentive amounts for manual submissions.

We encourage providers who aren't yet submitting self-reported forms electronically to review instructions for electronic submission on web-DENIS.

The 2018 booklet, forms, and instruction guides are available on web-DENIS. To find the documents:

- Log into web-DENIS and go to *BCN Provider Publications and Resources*.
- Click on *Behavioral Health* under *Resources*.
- Scroll down to Behavioral Health Incentive Program.

Behavioral Health



Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Blue Care Network now gives members access to in-home long-acting injectable program

Blue Care Network is helping BCN HMO (commercial) and BCN Advantage members to get access to long-acting injectable medications for the treatment of certain psychiatric and substance use disorders.

We've contracted with home health care agencies that can visit the member's home to administer the injection and complete a nursing assessment. The agencies can be used when the primary care physician, psychiatrist or facility is unable to administer these medications.

The newer long-acting injectable medications may be used for both behavioral health and medical assisted treatment for substance use disorders. These medications have fewer side effects and are better tolerated than some older formulations. They're also now usually preferred early in treatment and should often be the first line of treatment for certain psychiatric and substance use disorders.

The member needs a doctor's order to be sent to the agency. The doctor also needs to order the medication through AllianceRx Walgreens Specialty Pharmacy on behalf of the member.

By providing this service, we're removing a barrier for members. We're providing a place to get the injection.

For information and the process on how to use this service, go to ereferrals.bcbsm.com. Click *BCN* and then click *Behavioral Health*. Finally, click the document, **Administering long-acting injectable medications at home (behavioral health)**. It outlines:

- The steps to take to initiate and continue the administration of the medications in the member's home
- A sample list of the long-acting injectable medications that can be obtained through AllianceRx Walgreens Prime Specialty Pharmacy
- A list of the BCN-contracted home health agencies that provide in-home long-acting injectables

Quality Counts

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Best Practices

Follow-up appointments for ADHD focus on medication effectiveness, education and compliance

An interview with Dr. Salvatore Ventimiglia, Shelby Pediatric Associates, Shelby Township

How do you assure that parents bring children in for a follow-up within 30 days of an initial prescription for ADHD?

When I do an initial assessment, we discuss medication and the follow-up and make an appointment. I usually say I'd like to see the patient within two to three weeks to be sure I follow-up within the 30-day timeframe.

I tell parents their child will be feeling different within the first week. I may have to tweak medication doses. The first few months may even require some medication adjustments so I set the expectation that we'll be seeing a lot of each other.

What are you looking for in a follow-up visit?

I first look first at behavior and how the patient and parent are coping. And I check for any untoward side effects, like irritability, excessive weight loss or mood change. I also do a depression screen if they're old enough to see if I've unmasked a comorbid condition of depression or anxiety.

I also look to see if the teachers are satisfied or if there's a need for written reassessments to gauge how they're doing in school. Some kids who are not hyperactive will not see dramatic changes, but will see more subtle changes in grades and learning skills. We wait a few months to look for those changes.



Dr. Salvatore Ventimiglia and patient Myles Shroyer

Lastly, we look at physiological changes. I make sure the child has no stomach aches or headaches. I check their weight. Weight loss is one of the biggest concerns with some stimulants.

In my initial education session with parents, I tell them their children will likely be skipping lunch if they're not hungry. We come up with alternative meals to meet nutritional needs. That might be a shake or smoothie instead of lunch.

How do you tailor your conversations with kids based on age?

For children ages 6 to 11, conversations are more parent-driven because parents are controlling the medication and making sure their children take it appropriately. I'll also turn to the child to show them pictures of pills, or syringes for liquid medications to try to give them an idea of the taste and texture so they're not surprised by it.

For older children, 11 to 13 and up, I come up with a contract with them about what the medication is, what it's supposed to be, what they should or shouldn't feel when taking it. I make it clear they can call or text me with any questions they may have or, if they prefer, their parent can call. I also go over issues of confidentiality with adolescents to let them know what they can tell me. It's a team effort. When adolescents are engaged, I get better compliance.

Please see [Best Practices](#), continued on Page 27

Quality Counts

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



Best Practices, continued from Page 26

What are some of the challenges associated with treating patients on ADHD medication?

Sometimes, children take the medication only if they think they need it, or they don't take it at all because they think they're better. And, if they're of the age that they can drive themselves to appointments, maintaining compliance can be harder. I get their phone and email address and put in our system so they get text reminders. I email parents as well. Everyone gets reminders. If they don't come in, we hold their medications. We make it clear at every appointment that medications are important and I'll explain that if the patient isn't having side effects, it doesn't mean in the next three months or six months, you may not.

We also get kids who talk about going off their medications. If they feel they don't need it any longer, I say, 'Let's have a discussion if you want to be weaned off the medication.' As kids get older, we talk about weaning and medication holidays.

Do you coordinate with behavioral health specialists when treating patients with ADHD?

We have a pediatric neuropsychologist at our office who does initial evaluations and recommendations. If a patient has some comorbid conditions, we may refer him or her to therapy. Or if a child is having a hard time with medications, we may refer to a psychiatrist.

Do you have any final thoughts?

There's a myriad of medications that can be used for ADHD. I prefer longer acting medications that can be taken once a day so there's no social stigma of taking medications in school and going to the nurse's office.

Medications should be tailored to how long the child's day is, including extracurricular activities.

I also educate patients about misuses and say bluntly, 'If I hear you're selling it, you're out.' I've had kids who've been caught selling their medications and then we have to have a tighter leash on them.



Quality Counts

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Report focuses on health care disparities by race and socioeconomic status

The 2016 National Healthcare Disparities Report concluded that while 20 percent of the measures show disparities getting smaller for African-Americans and Hispanics, most disparities haven't changed significantly for any racial and ethnic groups. Also, more than half of measures show that poor and low-income households have worse care than high-income households. For middle income households, more than 40 percent of measures show worse care than high-income households.

The National Healthcare Disparities Report is a government report that focuses on health care disparity issues in the United States. Each year since 2003, the Agency for Healthcare Research and Quality has reported on progress and opportunities for improving health care quality and reducing health care disparities.

The NHDR focuses on disparities related to race, ethnicity, and socioeconomic status as evident by the chart below.

Groups	Disparities improving	Disparities worsening
African-American compared with Caucasian	HIV infection deaths per 100,000 population New AIDS cases per 100,000 population age 13 and over Admissions for uncontrolled diabetes without complications per 100,000 population, ages 18 and older	Maternal deaths per 100,000 live births Postoperative pulmonary embolism or deep vein thrombosis per 1,000 surgical Admissions, ages 18 and older People with current asthma who report taking preventive medicine daily or almost daily (either oral or inhaler)
Asian compared with Caucasian	Patients younger than 70 with treated chronic kidney failure who received a transplant within three years of date of renal failure Hospital patients ages 65 and older with pneumonia who received a pneumococcal screening or vaccination Adult hospital patients who sometimes or never had a good communication with nurses In the hospital	Adults ages 18 to 64 at high risk who ever received pneumococcal vaccination Children 0 to 40 lbs for whom a health provider gave advice within the past two years about using a child safety seat while riding in a car Live-born infants with low-birth weight (less than 2,500 grams)
AI/AN compared with Caucasian	Adjusted incident rates of end stage renal disease due to diabetes per million population Patients under age 70 with treated chronic kidney failure who received a transplant within three years of date of renal failure Surgical resection of colon cancer that includes at least 12 lymph nodes	Adults older than 50 who ever received a colonoscopy, sigmoidoscopy, or proctoscopy

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45

Quality Counts

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Disparities, continued from Page 28

Groups	Disparities improving	Disparities worsening
Hispanic compared with non-Hispanic Caucasian	<p>New AIDS cases per 100,000 population age 13 and over</p> <p>HIV infection deaths per 100,000 population</p> <p>Admissions for uncontrolled diabetes without Complications per 100,000 population, age 18 and over</p>	<p>Home health care patients who have less shortness of breath</p> <p>Adults age 50 and over who ever received a colonoscopy, sigmoidoscopy, or proctoscopy</p> <p>People with a usual source of care who usually ask about prescription medications and treatments from other doctors</p>
Poor compared with high income	<p>Adolescent females ages 13 to 15 years who received three or more doses of human papillomavirus (HPV) vaccine</p> <p>Rating of health care 0 to 6 on a scale from 0 to 10 (best grade) for children who had a doctor's office or clinic visit in the last year</p> <p>Children who needed care right away for an illness, injury, or condition in the last year who sometimes or never got care as soon as wanted</p>	<p>Adults older than 50 who ever received a colonoscopy, sigmoidoscopy, or proctoscopy</p> <p>Admissions with diabetes with short-term complications per 100,000 population, ages 18 and older</p>

Key: CMS = CMS publicly reported measures; CC = cancer care; DC = diabetes care; HD = heart disease; AC = access.

Blue Care Network is striving to capture more self-reported member data on language, race and ethnicity. This data will help us partner with the provider community in identifying and acting upon disparities present within our population.

We've also identified health care disparities among certain ethnic groups and have formed a committee to develop actions to address health care gaps. We encourage all contracted providers to identify member demographics in Health e-Blue website.

To read the report, go to the [AHRQ website](#).

References:

<https://archive.ahrq.gov/research/findings/nhqrdr/nhqr13/2013highlights.pdf>

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Jacoby M, Sullivan T, Warren E. Medical problems and bankruptcy filings. *Norton's Bankruptcy Law Advisor* 2000 May;5:1-12.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Do your patients have a COPD action plan? Tips to improve HEDIS measures

Chronic obstructive pulmonary disease was the third leading cause of death in the United States in 2014. Approximately 50 percent of patients with COPD have at least one exacerbation per year, and more than 20 percent are readmitted within 30 days. Recurrent COPD exacerbations result in accelerated lung-function decline and worsen mortality.

That's why HEDIS® includes two quality measures targeting pharmacotherapy management of COPD exacerbation. The measures look for systemic corticosteroids and a bronchodilator following an inpatient stay or emergency room visit for a COPD exacerbation. Appropriate treatment of an acute exacerbation is critical but having an action plan can be a big help.

What's an action plan?

An action plan is tailored to each patient and should be completed by the provider and the patient together. It's intended to promote self-management of exacerbations that may otherwise necessitate acute care.

Patients can better recognize when their symptoms change and what actions they should take (typically antibiotics and oral corticosteroids). The American Lung Association provides a **My COPD Action/Management Plan** along with other resources for providers and patients.

For more information on the COPD measures and other tips on how to improve HEDIS scores, please see Blue Cross' Clinical Quality Corner for **provider tip sheets**.

You can also learn more about how you're performing on COPD and other HEDIS measures by checking out the quality summary report in Health e-BlueSM.

Sample Health e-Blue report

	You			Current Reporting Period Specialty Specific				
	Total Members Eligible	Eligible Members Meeting Criteria	Current Period	PO	Region	State	State 90th percentile	Plan Goal
Pharmacotherapy Management of COPD Exacerbation								
Systemic Corticosteroid Dispensed	1	0	0.00%	60.00%	75.00%	77.49%	N/A	84%
Bronchodilator Dispensed	1	0	0.00%	80.00%	71.09%	73.82%	N/A	89%

References

Wedzicha JA., Singh R., Mackay AJ. "Acute COPD exacerbations." *Clinics in chest medicine* 35.1 (2014): 157-163

Restrepo RD., et al. "Medication adherence issues in patients treated for COPD." *International journal of chronic obstructive pulmonary disease* 3.3 (2008): 371.

"Fact Sheets." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 12 Mar. 2015, www.cdc.gov/copd/maps/index.html.

Yawn B., Kim V. "COPD in Primary Care: Key Considerations for Optimized Management: Treatment Options for Stable Chronic Obstructive Pulmonary Disease: Current Recommendations and Unmet Needs." *The Journal of family practice* 67.2 Suppl (2018): S28-S37.

Jalota L., Jain VV. "Action plans for COPD: strategies to manage exacerbations and improve outcomes." *Int J Chron Obstruct Pulmon Dis* 2016; 11: 1179-1188

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

Discuss medication adherence with patients

Did you know, on average only 40 to 60 percent of patients with COPD adhere to their prescribed regimen?

Don't forget to discuss the importance of medication adherence with your patients. Patients with COPD who are adherent experience less severe and fewer exacerbations, as well as an overall improved quality of life.

For questions regarding this article please contact RxQualityPrograms@bcbsm.com.

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Saving lives through better maternal health

Did you know that women in Detroit die of pregnancy-related causes at three times the national rate?

Detroit has the highest maternal death rate of any major U.S. city — higher than many developing countries, including Libya, Uruguay and Vietnam.

Poverty, along with uncontrolled chronic health conditions that are more common in African-American women, are to blame, said Dr. Patricia Ferguson, a board-certified OB/GYN and physician consultant for Blue Care Network's case management department.

"At least half of these deaths are preventable," she said at a recent Strategy and Public Affairs Diversity Employee Committee special session. "Poverty deprives low-income women of health insurance and access to health care. Detroit has more people living under the poverty line — 42 percent — than any major city in America."

Minority women have higher rates of high blood pressure, obesity and diabetes, Ferguson added.

The social determinants of health attached to poverty — such as housing stability, lack of transportation, access to nutritious food, and access to health care and insurance — also play a role.

These disparities "create a perpetual slippery slope, with no way up until we determine how to break the cycle," Dr. Ferguson said. "While there are individuals who are able to break out of the cycle, the question is, how do we impact the community as a whole?"

Even when all social determinants are taken out of the equation, African-American women still have three to four times the incidence of maternal mortality. Studies have shown that a major contributor is the implicit bias of health care professionals.

"We all need to step back and examine our personal biases and become more sensitive to how they may impact our decision-making," Dr. Ferguson said. "An important first step would be to look through a lens of empathy and put ourselves in the other person's shoes."

Empathy, by definition, is the ability to understand and share the feelings of another. Many times, patients who are faced with health challenges also face other challenges, such as lack of social support, financial need and transportation. These challenges become barriers to care. Rather than face the perception or fear that they will be looked down upon, or judged for their circumstance, they delay seeking help. This can result in even bigger or more serious problems. Physicians can brand themselves as providers who care, opening the pathway to developing relationships that encourage and inspire health and healing for those who need it most.

There's hope in the form of the **MI Alliance for Innovation on Maternal Health** (MI AIM). Dr. Ferguson represents Blue Cross on the MI AIM executive committee. MI AIM is dedicated to ensuring that women in Michigan have timely access to safe, quality health care in pregnancy, labor and delivery.





Reminder: MQIC releases new guidelines for opioid use in adults

The Michigan Quality Improvement Consortium issued a new guideline in November 2017, *Opioid Use in Adults Excluding Palliative and End-of-Life Care*. The guideline is sourced from the 2016 *CDC Guideline for Prescribing Opioids for Chronic Pain*.

MQIC's vision remains as a collaborative approach to develop and implement evidence-based clinical practice guidelines. Its mission is to provide a core set of guidelines, achieve consistent delivery of evidence-based services and, most importantly, better health outcomes.

The MQIC opioid guideline provides concise recommendations to encourage appropriate prescribing, and discontinuation of opioids when risks outweigh the benefits.

Key recommendations include:

- Treat pain with non-drug therapy, and non-opioid medications if possible.
- Screen for risk of dependence; obtain a Prescription Drug Monitoring Program report; urine drug testing when warranted.
- Discuss risks of dependency, overdose and death.
- Prescribe the lowest effective dose, three days or fewer for acute pain.
- Discuss realistic goals for pain and function, including discontinuing therapy if benefits don't outweigh the risks; re-evaluate pain and function throughout the treatment period.
- Avoid prescribing opioids with benzodiazepines, muscle relaxants or hypnotics.
- Consider naloxone when there are risk factors for overdose; emergent referral to a hospital emergency department if Naloxone used.
- Careful justification if increasing dose to ≥ 90 MME/day, document the decision.
- Avoid renewal without clinical reassessment.

MQIC membership consists of 13 Michigan health plans, several professional organizations including the Michigan Department of Health and Human Services and Michigan State Medical Society.

Quality Counts

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index





MAPS using new technology platform to help providers make better decisions about substance use disorders

Pharmacy News

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index

The Michigan Automated Prescription System is Michigan’s prescription drug monitoring system to track and monitor controlled substance prescriptions dispensed in the state. As of December 4, 2017, the appearance and information provided by MAPS has changed. The new technology, NarxCare, helps providers make better-informed decisions when it comes to identifying, preventing and managing substance use disorders.

Key features

Risk indicators	Risk scores based on the number of providers, pharmacies, morphine milligram equivalents and overlapping prescriptions are intended to help aid in decision-making. Scores are available for narcotics, sedatives and stimulants, including risk of unintentional overdose death.
Prescription graphs	Interactive, color-coded prescription graphs provide the patient’s prescription history and incorporates morphine milligram equivalents.
MAT providers	A ZIP code locator is available to find SAHMSA*-supported medication-assisted treatment providers. The report generates a list of 30 providers closest to the patient.
Educational resources	Printable pamphlets for patients are available on topics such as safe pain management, what to know about opioids and an overdose tip card. Prescribing checklists and other resources are available for providers.
Prescriber report	Prescribers can view a personalized report of his or her controlled substance prescriptions for the last four quarters.

*SAHMSA: Substance Abuse and Mental Health Services Administration

Effective June 1, there are new state requirements for MAPS

Licensed prescribers who prescribe or dispense a controlled substance to a patient need to register with **MAPS**. Before prescribing or dispensing a controlled substance exceeding a three-day supply, the prescriber must obtain and review a report from MAPS. Some exceptions apply. Refer to Public Act **248** and **252** of 2017 for more information.



Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Reminder: Fax numbers changed for BCN medical benefit drug authorization requests

As a reminder, two fax numbers changed on March 19, 2018, for submitting requests to authorize drugs covered under the medical benefit.

Here's what changed:

- The fax number for BCN Advantage Medicare Part B authorization requests is now 1-866-392-6465. It's the same number you've been using for Blue Cross Medicare Plus BlueSM PPO requests.
- The fax number for BCN HMOSM (commercial) requests is now 1-877-325-5979. It's the same number you've been using for Blue Cross PPO (commercial) requests.

We encourage you to submit all authorization requests for drugs covered under the medical benefit using the Novologix[®] electronic system. It's the most efficient way to submit a request and get a determination.

When you need assistance, you can call the Pharmacy Help Desk at 1-800-437-3803 or fax your request using the appropriate number.

The *BCN Provider Manual* has been updated with this change. The **Medical Benefit Drugs-Pharmacy** page in the BCN section of the **ereferrals.bcbsm.com** website has also been updated. You can find additional information about drugs covered under the medical benefit on that page.

Blue Cross and BCN now cover Shingrix shingles vaccine

Blue Cross Blue Shield of Michigan and Blue Care Network Commercial Pharmacy now covers Shingrix[®] shingles vaccine with no cost share effective April 1, 2018, for members ages 50 and older. Shingrix prevents shingles and complications from the disease.

Shingrix was approved in October 2017 for the prevention of herpes zoster in healthy adults ages 50 and older. It's the shingles vaccine preferred by the Centers for Disease Control and Prevention.

We currently cover the shingles vaccine Zostavax for members age 60 and older with no cost share.

The CDC recommends that healthy adults age 50 and older get Shingrix even if in the past they:

- Had shingles
- Received Zostavax
- Arent sure if they had chickenpox

Shingrix should not be administered less than two months after Zostavax was administered.

Shingrix is administered as two injections. The second injection should be administered at least 60 days and up to six months after the first injection.

We'll cover Shingrix with no cost share for eligible members age 50 and older. We'll also continue to cover Zostavax for eligible members age 60 and older. Most Blue Cross and BCN commercial (non-Medicare) members with prescription drug coverage are eligible.



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45

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



Blue Cross and BCN won't cover select insulins, effective June 1

To address the high cost of drugs and provide the best value for our members, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans won't cover any formulations of the following insulin products for all drug lists, effective June 1, 2018:

- Apidra[®], Apidra[®] SoloSTAR[®]
- Humalog[®], Humalog[®] Mix
- Humulin[®] (except U-500), Humulin[®] Mix

Insulin products of the same type are interchangeable and work the same way to lower A1c. The following table includes covered comparable alternatives available at a lower cost to the member:

Insulin products not covered beginning June 1, 2018	Cost to Blue Cross (PPO) member	Cost to Blue Care Network (HMO) member
Apidra [®] , Apidra [®] SoloSTAR [®]	Full cost (not covered)	Full cost (not covered)
Humalog [®] , Humalog [®] Mix		
Humulin [®] (except U-500), Humulin [®] Mix		
Covered alternatives	Cost to Blue Cross (PPO) member	Cost to Blue Care Network (HMO) member
Novolin [®] (all forms)	Preferred brand copayment	Generic copayment
Novolog [®] , Novolog [®] Mix		

Members currently using Humalog[®] Junior KwikPen[®] will be grandfathered.

As part of this ongoing initiative, Blue Cross and BCN will continue to identify select drugs and stop covering them when there are more cost-effective or over-the-counter alternatives available for our commercial members.

Pharmacy News

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Effective July 1, Krystexxa, Stelara (SQ/IV) and Brineura are subject to a site-of-care requirement for BCN members

Starting July 1, 2018, BCN is adding the following three medical benefit drugs to its site-of-care optimization program:

Brand name	HCPCS code	Generic name
Krystexxa®	J2507	pegloticase
Stelara® (SQ/IV)	J3357, J3358	ustekinumab
Brineura™	J3490	cerliponase alfa

This requirement applies only to BCN HMOSM (commercial) members, for both first-time and current users of these medications. It does not apply to BCN AdvantageSM members.

If you feel a member isn't a candidate to receive these drugs at a site other than the outpatient hospital, you must provide documentation supporting medical necessity to the plan for review. Those requests will be evaluated on a case-by-case basis.

Requests for Krystexxa, Stelara (SQ/IV) and Brineura must meet applicable authorization criteria in addition to the site-of-care requirement.

The site-of-care program redirects members receiving select medical benefit drugs in an outpatient hospital setting to a lower-cost, alternate site of care, such as the physician's office or the member's home.

For additional requirements related to drugs covered under the medical benefit, including all drugs identified as subject to site-of-care requirements, refer to the **Medical Benefit Drugs – Pharmacy** page in the BCN section at ereferrals.bcbsm.com. Click **Requirements for drugs covered under the medical benefit – BCN HMO** under the heading "For BCN HMO (commercial) members."

The new site-of-care requirement for Krystexxa, Stelara and Brineura is included in the list.

Blue Cross, BCN will continue to cover hyaluronic acid knee and temporomandibular joint injections until further notice

Earlier this year, we notified you and members that Blue Cross Blue Shield of Michigan and Blue Care Network will no longer cover hyaluronic acids, beginning April 1.

However, we've decided to continue covering hyaluronic acids and TMJ injections while we conduct additional research on this policy. We anticipate a final decision in the next few months and will continue to update you on this critical initiative.

Members will receive letters with updated information.

Pharmacy News

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



BCN and Blue Cross won't cover certain topical lidocaine products, effective May 1

To address the high cost of drugs and provide the best value for our members, Blue Care Network and Blue Cross Blue Shield of Michigan commercial plans are making some changes to the drugs we cover.

We will no longer cover certain topical lidocaine products, effective May 1, 2018. Affected members can continue to fill prescriptions through April 30, 2018, but will be responsible for the full cost after this date.

The following table includes the products that are not covered effective May 1, and over-the-counter alternatives that are available for members without a prescription:

Prescription drug not covered beginning May 1, 2018
Lidocaine jelly 2%
Lidocaine ointment 5%
Over-the-counter alternatives
Lidocaine gel 2%, 4%
Lidocaine ointment 2%, 4%, 5%

Note: The chart above is a correction to one that was published along with an article in the March-April issue. We originally listed benzocaine as one of the drugs we don't cover, but it is not part of this exclusion.

As part of this ongoing initiative, we'll continue to identify select drugs and will stop covering them when there are more cost-effective or over-the-counter alternatives available for our commercial members.



Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Blue Cross and BCN to remove multiple sclerosis medications from the prior authorization program

Blue Cross Blue Shield of Michigan and Blue Care Network currently include MS drugs in the prior authorization program under the medical benefit. Upon further clinical review, we've decided to remove multiple sclerosis medications from prior authorization program, effective July 1, 2018. These changes will apply to the following medications:

Drug name	Generic Name	HCPCS code
Lemtrada	alemtuzumab	J0202
Ocrevus	ocrelizumab	J2350
Tysabri*	natalizumab	J2323

***Note:** In the March/April issue, we reported that Tysabri would be added to the BCN HMO medical drug prior authorization program for commercial members, starting April 1. Tysabri is now excluded from this program, **effective immediately**.

For Blue Cross and BCN members with an active authorization for one of these medications, no additional action is required by the member or provider. These changes do not apply to BCN AdvantageSM, Medicare, Medicare Advantage or Federal Employee Program[®] members.

Multiple sclerosis is an unpredictable, often disabling disease of the brain and spinal cord (central nervous system). The progress, severity and specific symptoms of MS in any one person cannot yet be predicted. A growing body of evidence indicates that early and ongoing disease treatment with disease-modifying therapy is the best way to modify the course of the disease, prevent the accumulation of disability, and protect the brain from damage due to MS.

For a full list of drugs in the prior authorization programs:

BCN HMO (commercial)

1. Go to ereferrals.bcbsm.com.
2. Select *BCN* at the top.
3. Click on the link for *Medical Benefit Drugs – Pharmacy*.
4. Click **Requirements for drugs covered under the medical benefit – BCN HMO** under the heading "For BCN HMO (commercial) members."

Blue Cross

1. Log in as a provider at bcbsm.com/providers.
2. Click *BCBSM Provider Publications and Resources* on the lower right side of the page.
3. Click *Newsletters and Resources*.
4. Click the *Forms* link in the left navigation.
5. Click *Physician administered medications*.

References:

1. Multiple Sclerosis. Mayo Clinic. Accessed on March 21st, 2018. Available at: <https://www.mayoclinic.org/diseases-conditions/multiple-sclerosis/symptoms-causes/syc-20350269>
2. Access to MS Medications. National Multiple Sclerosis Society. Accessed on March 21st, 2018. Available at: <http://www.nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Advocacy/Access-to-MS-Medications-leave-behind.pdf>

BCN clinic code policy clarified

We've received questions about clinical code billing requirements. Here's some information to help clarify the requirements for billing clinical visits for your BCN patients.

It's Blue Care Network's policy not to pay facilities for clinical visits. UB-04 claims with a revenue code of 0510-0529 will be denied with a request that the service be billed on a CMS-1500 claim form. Revenue code 0516 is exempt from clinical billing; it's classified as urgent care.

Hospitals may continue to bill for clinic services related to surgeries. Surgeries billed in conjunction with clinic codes are allowed on UB-04. Surgeries will be processed and paid.

- Cover Story**
- Network Operations**
- BCN Advantage**
- Patient Care**
- Behavioral Health**
- Quality Counts**
- Pharmacy News**

Filing requirements

All clinical claims must be received on a CMS-1500. All claims must be submitted using the appropriate procedure code.

You must also bill specific revenue codes for services provided. For example, cardiac rehabilitation should be reported with revenue code 0943. Don't submit a 0510-0519 clinic code.

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:

- Anesthesia and interventional pain procedures
- Transitional care management services



Billing Bulletin

Billing Q&A



Question:

I was told that there are new NCCI edits regarding evaluation and management services with a 25 modifier attached, when another procedure is done at the same visit. I have been seeing denials from Blue Cross for the E&M – 25 modifier that states, “The procedure code is inconsistent with the modifier used or a required modifier is missing.”

Can you clarify?

Answer:

We’ve published several articles in *BCN Provider News* over the past few years regarding this topic. The articles can be found in the Billing Section, under Clinical editing billing tips. Two are specific to modifier 25; one focuses on medical record documentation, but may be helpful to you. The articles, are as follows:

- March-April 2017: **Medical record documentation.**
- January-February 2017: **Modifier 25 – Should it be reported or not?**
- March-April 2015: Modifier 25 usage (See PDF below)

Blue Care Network continues to reinforce the appropriate use of modifier 25, following the guidelines that its use is only appropriate when the evaluation and management service reported is significant and separately identifiable from the procedure reported on the same day. We continue to review and enhance our edit on the use of modifier 25 that was implemented in 2015.

In line with coding guidelines, we expect that modifier 25 will be reported:

- On the evaluation and management code
- When the E&M is significant and separately identifiable from the procedure and both the E&M and procedure are clearly supported in the medical record documentation
- When performed by the same provider or a provider of the same specialty in the same group

While the use of modifier 25 doesn’t require different diagnosis codes, our system won’t allow a modifier 25 to override the visit edit and allow payment for the E&M without a record review when patients have repeated visits and procedures for the same conditions.

Because we don’t expect that patients with frequent office visits need both an E&M and a procedure at each visit, this edit helps to ensure the E&M reported is truly separate from the procedure and the prior visit.

If you receive one of those edits on a remittance advice (QM3), and you wish to appeal the edit, you should submit the records of the denied visit, including the services performed that day, as well as the patient’s prior E&M or face to face visit.



Modifier 25 usage



Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

Feedback

Billing Q&A, continued from Page 40

Question:

Where can we find BCN guidelines for when to bill a HCPCS code with modifier 50 and when not to?

Our facility is receiving rejections for some HCPCS codes we are performing bilaterally:

- CPT 20552*
- CPT 58661*

Answer:

Blue Care Network has general guidelines for use of modifier 50. You can find these guidelines by visiting bcbsm.com/providers.

1. Log in to Provider Secured Services.
2. Click *BCN Provider Publications and Resources*.
3. Click *Billing / Claims*.
4. Click on the document, *Appropriate modifier usage* under Clinical editing resources.

We follow national coding standards in our reviews and clinical editing practices. We don't follow one set of standards, but incorporate the various national standards, including Centers for Medicare & Medicaid Services guidelines, as well as CPT guidelines from the American Medical Association and other nationally accepted guidelines.

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. Call Provider Inquiry if your question is urgent or time sensitive. Do not include any personal health information, such as patient names or contract numbers.

As a general practice, CMS is reviewed. The CMS fee schedule indicates whether a code is allowed with modifier 50. The code is listed on the fee schedule with indicators 0, 1, 2, 3 or 9.

Indicator	Description
0	Bilateral surgery rules do not apply. Do not use 50 modifier.
1	Bilateral surgery rules apply (150%). Use 50 modifier if bilateral. Units = 1.
2	Bilateral surgery rules do not apply. Already priced as bilateral. Do not use 50 modifier. Units = 1.
3	Bilateral surgery rules do not apply. Do not use 50 modifier. Units = 1 or 2.
9	Bilateral surgery concept does not apply.

CPT code 20552* has an indicator of 0. Therefore, this code should not be reported with a 50 modifier.

CPT code 58661* has an indicator of 1 in the CMS fee schedule, but the May 2010 issue of CPT® Assistant stated:

"Code 58661 describes a bilateral procedure, which includes the excision and removal of tubes or ovaries, by any method. Therefore, if a laparoscopy and bilateral removal of ovaries or fallopian tubes are performed, it would not be appropriate or necessary to append modifier 50 to indicate the procedure was performed bilaterally. In addition, if the surgeon performs a laparoscopy with removal of an ovary or fallopian tube on one side, code *58661 would still be reported without modification."

Therefore, in alignment with this coding guidance we don't recognize modifier 50 for this procedure code.

*CPT codes, descriptions and two-digit modifiers only are copyright 2017 American Medical Association. All rights reserved.

Referral Roundup

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

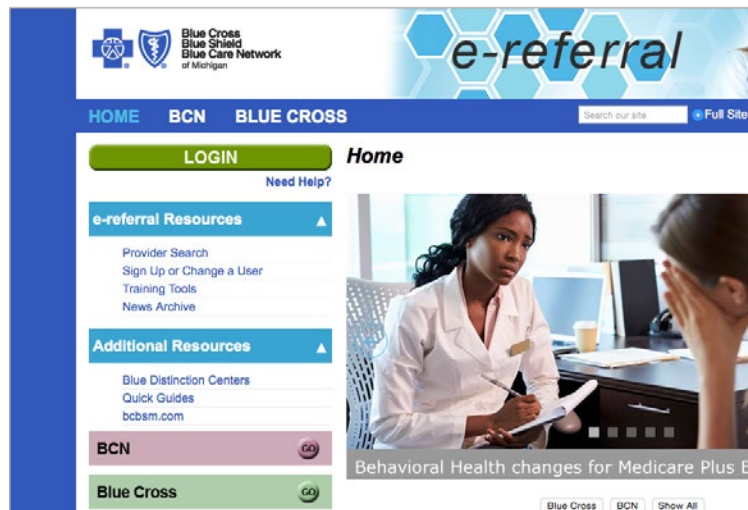
[Feedback](#)

Blue Cross and BCN e-referral systems combined, upgraded

The e-referral system has recently been upgraded to streamline and enhance users' experience. The biggest change is the consolidation of the separate Blue Cross Blue Shield of Michigan and Blue Care Network e-referral systems into one portal. Once logged into the Provider Secured Services home page, users only need to click the e-referral link to access the system for both Blue Cross and BCN cases. A new sortable "Plan" column has been added within e-referral denoting BCBSM or BCN cases. Other e-referral changes include:

- Updated language at the top of the dashboard home page
- Case communications are now sent to "Utilization Management" instead of "Care Management"
- All references to BCN contact information have been removed from the Contact Us page

The **e-referral User Guide** and **e-Learning modules** have been updated on the **Training Tools** page of **ereferrals.bcbsm.com** to reflect these changes.



eviCore to handle BCN initial and follow-up authorization requests for PT, OT and ST starting later in 2018

Later this year, providers who now submit their initial authorization requests for physical, occupational and speech therapy, or for physical medicine services by chiropractors, through the e-referral system or by calling BCN will submit these requests through eviCore healthcare's provider portal instead.

At the same time, requests to authorize follow-up services will also be submitted through the eviCore provider portal instead of through the Landmark Healthcare portal.

This change will apply to requests for BCN HMOSM (commercial) and BCN AdvantageSM members and to the following providers:

- Facilities
- Therapists performing physical, occupational and speech therapy
- Chiropractors performing physical medicine services
- Referring physicians
- Podiatrists

In addition, BCN is working with eviCore to implement the corePathSM authorization model for these requests for BCN HMO (commercial) and BCN Advantage members. corePath will streamline the authorization process and make it easier for providers to submit authorization requests. It's the same model that was implemented for Blue Cross Medicare Plus BlueSM PPO authorization requests starting Jan. 1, 2018.

More details about these changes will be provided in the coming months.

Referral Roundup



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Use the flight information form for non-emergency air ambulance authorization requests

As a reminder, effective for dates of service on or after April 2, 2018, all non-emergency air ambulance transports for Blue Cross Blue Shield of Michigan PPO (commercial) and Blue Care Network HMOSM (commercial) members require authorization.

Requests to authorize non-emergency flights must be submitted to and approved by Alacura Medical Transportation Management, LLC, prior to the flight. This requirement applies to both in-state and out-of-state air ambulance transports.

Emergency flights — when the patient cannot safely wait six hours to take off — do not require authorization. This includes situations that involve delays due to weather or stabilizing the patient. When it's an emergency, just transport the patient.

How to request an authorization for non-emergency flights

To contact Alacura about authorizing a non-emergency flight request, do the following:

1. Complete and fax the **Air ambulance flight information (non-emergency)** form, along with clinical documentation in support of the request, to 1-844-608-3572.
2. Call Alacura at 1-844-608-3676 to obtain an authorization number.

Reason for authorization requirement

Air ambulance transports that are not medically necessary or are flown by non-contracted providers expose Blue Cross and BCN members to significantly greater out-of-pocket costs and are much costlier for the plan. The requirement for authorization prior to non-emergency flights is expected to lower costs for Blue Cross and BCN members and customers.

Additional information

Additional details about this change are available in the original articles published on this topic:

- In the March 2018 issue of *The Record*.
- In the March-April 2018 issue of *BCN Provider News*, Page 41.

Referral Roundup

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

Respondents to physician satisfaction survey suggest referrals, appeals improvements

Practitioners who responded to our 2017 physician satisfaction survey show you're mostly satisfied with Blue Care Network's Utilization Management and Case Management services.

Overall, satisfaction ratings ranged from 50 percent satisfaction with overall medical director consideration of your problems to 85 percent with timeliness of our review decisions.

Responses and comments also tell us we still have some things to work on. Here are the topics that received the most comments and our responses to suggestions you made with these processes:

- **Referral process:** An updated *e-referral User Guide* was updated for 2017 on the *Training Tools* page. Self-paced e-learning modules were used by 41 percent of respondents, conferring general "pretty straight forward" comments. Go to the **e-referral** home page to view these and other tools and resources.
- **Authorization process:** BCN's e-referral home page contains the link to the referral and authorization requirements document as well as online tools. Respondents repeatedly request better timeliness of decisions and want a fax option for smaller facilities. We are looking at ways to increase the timeliness of reviews when possible. We're evaluating services that require authorization to determine necessity.
- **Appeals process:** We're conducting further research to determine how to ensure clarity and effortless use of the appeal process. Survey responses are clear that better communication throughout the process needs improvement. It's been noted frequently that required information is missing from the request, then later submitted for the appeal. To mitigate this, and improve provider education, an initiative to post a document on web-DENIS and work with vendors is underway. Denial letters and the *BCN Provider Manual* have instructions on the appeal process

About the survey

The survey was conducted last fall. The 2017 physician satisfaction survey was available electronically on our website during October, November and December 2017. More than 700 practitioners participated and qualified for our drawing to win one of two \$250 gift cards. We chose two winners in a random drawing.

The survey questions were designed to gather information about how you use utilization and case management services and to measure your satisfaction with each of the eight functional units within Care Management.

- Referral process
- Admission and concurrent review process
- Care coordination process for BCN Advantage
- Clinical review (now called authorization review) process
- Plan medical directors
- Complex case management program
- Chronic condition management program
- Provider appeal process

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.

We also offered you the chance to tell us what Blue Care Network could do to improve your satisfaction with our programs. Your comments provide valuable information about your experience with us and guide us in our efforts to improve our services.

We value your opinion and welcome your feedback about our processes and programs. It helps us identify ways to improve our services.

Index

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

INDEX: May–June 2018

BCN Advantage

Most BCN Advantage services do not require referrals **Page 8**
 BCN Advantage has special rules for local networks **Page 8**
 Medicare Advantage Diagnosis Closure Incentive program continues in 2018 **Page 9**
 BCN Advantage encourages members to speak to their physicians about exercise, mental health **Page 10**
 How health care providers are helping Blue Cross reach for the stars **Page 11**
 Reminder: Medicare patients at risk for Type 2 diabetes eligible for new diabetes prevention program **Page 13**

Behavioral Health

Blue Care Network pilots substance abuse treatment protocol with two hospital partners **Page 23**
 Starting July 1, we'll only accept electronic submissions for the 2018 Behavioral Health Incentive Program **Page 24**
 Blue Care Network now gives members access to in-home long-acting injectable program **Page 25**

Billing Bulletin

Coding Corner **Page 39**
 Clinical editing billing tips **Page 39**
 BCN clinic code policy clarified **Page 39**
 Billing Q&A **Page 40**
 Have a billing question? **Page 41**

Network Operations

Blue Cross and BCN consultant model will bring long-term benefits to providers **Page 1**
 Consultant Model **Page 1**
 Blue Care Network won't accept late claims, effective July 1 **Page 1**
 long-term benefits **Page 1**
 Provider forums coming to a town near you **Page 3**
 Blue Care Network now covers digital breast tomosynthesis **Page 3**
 Blue Cross designates centers of distinction for expectant parents **Page 4**
 Blue Cross designates top bariatric treatment centers **Page 5**
 CAQH ProView application reminders **Page 6**
 Medical residents: Here's how you can join our network **Page 7**
 Blue Cross and BCN's newborn coverage policy changes **Page 7**

Patient Care

Communicating screening and treatment options for prostate cancer **Page 14**
 Diagnosis and treatment of cancer **Page 15**
 Blue Care Network promotes continuity of care in some situations **Page 16**
 Blue Care Network promotes coordination of care with specialists **Page 17**

Medical record guidelines policies require providers to maintain member records **Page 17**
 Hypertension is Michigan's top health problem **Page 18**
 Michigan's top 10 health concerns **Page 18**
 Men's health is being celebrated internationally June 11-17, 2018 **Page 19**
 Do your patients have unused pills sitting at home? What you should tell them **Page 20**
 Help patients find a local opioid drop-off location **Page 20**
 How to dispose of medicines in the household trash **Page 20**
 Mi-CCSI offers basic and advanced pain management training **Page 21**
 Provider resources available for CDC opioid prescribing guideline **Page 21**
 Referral to BCN not needed for diabetic retinopathy exam **Page 22**
 Medical policy updates **Page 22**

Pharmacy News

MAPS using new technology platform to help providers make better decisions about substance use disorders **Page 33**
 Effective June 1, there are new state requirements for MAPS **Page 33**
 Reminder: Fax numbers changed for BCN medical benefit drug authorization requests **Page 34**
 Blue Cross and BCN now cover Shingrix shingles vaccine **Page 34**
 Blue Cross and BCN won't cover select insulins, effective June 1 **Page 35**
 Effective July 1, Krystexxa and Stelara (SQ/IV) are subject to a site-of-care requirement for BCN members **Page 36**
 Blue Cross, BCN will continue to cover hyaluronic acid knee and temporomandibular joint injections until further notice **Page 36**
 BCN and Blue Cross won't cover certain topical lidocaine products, effective May 1 **Page 37**
 Blue Cross and BCN to remove multiple sclerosis medications from the prior authorization program **Page 38**

Quality Counts

Follow-up appointments for ADHD focus on medication effectiveness, education and compliance **Page 26**
 Report focuses on health care disparities by race and socioeconomic status **Page 28**
 Do your patients have a COPD action plan? Tips to improve HEDIS measures **Page 30**
 Discuss medication adherence with patients **Page 30**
 Saving lives through better maternal health **Page 31**
 Reminder: MQIC releases new guidelines for opioid use in adults **Page 32**

Referral Roundup

Blue Cross and BCN e-referral systems combined, upgraded **Page 42**
 eviCore to handle BCN initial and follow-up authorization requests for PT, OT and ST starting later in 2018 **Page 42**
 Use the flight information form for non-emergency air ambulance authorization requests **Page 43**
 Respondents to physician satisfaction survey suggest referrals, appeals improvements **Page 44**
 About the survey **Page 44**

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45