

# BCN Provider News



*Dr. Christine Jones and patient John Boyer*

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index

## Best Practices: Partnering with patients helps them adopt healthier lifestyles

*An interview with Dr. Christine Jones, Ann Arbor*

**Question: How do you make sure BMI is documented for all your patients according to HEDIS?**

**Dr. Jones:** In our office, it's standard to obtain a height, weight, and calculated BMI at each patient visit as part of the vitals. The BMI value flows to the patient plan at least once yearly, with provider instructions to help promote healthy lifestyle modifications when necessary.

Please see [Best Practices](#), continued on Page 2

## BCN is updating its clinical editing system

We're replacing the current Change Healthcare (previously McKesson) ClaimCheck® software with the company's enhanced clinical editing solution, ClaimsXten, in the third quarter of 2018.

BCN has had a long relationship with Change Healthcare, with ClaimCheck software integrated into our claims payment system. ClaimCheck is one of the tools that has allowed us to better align payment policy with national rules and coding guidelines. But health care is constantly changing and requires faster, more flexible business applications.

ClaimsXten is a valuable tool that can help meet these challenges, deliver appropriate outcomes and move BCN to the next stage of readiness in health care. The new software will:

- Improve the accuracy of the BCN payment policy application
- Provide enhanced technical functionality
- Improve overall claims management
- Assist with maintaining a consistent payment policy in alignment with state and national mandates

We'll provide more information about ClaimsXten in a future issue of *BCN Provider News* or on web-DENIS.

Inside this issue...

**04** Healthy *Blue Living* reminders

**15** State opioid commission releases prescribing guidelines

**23** BCN offers incentive for primary care physicians to provide medication-assisted treatment

**31** Coding corner: Coding for immunosuppression and immunodeficiency

## Feedback | [Subscribe](#)

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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

# 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](#)

**Best Practices**, continued from Page 1

**Question: How frequently do you recommend follow-up for patients with high BMI?**

**Dr. Jones:** For a BMI between 25 and 30, I like to see a patient every six to 12 months, especially if the person has medical comorbidities. If the BMI is 30 or higher, I try to follow up with the patient more regularly, every three to six months or as often as they need medical and emotional support on their weight-loss journey.

**Question: How do you approach conversations about losing weight?**

**Dr. Jones:** I aim to establish a partnership with my patients. I encourage lifestyle modifications by way of a balanced, healthy diet and regular exercise program to help achieve weight loss goals. I often refer patients to mobile support programs like MyFitnessPal for calorie tracking, or FitBit technology to monitor steps. For certain individuals, the creation of a personal 60-second video on their smartphone is a very effective motivational tool. I request that patients record a brief video for their eyes only, stating why weight loss is important to them; it has to be something so powerful that the video evokes emotion, and often nearly brings them to tears. Examples include a desire to be alive for a child’s wedding, staying healthy enough to take the trip of a lifetime, or trying to avoid multiple lifelong

medications or specific adverse health outcomes. On days where it is difficult to adhere to a diet plan, exercise program, or both, I ask patients to watch their video to remind them why their personal weight-loss goal is so important, which often allows people to stay focused and inspired by self-motivation.

**Question: How do you educate patients about long-term consequences?**

**Dr. Jones:** My goal and approach is to empower patients to make healthy lifestyle decisions, and I serve as their accountability partner when needed. I educate patients about the potential long-term consequences of obesity, which can include metabolic syndrome, clinical diabetes mellitus, hypertension, cardiovascular disease, sleep apnea, and a multitude of other health complications. By reviewing lab results and their potential implications with patients, and encouraging them to make changes that could minimize or eliminate the need for lifelong medication or serious interventions, most patients are enthusiastic about setting goals for weight loss.

Please see [Best Practices](#), continued on Page 3

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12  
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21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36

# 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](#)

**Best Practices**, continued from Page 2

**Question:** You mentioned partnership earlier. Is it your goal to partner with your patients or for them to find a weight-loss loss partner?

**Dr. Jones:** At the end of a patient appointment or physical, if their BMI is greater than 30, I will often state that their primary health goal for the year should be weight loss. I offer to serve as their accountability partner if they wish to return for periodic weight checks, nutritional counseling, or vital sign evaluation and laboratory monitoring. I help them understand that I will encourage and congratulate their successes, and even support them through setbacks, but ultimately I am only responsible for a minimal part of their weight-loss story; the rest is up to them and what they do after they leave the office. I have patients who have minimized their A1c values as though they were on insulin with clean eating and exercise, I have patients who have lost weight equal to that achieved with bariatric surgery without ever going under the knife. Each patient is different, and it is often a matter of saying the right thing to the right person at the right time that eventually resonates. Weight loss requires ongoing discussions with frequent revisions of goals and “reasons why” and attention to each small success.

**Question:** Do you have any other thoughts or recommendations?

**Dr. Jones:** As a physician, my job is to promote healing and encourage patients to achieve wellness within a spectrum of evidence-based medicine and clean living. It is a privilege to work with people toward their weight-loss goals. Altering eating habits by avoiding “white foods” like bread, pasta, rice, potatoes, etc. and minimizing drinkable calories like juice, soda, and alcohol are measures that can create dramatic change. Most people understand that it is best to shop the perimeter of the grocery store for health benefits, as well. One day at a time, the realization of small goals tends to have cumulative benefits and engender positive outcomes, which empowers patients to feel proud of their achievements and remain motivated to set an example for others.



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22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



## Healthy *Blue* Living reminders

We've experienced some missed deadlines this year for our Healthy *Blue* Living<sup>SM</sup> plan and want to prevent our members from being penalized for missing deadlines for examinations and qualification form submissions, as required by the plan. Here's how you can help:

- Providers must submit each member's completed qualification form electronically into Health e-Blue<sup>SM</sup> within the first 90 days of the plan year, for our Healthy *Blue* Living members, even if the member doesn't bring his or her qualification form to their visit with you.
- Enter the information from the qualification form electronically into Health e-Blue. We don't accept faxed forms. If you don't have access to Health e-Blue, contact Provider Inquiry at 1-800-344-8525.
- You must conduct the physical exam within the last 180 days of the eligibility effective date or renewal date in order for the data to be used for the qualification form. For example, if the member renews in January and has

already had a physical in November, the lab values and results from that examination may be used to complete the form.

- Please try to accommodate members so their physical exams for Healthy *Blue* Living can be performed in the first 90 days of the plan year. Failure to submit the qualification form by the deadline results in increased out-of-pocket costs for the member.
- Make sure that all members who deny tobacco use have at least one negative cotinine test on file. Include the test type and result when submitting the form.
- We do not limit the number of physical exams for BCN members in a year.

## Blue Care Network updates professional fees July 1

Blue Care Network will update fee schedules, effective with dates of service on or after July 1, 2018. This change applies to services provided to BCN HMO commercial members.

We'll use the 2018 Medicare resource-based relative value scale for most relative value unit-priced procedures for dates of service on and after July 1.

Changes in resource-based relative values can affect fees. Procedure code maximum fees will increase or decrease based on the new relative value units and Blue Cross Blue Shield of Michigan or BCN conversion factors.

In alignment with Blue Cross, the conversion factor used to calculate anesthesia base units for anesthesia procedures will remain at \$58.65 throughout Michigan.

Blue Cross conducts a comprehensive analysis of professional provider performance and current economic indicators annually to calculate practitioner fees, with consideration for corporate and customer cost concerns.

Blue Cross and BCN remain committed to reviewing professional provider performance to determine the need for increases or decreases in our maximum payments.

Only claims submitted with dates of service on or after July 1 will be reimbursed at the new rates.

Note: The Blue Cross Physician Group Incentive Program allocation of professional fees will increase from 5 to 7 percent for fees effective on or after July 1. This component continues to be excluded from BCN professional fees.



## Helpful hints to expedite your Provider Secured Services application

Use the following guide while completing an **application for Provider Secured Services**. These section-by-section hints help you fill out the application accurately, which helps us process your application and give you faster access to the portal.

### Section 1 — Applicant demographics

- We need **all** information requested in this section to process the application.
- Fill out this section in its **entirety** and **electronically** (we can't process hand written data).
- The address must be the user's physical location. (A post office box is invalid.)
- If the practice has multiple locations, give the actual, physical location of the specific user.
- If there's a specific suite number in the user's address, include it here, too.
- The *Use and Protection Agreement* is also within the application document; send it with each application.
- The practice's name must match on both the Provider Secured Services application and the *Use and Protection Agreement*.
- Send **all** pages of both the application and *Use and Protection Agreement* to us.

### Section 2 — Clone IDs

- If your practice doesn't have access to Provider Secured Services, leave this section blank.
- If your practice has Provider Secured Services access, cloning a user ID will give new users the same PINs that are assigned to it currently, but it doesn't duplicate its access (the access request is in *Section 6*).
- Only the user ID that needs cloning goes in *Section 2*.
- If you've listed a clone ID in *Section 2*, **leave Section 4 blank**.

### Section 3 — e-Referral

- For offices requesting *e-Referral* access for the first time, leave *Section 3* blank.
- If your office has *e-Referral* access, add your set ID here.
- No other information should be in this section.

### Section 4 — New access NPIs

- This is where you add NPIs when there's no user ID listed for cloning in *Section 2*.
- If you've put a clone ID in *Section 2*, leave this section blank.
- If your office needs access to more NPIs than space allows in this section, fill out an additional page and attach it to the application.
- If your office has existing users that need additional PIN access, submit the ***Authorization to Modify BCBSM and or BCN Provider Codes on your Provider Secured Services ID***.

### Section 5 — Health e-Blue access

- *Health e-Blue* helps you generate reports about patient health and helps you fill out Healthy Blue Living<sup>SM</sup> qualification forms.
- Specialty and mental health providers don't qualify for *Health e-Blue* access.
- Add users or remove access by submitting an ***Authorization to Add/Remove access for BCN, MAPPO, Commercial Health e-Blue*** form.

# 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](#)

Provider Secured Services application, continued from Page 5

## Section 6 — User features

- List all users' names, phone numbers and select the access features each user needs.
- We can't create a user ID without a user phone number.
- A user phone number is mandatory, and it must be the practice phone number, not the user's personal cell number.

Access features include:

- **Claims Tracking & EFT** — This access allows Blue Cross Blue Shield of Michigan and Blue Care Network providers and facilities the ability to track claims and receive electronic funds deposits and vouchers online.
  - **BCN PCP Claims Summary** — Access to this feature allows BCN primary care physicians the ability to view BCN claim summaries.
  - **E-referral** — Allows users to submit and review referrals
  - **Health e-Blue** — Allows users to view patient information about gaps in care and make updates to patient health information online. BCN PCPs also use this feature to enter *BCN Qualification Form* details for Healthy *Blue Living*<sup>SM</sup> HMO members.
  - **Medical Drug PA** — Allows physicians to complete medical drug prior-authorization requests online (only Type 1 NPIs qualify for this access).
- Behavioral Health providers don't qualify for *BCN PCP Claims Summary* or *Health e-Blue*.
  - If new users only need access to eligibility, don't check any of the access boxes in this section.
  - As a reminder, if the user is only requesting eligibility access, there shouldn't be a user ID (for cloning) in *Section 2* or NPIs listed in *Section 4*.

## Section 7 — Authorization

- This section is mandatory. Fill it out completely.
- Make sure the authorized signer's printed name matches his or her signature.
- Fill in the *Date* field.
- If the name and signature don't match, or the name and signature is missing, we'll return your application for correction. This will delay the processing of your application.
- **We don't accept stamped signatures. We'll return applications to you for correction.**

If you have any questions while completing these forms, please contact the Web Support Help Desk at 1-877-258-3932, Monday through Friday, from 8 a.m. to 8 p.m. Eastern time.





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

Blue Cross Blue Shield of Michigan and Blue Care Network corporate offices are closed on Wednesday, July 4 for Independence Day and Monday, Sept. 3 for Labor Day.

During holiday closures, BCN's inpatient utilization management area remains available to accept inpatient authorization requests for BCN HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members.

Here's what you need to know about submitting inpatient authorization requests when our corporate offices are closed.

### Acute initial inpatient admissions

Submit these authorization requests through the e-referral system, which is available 24 hours a day, seven days a week.

### Post-acute initial and concurrent admission reviews

Follow the current process you use to submit these requests by fax at 1-866-534-9994.

### Other authorization requests

The requests listed below must be submitted by fax:

- Acute inpatient concurrent reviews and discharge dates, but only for facilities reimbursed on the basis of DRGs
- Authorization requests for sick or ill newborns
- Requests for enteral and total parenteral nutrition

For these requests, we accept faxes from midnight on Sunday through 4 p.m. on Friday. We don't accept faxes on weekends. Fax BCN HMO (commercial) requests to 1-866-313-8433. Fax BCN Advantage requests to 1-866-526-1326.

### Additional information

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

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

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

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

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



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

## What you need to know about Medicare fraud, waste and abuse

Medicare, through BCN Advantage<sup>SM</sup>, pays doctors, hospitals, pharmacies, clinics and other health care providers to care for certain people who need help getting medical care. Sometimes, providers and patients misuse Medicare resources, leaving less money to help people who need care. This misuse falls in the following categories: fraud, waste or abuse.

### Definition of fraud

Fraud is intentional deceit or misrepresentation of the truth that results in some extra cost to the health care system. Fraud schemes range from those committed by individuals acting alone to broad-based activities by institutions or groups of individuals. Seldom do these schemes target only one insurer or the public or private sector exclusively. Most are simultaneously defrauding several private and public-sector victims, including Medicare and Medicaid. Medicare health care fraud is defined in Title 18, United States Code (U.S.C.) § 1347, as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

### Definition of abuse

Abuse occurs when a provider or a patient behaves in a way that is inconsistent with sound business or medical practices, resulting in an unnecessary cost to the Medicare program. Abusive practices can involve payment for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

### Differences between fraud and abuse

Fraud is distinguished from abuse in that there is clear evidence that fraudulent acts were committed knowingly and intentionally. Abusive practices, on the other hand, may not be intentional or it may be impossible to show that intent existed. Although these types of practices may initially be classified as abusive, they may develop into fraud if there is evidence that the provider or patient was intentionally conducting an abusive practice.

### Definition of waste

Waste describes the outcome from practices that result in unnecessary costs to the health care system, but generally do not involve intentional or criminally negligent actions. Waste can result from poor or inefficient billing or treatment methods, for example.

Minimizing fraud, waste and abuse means the federal government, through BCN Advantage, can provide more care to more people and make the Medicare program stronger.

Please see [Medicare fraud, waste and abuse](#), continued on Page 9



- 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





**Medicare fraud, waste and abuse**, *continued from Page 8*

**Fraud, waste and abuse prevention**

See our policy and applicable laws on web-DENIS under *BCN Provider Publications and Resources*. Click on *Policies and Information* and then *Detection and Prevention of Fraud, Waste and Abuse Policy*. Information on fraud, waste and abuse can also be found in the *BCN Provider Manual*.

BCN Advantage HMO-POS<sup>SM</sup> and BCN Advantage HMO<sup>SM</sup> providers and members can report fraud and abuse to the anti-fraud hotline for Blue Cross Blue Shield of Michigan at 1-888-650-8136.

You may also contact the Office of Health Services Inspector General at 1-800-HHS-TIPS (1-800-447-8477) or on line at [Medicare.gov/fraud](http://www.Medicare.gov/fraud).

In writing, contact:

Office of Inspector General  
 Attention: OIG Hotline Operations  
 P.O. Box 23489  
 Washington, D.C. 20026

**Fraud, waste and abuse compliance training**

The Centers for Medicare and Medicaid Services requires annual training to detect, prevent, and correct fraud, waste and abuse.

All providers and their employees, contractors, governing bodies and downstream entities who partner with Medicare Advantage organizations and prescription drug plans are required to take the training. New hires need to complete the training within 90 days of being hired and then annually.

Records of the training, including participant names, must be retained and available for inspection upon request for 10 years after the end date of the contract with Blue Cross Blue Shield of Michigan or Blue Care Network.

See our [website](#) for more information and how to get to the training.

**Notice of Medicare Noncoverage for BCN Advantage members**

Medicare regulations require providers to use the approved Medicare form, *Notice of Medicare Non-Coverage*, to notify BCN Advantage<sup>SM</sup> members in writing, that BCN Advantage or the provider has decided to end their covered skilled nursing facility or home health agency care. The form also provides notification to the member of the right to expedite the appeal if they disagree with the decision to end covered services.

BCN must receive copies of all NOMNC forms signed by the member.

We're required to provide copies of signed NOMNC forms during Medicare audits. As we prepare for the audits, we find that not all providers have a complete understanding of Medicare regulations or BCN's process to ensure compliance.

Medicare regulations require that providers deliver the NOMNC form to members at least two days before covered services end at skilled nursing facilities, and at least two days before the last services end from home health agencies.

The form should only be given to members when skilled nursing facility criteria are no longer met and no further days are authorized by BCN, or two days prior to a scheduled discharge date.

It's important to use the correct **NOMNC form** approved by Medicare that includes:

- The date that covered services are expected to end
- The date that the member's financial liability begins
- A description of special appeal rights for members that allow a fast-track appeal if the member disagrees with the decision to end covered services
- Detailed instructions about how the member may request an immediate appeal directly to KEPRO (Michigan's QIO) including their address and phone number
- Instructions to the member about how to request an expedited review from BCN if they miss the deadline to file for review from KEPRO
- The date of the member's signature

# BCN Advantage

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



## NOMNC, continued from Page 9

Please note that BCN may issue a next review date when authorizing skilled nursing services. The next review date doesn't mean BCN is denying further coverage. Submit an updated clinical review on the next review date. If upon review of the updated clinical information a denial decision is given, BCN allows for two additional days for the provider to supply the member with the NOMNC.

If there is a change in the member's condition after the NOMNC is issued, both BCN Advantage and providers should consider the new clinical information. If the effective date of coverage end date changes, providers should inform the member that services will continue. The provider must then inform the member of the new coverage end date either through delivery of a new or amended NOMNC at least two days before services end.

BCN values our partnership with our contracted providers. We trust that our providers will adhere to the provisions in our contract and continue to provide us with the required Centers for Medicare & Medicaid Services NOMNC forms.

**Note:** Contracted facilities should use the appropriate **NOMNC forms**, available in PDF or Word format on BCN's e-Referral home page or Web DENIS.

Providers should insert their name, address and phone number in the spaces provided at the top of the form. NOMNC forms with the BCN Advantage logo at the top should not be used by SNF or home care agency providers.

## Some important facts about the NOMNC

- BCN is required to ensure compliance to Medicare regulations by BCN Advantage contracted providers.
- Medicare requires that SNF and HHA providers deliver the NOMNC form to *all* members at least two days before covered services end, whether the member agrees with the plan to end services or not.
- BCN encourages providers to deliver the NOMNC no earlier than four days prior to the last day that covered services end.

Members need to sign and date the form, acknowledging its timely delivery. If members refuse to sign the form, the facility must document the time and date it was delivered to the member.

Providers are expected to keep a copy of the signed NOMNC form and fax a copy to BCN Care Management at 1-877-372-1635, Attention: Medical Records.

For more information about the form see the BCN Advantage chapter of the *BCN Provider Manual*.



# Blue Care Network's Care Transition program helps BCN Advantage patients transition to home

Our Care Transition program is a free service that helps BCN Advantage<sup>SM</sup> patients transition from hospital to home. It also provides education and support to help them get well and stay healthy.



Returning home from the hospital can be overwhelming and stressful. People have questions about their care and are unsure of how to take care of themselves and manage their illness after they return home. By providing care coordination, education and support, our care coordinators can help

your patients safely transition from hospital to home and avoid returning to the hospital or emergency department.

After we're notified of your patient's hospitalization, our care coordinators may contact the patient during his or her hospital stay to introduce the program and discuss next steps.

Through follow-up calls once the patient is home, the care coordinator can:

- Arrange timely follow-up with the doctor and obtain transportation, if needed
- Provide tips to manage medications
- Explain hospital discharge instructions and how to manage any conditions
- Discuss signs and symptoms of possible complications and what to do next
- Coordinate needed tests, services or equipment, or arrange home health care
- Offer other health services and related programs to support the member in the home
- Provide available community resources
- Recommend preventive health screenings, lab tests and other services

To learn more about our Care Transition Program or to speak to a care coordinator, call 1-800-775-2583, from 8 a.m. to 5 p.m., Monday through Friday.

## Starting Aug. 7, Fasenra and Luxturna require authorization for Medicare Advantage members

For dates of service on or after Aug. 7, 2018, authorization is required for the following Part B specialty drugs covered under the medical benefit:

- Fasenra<sup>TM</sup> (benralizumab)
- Luxturna<sup>TM</sup> (voretigene neparvovec-rzyl)

See the article on [Page 29](#) for details

# 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](#)

## Starting Oct. 1, additional specialty medications require authorization for BCN Advantage members

For dates of service on or after Oct. 1, 2018, additional specialty medications covered under the Medicare Part B medical benefit require authorization for BCN Advantage<sup>SM</sup> members. The brand names and HCPCS codes for these medications are:

- Actemra<sup>®</sup> – J3262
- Aredia<sup>®</sup> – J2430
- Benlysta<sup>®</sup> – J0490
- Cimzia<sup>®</sup> – J0717
- Entyvio<sup>®</sup> – J3380
- GamaSTAN<sup>®</sup> (1 mL) – J1460
- GamaSTAN<sup>®</sup> (over 10 mL) – J1560
- Krystexxa<sup>®</sup> – J2507
- Nplate<sup>®</sup> – J2796
- Orencia<sup>®</sup> – J0129
- Privigen<sup>®</sup> – J1459
- Simponi Aria<sup>®</sup> – J1602
- Soliris<sup>®</sup> – J1300
- Spinraza<sup>®</sup> – J3490
- Vivaglobin<sup>®</sup> – J1562
- Xolair<sup>®</sup> – J2357

See the article on [Page 28](#) for details



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

Patient Care

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



## It's not too early to prepare for next flu season

By Dr. Felecia Williams



Influenza vaccine is typically available by September — less than three months away. It would be great if we had a universal flu vaccine that would cover most strains of the flu. But until one is developed, we must remain vigilant in following the recommendation of universal flu vaccination.

In 2010, the Centers for Disease Control and Prevention released a comprehensive update on flu vaccination. The updated

recommendation was for universal flu vaccine for individuals six months and older and was based on the CDC's Advisory Committee for Immunization Practices. The CDC launched a campaign to educate health care providers and the public about the new recommendations and the benefits of vaccination as well as to dispel myths about the flu vaccine.

### Vaccination rates are suboptimal

Despite these efforts, flu vaccinations rates have not increased appreciably over the last seven years. It is estimated that 38 percent of the population had received flu vaccine by early November 2017 — similar to November 2016 rates. While the 2017 – 2018 estimated flu vaccination rates won't be available until September, it's likely that they'll be similar to the 2016 –2017 season's rate of 48.6 percent. There is also an opportunity to improve vaccination rates for health care providers which are typically under 70 percent.

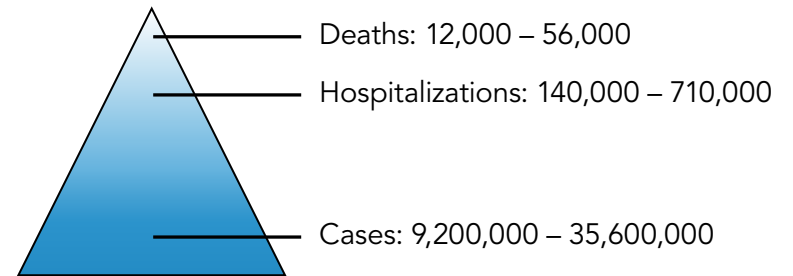
### Vaccine effectiveness

Flu vaccine normally provides 50 to 60 percent protection. Unfortunately, during this past flu season we saw a perfect storm. H3N2, which was the predominant strain affecting individuals, can be particularly virulent and associated with complications. H3N2 is more pervasive due to lack of immunity to this strain. Lastly, a mutation of the H3N2 strain resulted in decreased immunity in individuals against the H3N2 strain for those who received the egg-grown vaccine. These factors resulted in a vaccine that was only 20 to 30 percent effective.

### Disease burden and economic costs

In addition to disease burden, the economic impact of influenza is staggering – \$10.4 billion in direct medical costs and \$16.8 billion in lost earnings annually. The estimated total economic burden of Influenza is thought to be \$87 billion.

#### Disease Burden of Influenza



Source: <https://www.cdc.gov/flu/about/disease/burden.htm>

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 13*

### Providers can improve vaccination rates

Health care providers can have a significant impact on immunization rates by educating patients about the benefits of vaccination, encouraging vaccination, removing barriers to vaccination and addressing vaccination myths.

- Provider recommendation and reinforcement is a powerful motivator to vaccination. Patients tend to value and respect health care providers' recommendations.
- Everyone's busy, so verbal or written patient reminders are essential. If available, using the patient portal of the EMR to send alerts can motivate patients to return for vaccination. Depending on the demographics of your practice, it might be effective to send a text message to notify patients that flu vaccine is available.
- Provider recall and reminder messages can also improve immunization rates.
- Use all patient encounters to eliminate missed opportunities. Patients' immunization status should be assessed at every encounter, including non-face-to-face encounters. If no true contraindications exist, immunizations should be encouraged. Engaging and educating all office staff and implementing standing orders can prevent missed opportunities.
- Reducing physical barriers to vaccination by:
  - Allowing patients to walk-in for vaccinations
  - Offering extended hours and weekend hours
  - Minimizing waiting times
  - Reminding patients that Blue Cross Blue Shield of Michigan and Blue Care Network allow members to receive flu vaccine as well as other vaccine at retail pharmacies

### Help dispel vaccination myths

Educate patients about the flu vaccine by telling them the following:

- The flu shot (inactive virus) does not cause the flu.
- Patients need a flu vaccine prior to every flu season as a universal vaccine has not been developed.
- The flu vaccine is beneficial and, while its effectiveness varies, influenza-related illness can cause serious morbidity and mortality.
- Pregnant women should be vaccinated.
- High dose vaccine is recommended for individuals 65 years and older.
- The most common side effects are injection site pain and discomfort .
- While antibiotics will address a secondary bacterial infection, they do not cure the flu.
- Flu vaccine should be given by the end of October but it can be effective even when given well into the flu season.
- Just because you haven't experienced the flu in the past doesn't mean you're immune from getting the flu.
- Studies have proven that flu vaccines are safe.
- Individuals with underlying conditions or chronic illness are at risk for flu-related complications and death. Flu also causes death in healthy individuals.
- Lastly, advise patients regarding signs and symptoms and when to seek medical attention.

While we hope the upcoming flu season will be milder than the 2017 – 2018 epidemic, we encourage health care providers to begin conversations about influenza early and to do so often in an effort to improve vaccinations rates and decrease the burden of disease.

References: [CDC www.cdc.gov](http://www.cdc.gov)

# Patient Care



## State opioid commission releases prescribing guidelines

The Michigan Prescription Drug and Opioid Abuse Commission recently released their prescribing recommendations. They can be viewed by clicking on the PDFs at the right.

The recommendations are for dental, emergency departments and surgical departments. These guidelines are a summary of best practices and do not replace individual clinical judgement.

The recommendations were developed by the Commission in partnership with the Opioid Prescribing Engagement Network, known as M-OPEN, and the University of Michigan Injury Prevention Center.



*Acute Care Opioid Treatment and Prescribing Recommendations – Dental*



*Acute Care Opioid Treatment and Prescribing Recommendations – ED*



*Acute Care Opioid Treatment and Prescribing Recommendations – Surgical*

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## SAMHSA publishes clinical guidance to help broaden health care professionals' understanding of medications to treat opioid use disorder



Substance Abuse and Mental Health Services Administration, known as SAMHSA, has published new **guidance** to help expand health care providers' understanding of using medications to treat people with opioid use disorder. Treatment Improvement Protocol (TIP) 63, *Medications for Opioid Use Disorder*, reviews the use of the three U.S. Food and Drug Administration-approved medications to treat opioid use disorders:

- Methadone
- Naltrexone
- Buprenorphine

TIP 63 is the latest in a series of topic-specific, best-practice guidelines that SAMHSA has developed as part of its effort to combat the nation's opioid crisis. These guidelines give health care professionals up-to-date practices for treating opioid use disorder.



## Blue Cross develops opioid resource guide for employers

### Patient Care

Blue Cross Blue Shield of Michigan has developed an opioid resource guide to help employers navigate the opioid epidemic. It includes a wide range of information including flyers on the following topics:

- Opioid 101 — key facts about opioids and how to prevent opioid misuse
- Medication safety, storage and disposal
- List of opioid resources

To access it, go to [bcbsm.com/engage](https://bcbsm.com/engage) and scroll down to “Opioid resources.”

See our new website, [mibluesperspectives.com/opioids101](https://mibluesperspectives.com/opioids101), which includes resources for employers, tools for safe storage and disposal and a community action plan.

### Cover Story

### Network Operations

### BCN Advantage

### Patient Care

### Behavioral Health

### Quality Counts

### Pharmacy News

### Billing Bulletin

### Referral Roundup

### Index



## NIH doubles funding for scientific solutions to opioid crisis



At the 2018 National Rx Drug Abuse and Heroin Summit in April, the National Institutes of Health Director Francis S. Collins, M.D., Ph.D., announced the launch of the Helping to End Addiction Long-Term Initiative. Under the initiative, NIH has doubled funding for research on opioid misuse/addiction and pain from approximately \$600 million in 2016 to \$1.1 billion in 2018.

The initiative has two main research pathways: preventing addiction through enhanced pain management and improving treatments for opioid misuse disorder and addiction.

More information is available in the NIH [news release](#).





## Emergency room data show increase in opioid overdoses

Emergency room data shows an increase in opioid overdoses, according to the latest *Vital Signs* report by the Centers for Disease Control and Prevention, released earlier this year.

Overall, emergency department visits (reported by 52 jurisdictions in 45 states) for suspected opioid overdoses increased 30 percent in the United States, from July 2016 through September 2017.

Opioid overdoses increased for men and women, all age groups and all regions, but varied by state, with rural and urban differences

Details are available on the [CDC website](#).

The CDC also links to an article, "Opportunities for Prevention and Intervention of Opioid Overdose in the Emergency Department" in the [Annals of Emergency Medicine](#).

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



## Consider patient's alcohol use when screening for opioid use disorder



Did you know that approximately one in five opioid overdoses are alcohol-related? That's why it's so important to screen for alcohol use disorder when assessing the risk of opioid use disorder.

The Centers for Disease Control and Prevention recently issued a [fact sheet](#) on alcohol screening for people who consume alcohol and use opioids. The CDC also developed a [new portal](#) detailing the effects of drinking alcohol on your health.

# Patient Care



## AHIP responds to senate Democrats on opioid issues

On March 29, American’s Health Insurance Plans, an advocacy and trade association, addressed a letter to a group of 15 senate Democrats, responding to their request for information on efforts by health insurance providers to promote evidence-based treatments for both pain management and opioid use disorders.

The letter highlights the industry’s leadership in launching the **Safe, Transparent Opioid Prescribing (STOP) Initiative**, the **STOP Measure** and the release of nationwide benchmark data, and **STOP Playbook** outlining steps relating to prevention, early intervention, and treatment of opioid use disorders.

AHIP noted that health insurance providers cover evidence-based treatment for substance use disorders including medication-assisted treatment, counseling, and recovery support to help a person manage substance use disorder as a chronic condition. The organization also provided information on prevention strategies that have been adopted by health insurance providers and outlined policy recommendations.

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



## Michigan requires health care professionals to provide opioid education before prescribing



Effective June 1, 2018, the state of Michigan requires health care professionals to provide opioid education before prescribing an opioid to a patient.

Education may be provided using the state’s **Start Talking** form, or similar form, when prescribing an opioid medication. If providers use a similar form, it must still cover all the topics identified by the Opioid Start Talking form. The form must be completed, signed and saved in the patient’s medical record.

Additional information can be found at the **Michigan Department of Health & Human Services** or the state’s **Frequently Asked Questions** document on Michigan opioid laws.

# Patient Care

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



# Case management program helps you care for patients

Your patients who have complex medical needs can get personalized support from Blue Care Network's Care Management department. Our registered nurse case managers work with you and your patients to develop a case management plan of care and promote self-management.

Our case managers contact members by phone to provide education on disease, nutrition, medication and managed care processes. We also help patients access BCN and community resources as needed.

We identify members for case management through a predictive model that takes data from a variety of sources to find members that may benefit from case management services. We also accept direct referrals from treating physicians, employer groups and member and caregiver referrals. We may also identify BCN Advantage members through member health assessments.

Members enrolled in case management consistently report high satisfaction with the program and a willingness to recommend the program to other members.

We offer case management services as a benefit at no cost to BCN commercial and BCN Advantage members. Our programs can help members with one or more of the following health conditions:

- Advanced illness
- Cancer
- Complex wound care
- Heart disease
- Chronic obstructive pulmonary disease
- Joint replacement
- Multiple complex injuries
- Brain and nerve conditions
- Organ transplant
- Spinal cord injury
- Stroke

## Case management in 2018

We encourage our members active in managing their health and promote a collaborative relationship with you. Case managers work with you, your staff and your patient to support positive health outcomes.

You can find information about your members enrolled in a care management program on Health e-Blue<sup>SM</sup>, your secured clinical support tool. To learn more about BCN's case management program or refer a member to one of our programs, call 1-866-807-4811, from 8:30 a.m. to 5 p.m., Monday through Friday

BCN respects your right to:

- Have information about BCN's case management programs, case management staff and staff qualifications relative to the management of your patient when requested
- Be informed of how BCN coordinates its interventions with treatment plans for individual patients
- Know how to contact the person responsible for managing and communicating with your patients
- Submit complaints to the organization
- Make decisions interactively with patients regarding their health care
- Receive courteous and respectful treatment from the organization's staff

Note: Case managers may receive requests for services specifically excluded from the member's benefit package. Member benefits are defined by the limits and exclusions outlined by the individual member's certificate and riders. BCN doesn't make benefit exceptions and informs the member of alternative resources for continuing care and how to obtain care, as appropriate, when a service isn't covered or when coverage ends.

Patient Care

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



## Back-to-school tips for children with asthma, diabetes

As kids prepare to return to school, there are important steps primary care physicians and staff can take to ensure students are prepared to manage chronic conditions. The following checklists can help you do just that.

### For children with asthma

Establish an Asthma Action Plan and provide the school with a copy for the child’s record. The plan can be developed to fit the needs of the child.

- Obtain a copy of the Asthma Action Plan template. It’s available on web-DENIS. Go to *BCN Provider Publications and Resources*. Click on *Forms* (under Resources) and scroll down to the Asthma Action Plan for Children/Teens in the Chronic Condition Management section.
- Instruct the child and parents on all medications and the importance of having access to those medications — especially rescue inhalers — at all times. Refill prescriptions as needed.
- Discuss asthma condition and triggers that may occur.
- Provide the necessary documentation for the school support staff to keep on file in the event of an emergency. Information should be accessible to teachers, coaches and other adults who supervise children at school.
- Talk with the child about how to manage his or her asthma while at school. Sometimes a child can become overwhelmed with managing his or her condition and needs to discuss the changes he or she is experiencing.
- Instruct the child to wear a medical alert bracelet, if necessary.

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)**Tips**, continued from Page 20**For children with diabetes**

- Establish a Diabetes Care Plan and provide the school with a copy for the child's record. The plan can be developed to fit the child's needs.
  - To obtain a copy of the plan, log in to web-DENIS. Go to *BCN Provider Publications and Resources*. Click on *Forms* (under Resources). Scroll down to the Diabetes Care Plan for School in the Chronic Condition Management section.
- Instruct the child and parents on diabetes medication, storage and having access to medication and monitoring supplies at all times. Refill prescriptions as needed.
- Ensure the child knows how and when to check blood sugar if he or she is old enough to learn or advise parent to ensure that school is aware of the Diabetes Care Plan. A Diabetes **medical management plan** template is available from the American Diabetes Association.
- Have the child write down his or her blood sugar levels in a diary. A school nurse may be able to assist younger children.
- Ensure the child knows what the symptoms are for low blood sugar and high blood sugar.

- Reinforce that the child should have a rapid sugar release type of food available such as juice, hard candy or glucose tablets for symptoms of low blood sugar.
- Instruct the child and parents on eating healthy meals and refer to registered dietitian as necessary.
- Encourage parents to pack healthy snacks that can be eaten between meals to prevent low blood sugar occurrences.
- Instruct the child to wear a medical alert bracelet, if necessary.
- Provide the necessary documentation for the school support staff to keep on record in the event of an emergency. Information should be accessible to teachers, coaches and adults that interact with the child at school.
- Talk with the child about his or her diabetes. Sometimes a child can become overwhelmed with managing his or her condition and needs to discuss the changes he or she is experiencing.

The Michigan Quality Improvement Consortium **guidelines** include information on assessment and treatment of acute and chronic conditions, and preventive services.

**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**

- Ex vivo lung perfusion
- Genetic testing-human platelet antigen genotyping
- Miscellaneous genetic and molecular diagnostic tests
- Radiofrequency ablation of peripheral nerves to treat pain including COOLIEF\* Cooled RF
- Sleep disorders, diagnosis and medical management

**Covered services**

- Autografts and allografts in the treatment of focal articular cartilage lesions
- Genetic testing for the diagnosis of inherited peripheral neuropathies
- Genetic testing for retinal dystrophies
- Genetic testing for Tay-Sachs disease
- Identification of microorganisms using nucleic acid probes
- Intensity-modulated radiation therapy of the prostate
- Positron emission tomography for oncologic conditions
- Skin and tissue substitutes
- Transgender services
- Vagus nerve stimulation
- Genetic testing for  $\alpha$ -Thalassemia

**Medical Policy Updates**



# COPD diagnosis should include spirometry

Caring for patients with chronic obstructive pulmonary disease begins with diagnosing the condition through spirometry. It's necessary to periodically assess the disease, manage exacerbations and provide smoking cessation support. Pharmacologic therapy is pivotal as it provides important options for improvement of symptoms and treatment of exacerbations.

COPD remains underdiagnosed. Consider testing for COPD in smokers with symptoms or with a history of exposure to other COPD risk factors. This includes smokers older than 60 presenting with a chronic cough, or a diagnosis and treatment for respiratory tract infections or asthma.

A written COPD management plan can facilitate COPD care in your office and helps patients manage their symptoms. BCN asks physicians to complete the management plan during office visits and provide a copy to the member.

To obtain a copy of BCN's COPD management plan:

- Log in to web-DENIS.
- Go to *BCN Provider Publications and Resources*.
- Click on *Forms* under Other Resources.
- Click on *COPD Action Plan* in the Chronic Condition Management section.

## Spirometry

Spirometry is necessary to establish a diagnosis of COPD, according to BCN's clinical practice guidelines for the diagnosis and management of COPD. Spirometry also provides a useful diagnostic tool for patients with symptoms suggestive of COPD. (See table below). A post bronchodilator FEV<sub>1</sub>/FVC less than 70 percent confirms the presence of airflow limitation.

BCN's *Guidelines for the Diagnosis and Management of Chronic Obstructive Pulmonary Disease*, recommend that you consider COPD in patients 18 years or older with respiratory symptoms and those with a history of exposure (for example, occupational exposure) to risk factors for the disease, especially smoking. Characteristic symptoms include cough, sputum production that can be variable from day to day and chronic or progressive dyspnea.

I: Mild COPD	II: Moderate COPD	III: Severe COPD	IV: Very Severe COPD
FEV <sub>1</sub> /FVC < 0.70	FEV <sub>1</sub> /FVC < 0.70	FEV <sub>1</sub> /FVC < 0.70	FEV <sub>1</sub> /FVC < 0.70
FEV <sub>1</sub> ≥ 80% predicted	FEV <sub>1</sub> 50% ≤ FEV <sub>1</sub> and < 80% predicted	FEV <sub>1</sub> 30% ≤ FEV <sub>1</sub> and < 50% predicted	FEV <sub>1</sub> < 30% predicted or FEV <sub>1</sub> < 50% with deoxygenating

The Healthcare Effectiveness Data Information Set measures the percentage of members ages 40 and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis. CPT codes used to identify spirometry testing for this measure include \*94010, \*94014-94016, \*94060, \*94070, \*94375 and \*94620.

Source

*BCN Guidelines for the Diagnosis and Management of Chronic Obstructive Pulmonary Disease (COPD) QM 2071*

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

# Behavioral Health



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



## BCN offers incentive for primary care physicians to provide medication-assisted treatment

Blue Care Network is offering a new incentive for primary care physicians to provide medication-assisted treatment for patients with opioid use disorders. We're providing the incentive as a pilot in 2018.

Medication-assisted treatment has been shown to be safe, effective and long-lasting. See our article on MAT in the **March-April issue** of *BCN Provider News*.

You should have received a letter with an enclosed summary guide, outlining the measures and steps you can take to qualify for the rewards.

If you don't have a copy of your letter with the details of the program, get the summary guide with the details for the reward measures on BCN Health e-Blue<sup>SM</sup> in the Resources section.

Increasing medication-assisted treatment is part of our continued effort to combat the opioid epidemic. We look forward to working with our providers to ensure our members have options for appropriate treatment.

## We're making important changes to the Behavioral Health Incentive Program

Beginning July 1, 2018, Blue Care Network is suspending the Therapeutic Alliance and Primary Care Physician Contact measures for the Behavioral Health Incentive Program. This includes both electronic and manual formats.

We won't accept any submissions after June 30 for these measures, even if the submission is regarding a measure completed before June 30. Please send in all submissions as soon as possible.

This new timeline will be reflected in a revised BHIP booklet, as well as supporting BHIP documents and instruction guides.

We're making the change due to strategic improvements in our administrative resources, as we move away from manual processes.

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**



## Drs. Beecroft, DiFranco honored by American Psychiatric Association

The American Psychiatric Association recognized two of Blue Cross Blue Shield of Michigan’s top medical experts for their outstanding contributions to the field of psychiatry.

- Dr. William Beecroft, medical director of behavioral health for Blue Care Network was named a distinguished lifetime fellow.
- Dr. Duane DiFranco, senior medical director of Health Care Value for BCN, was named a distinguished fellow.



### Dr. Beecroft

His role at Blue Cross covers a variety of areas, including policy development. He is responsible for the day-to-day care management of members’ mental health benefits. He also has been involved in developing the clinical response to the opioid crisis for Blue Cross and BCN.

Dr. Beecroft is a board-certified psychiatrist, with added qualifications in geriatrics and psychosomatic medicine

by the American Board of Psychiatry and Neurology. He is a graduate of Michigan State University and has practiced primarily in Lansing for more than 35 years.

In his spare time, Dr. Beecroft also volunteers with nonprofit Wings of Mercy East, helping patients fly to and from the medical treatments they need for free.

### Dr. DiFranco

With the Health Care Value team, he supports decisions regarding how care is administered and mental health is treated.

He is a graduate of both the University of Notre Dame and University of Michigan, serving on the faculty at the latter for 10 years before joining BCN in 2007.



### About the honors

The fellowship is the highest membership honor the APA bestows. Only a select group of physicians receive it nationwide each year. It’s awarded to psychiatrists who have made major contributions to the profession. Honorees are required to have made an impact in at least five key areas:

- Administration
- Teaching
- Scientific and scholarly publications
- Volunteerism in mental health and medical activities of social significance
- Community involvement
- Clinical excellence

Lifetime status is achieved when a doctor’s age plus total years of membership equal 95; however, the traditional honor can be bestowed to any APA member who achieves the proper criteria.

In addition to their contributions to the profession, nominees of the fellowship are also required to have the following:

- At least eight consecutive years as a general member or fellow of the organization
- Certifications across several medical boards
- Supporting input and nomination from colleagues
- Involvement in medical organizations, community organizations or professional organizations
- Recognized contributions across a handful of neurology medical boards, administrative roles, teaching roles and publications

The doctors were presented with their honors during the annual APA meeting in New York City on May 7.

- 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



# 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](#)

## Reminder: Starting June 1, no authorization required for BCN routine outpatient behavioral health therapy

As a reminder, for dates of service on or after June 1, 2018, no authorization is required for routine outpatient therapy for mental health and substance use disorders, for contracted behavioral health providers in Michigan. This applies to both BCN HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members.

Authorization is required for these services if you are:

- A provider who is not part of the network assigned to a member’s plan
- A noncontracted provider (including providers outside of Michigan)

We first told you about this change in April, in a web-DENIS message and in a news item on our [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website.

The e-referral system is being updated to show a reminder that no authorization is required for these services if an authorization request is submitted.

There are some outpatient services that continue to require authorization through the e-referral system, for all providers. They are:

- Autism evaluation and treatment
- Electroconvulsive therapy
- Neurofeedback
- Transcranial magnetic stimulation

We’ve updated the Behavioral Health chapter of the *BCN Provider Manual* and other documents to reflect the change in authorization requirements.



## 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<sup>SM</sup> members to get access to long-acting injectable medications for the treatment of certain psychiatric and substance use disorders.

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

See the **article** in the May-June issue for details.

# 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](#)

## Quality improvement program information available upon request

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

Copies of the complete guidelines are available on [bcbsm.com/providers](http://bcbsm.com/providers). To access the guidelines:

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

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

Our Quality Improvement Program encourages adherence to MQIC guidelines and offers interventions to improve health outcomes for BCN members. Some examples

include member and provider incentives, reminder mailings, telephone reminders, newsletter articles and educational materials. We monitor compliance with the preventive health guidelines by conducting medical record reviews and quality studies.

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

To ensure our members have appropriate access to care, BCN has access and availability standards for the following types of appointments: preventive care, routine primary care, non-life threatening emergency and urgent care and after-hours access. Access monitoring is conducted throughout the year by quality management staff. Physicians who are noncompliant with access standards can make improvements. More information is available in the *BCN Provider Manual*. Log in to web-DENIS, click on *Provider Manual* and open the Access to Care chapter.

If you'd like additional information about our programs or guidelines, email our Quality Management department at [BCNQIQuestions@bcbsm.com](mailto:BCNQIQuestions@bcbsm.com), or call 1-248-350-6242.

## Quality corner: Clinical Quality Corner tip sheets updated for 2018

As part of our ongoing efforts to give you tools to improve health care quality, we've updated our Clinical Quality Corner tip sheets for 2018 and posted them on web-DENIS. Each of the 27 tip sheets focuses on a specific HEDIS® measure.\*\*

This year, they've been posted on both the *BCBSM Provider Publications and Resources* section of web-DENIS as well as the *BCN Provider Publications and Resources* section. Here's one way to access them:

From the homepage of web-DENIS:

- Click on *BCN Provider Publications and Resources*.
- Click on *Clinical Quality Corner* under the What's New section at the top of the page.

\*\*HEDIS®, which stands for Healthcare Effectiveness Data and Information Set, is a registered trademark of the National Committee for Quality Assurance, or NCQA.

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



BCN Provider News

[Feedback](#)

## We've added Humira to the pharmacy benefit drug prior authorization program

Blue Care Network added Humira®, or adalimumab, to the pharmacy benefit drug prior authorization program for commercial members under the BCN pharmacy plan, effective April 1. These changes don't apply to BCN Advantage<sup>SM</sup> members.

To address the high cost of drugs and provide the best value for our members, Blue Cross Blue Shield of Michigan and BCN commercial plans continue to make changes to the drugs we cover. We regularly review drug therapies as an extra safeguard to ensure your patients' medical plans cover the right medication for the right situation.

Members currently taking Humira won't need prior authorization. For members who are newly prescribed Humira, you'll need to submit a request for authorization from BCN before payment is approved. Medications not authorized in advance may not be covered. You can find drug approval requirements for coverage and all drug lists online at [bcbsm.com/pharmacy](http://bcbsm.com/pharmacy).

## Correction: Brineura won't be added to the site of care program

In the last issue of *BCN Provider News*, we incorrectly stated that Brineura would be added to the site of care program for HMO commercial members effective July 1. We are not adding Brineura to that program. We apologize for any inconvenience this may have caused.

## BCBSM and BCN drug lists updated, available online

Blue Cross Blue Shield of Michigan and Blue Care Network regularly update our drug lists. For the most recent updates, go to our [pharmacy page](http://bcbsm.com/pharmacy) on [bcbsm.com](http://bcbsm.com).

Please help our members get the care they need by talking with them about their drug copayment or coinsurance.

### Other useful links

#### Drug lists

<https://www.bcbsm.com/index/health-insurance-help/documents-forms/plan-types/pharmacy/drug-lists.html>

#### Quantity limits

<https://www.bcbsm.com/content/dam/public/Consumer/Documents/help/documents-forms/pharmacy/bcn-quantity-limits.pdf>

#### Prior approval and step therapy

<https://www.bcbsm.com/content/dam/public/Consumer/Documents/help/documents-forms/pharmacy/bcn-prior-authorization-step-therapy-guidelines.pdf>

## Cover Story

## Network Operations

## BCN Advantage

## Patient Care

## Behavioral Health

## Quality Counts

## Pharmacy News

## Billing Bulletin

## Referral Roundup

## Index



## Starting Oct. 1, additional specialty medications require authorization for BCN Advantage members

For dates of service on or after Oct. 1, 2018, additional specialty medications covered under the Medicare Part B medical benefit require authorization for BCN Advantage<sup>SM</sup> members. The brand names and HCPCS codes for these medications are:

- Actemra<sup>®</sup> – J3262
- Aredia<sup>®</sup> – J2430
- Benlysta<sup>®</sup> – J0490
- Cimzia<sup>®</sup> – J0717
- Entyvio<sup>®</sup> – J3380
- GamaSTAN<sup>®</sup> (1 mL) – J1460
- GamaSTAN<sup>®</sup> (over 10 mL) – J1560
- Krystexxa<sup>®</sup> – J2507
- Nplate<sup>®</sup> – J2796
- Orencia<sup>®</sup> – J0129
- Privigen<sup>®</sup> – J1459
- Simponi Aria<sup>®</sup> – J1602
- Soliris<sup>®</sup> – J1300
- Spinraza<sup>®</sup> – J3490
- Vivaglobin<sup>®</sup> – J1562
- Xolair<sup>®</sup> – J2357

These medications are not self-administered. They must be given by injection or infusion by a physician or health care professional in the office or outpatient facility setting.

### When authorization is required

Authorization is required for these medications when they are billed on a professional HCFA 1500 claim form or when the claim is submitted electronically via ANSI 837P, for the following sites of care:

- Physician office (Place of Service 11)
- Outpatient facility (Place of Service 19 or 22)

Authorization is not required for these medications when they are billed on a facility claim form (such as the UB-92, UB-04 or UCB).

### Why authorization is required

The authorization requirement helps ensure that health care providers use the most effective therapies available, according to the Centers for Medicare & Medicaid Services coverage guidelines for medical necessity, safety and efficacy. If authorization is not obtained, the claim will be denied. Authorization is not a guarantee of payment.

The member must also have the benefits that are required for the claim to be paid. The Centers for Medicare & Medicaid Services benefit coverage rules, exclusions and limitations apply.

### How to request authorization

The most efficient way to submit an authorization request is through the online NovoLogix<sup>®</sup> tool. To access the NovoLogix tool, follow these steps:

1. Visit [bcbsm.com/providers](http://bcbsm.com/providers).
2. Log in to Provider Secured Services.
3. Click *BCN Medical Benefit – Medication Prior Authorization*.
4. Follow the instructions.

If you have any questions about this process, call the Pharmacy Clinical Help Desk at 1-800-437-3803.

### Authorization requirements for other products

For all these medications, the authorization requirements already apply to Blue Cross Medicare Plus Blue<sup>SM</sup> PPO members. The authorization requirements for BCN Advantage members are intended to bring the requirements for both Medicare Advantage products into alignment.

Authorization is also required for Blue Cross PPO (commercial) and BCN HMO<sup>SM</sup> (commercial) members, except for Aredia, GamaSTAN and Vivaglobin.

### Additional information

Authorization is also required for Fasentra<sup>™</sup> and Luxturna<sup>™</sup>, for dates of service or on after Aug. 7, 2018. For additional information, see the article, *Starting Aug. 7, Fasentra and Luxturna require authorization for Medicare Advantage members*, on [Page 29](#).



# Pharmacy News

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



## Starting Aug. 7, Fasenra and Luxturna require authorization for Medicare Advantage members

For dates of service on or after Aug. 7, 2018, authorization is required for the following Part B specialty drugs covered under the medical benefit:

- Fasenra™ (benralizumab) 
- Luxturna™ (voretigene neparvovec-rzyl) 

This authorization requirement applies to Blue Cross Medicare Plus Blue<sup>SM</sup> PPO and BCN Advantage<sup>SM</sup> members. Authorization is already required for Blue Cross PPO and BCN HMO<sup>SM</sup> (commercial) members.

For Medicare Plus Blue and BCN Advantage members, these medications require authorization when they are billed on a professional HCFA 1500 claim form or by electronic submission via ANSI 837P, for the following sites of care:

- Physician office (Place of Service 11)
- Outpatient facility (Place of Service 19, 22 and 24 for Medicare Plus Blue members and Place of Service 19 and 22 for BCN Advantage members)

Authorization is not required for these medications when they are billed on a facility claim form (such as the UB-92, UB-04 or UCB).

Both medications are billed with HCPCS procedure code J3590.

You must submit authorization requests for these medications through the NovoLogix online tool. Authorization must be obtained prior to the medications being administered.

We first communicated this new requirement in a web-DENIS message dated May 4, 2018.

### Additional information

Authorization is also required for several other medications, for dates of service or on after Oct. 1, 2018. For additional information, see the article *Starting Oct. 1, additional specialty medications require authorization for BCN Advantage<sup>SM</sup> members*, **Page 28**.





# BCN reviews inpatient readmissions that occur within 14 days of discharge

Blue Care Network reviews inpatient readmissions from facilities reimbursed by diagnosis-related groups when the member is readmitted with the same or a similar diagnosis.

We review inpatient readmissions within 14 days of discharge, and decide whether the readmission should be billed separately or bundled with the previous admission. In some instances, the two admissions are combined into one for purposes of DRG reimbursement.

## Documents pertaining to readmissions

The documents listed below provide information on 14-day readmission bundling:

- Guidelines for bundling admissions
- The Care Management and Claims chapters of the *BCN Provider Manual*
- The readmission checklist, which facilities should use to ensure that all necessary documentation is available for the review of a readmission that has occurred within 14 days

## Additional information

Access these documents by completing the following steps:

1. Visit [bcbsm.com/providers](http://bcbsm.com/providers) and click *Login*.
2. Log in to Provider Secured Services using your user ID and password.
3. Click *BCN Provider Publications and Resources*.
4. Click either *Billing/Claims, Provider Manual or Forms*, to open the appropriate Web page and locate the documents.

The Care Management chapter is also available on the public website, at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Click *BCN*, click *Provider Manual Chapters* and then click **Care Management chapter**. Look in the section titled "Guidelines for observations and inpatient hospital admissions," in the subsection titled "Review of readmissions that occur within 14 days of discharge."

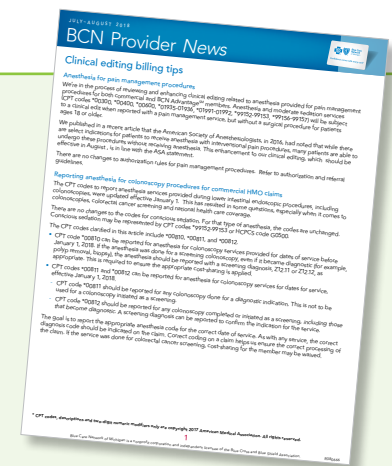
## Clinical editing billing tips

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:

- Anesthesia for pain management procedures
- Reporting anesthesia for colonoscopy procedures for commercial HMO claims





Patients on immunosuppressant medications are commonly assigned a diagnosis code for immunodeficiency. However, in the American Hospital Association's manual on ICD-10-CM codes, immunosuppression and immunodeficiency are not synonymous. They're represented by distinctly different ICD-10-CM codes.

### Immunodeficiency

Immunodeficiency is caused by a malfunction of the immune system. This malfunction can be either congenital (primary) or acquired.

#### Congenital immunodeficiency

There are more than 100 primary immunodeficiency disorders, classified by the specific part of the immune system they affect. Examples include:

- Common variable immunodeficiency
- Bruton's disease
- Severe mixed immunodeficiency syndrome
- Deficiency of a specific antibody
- Cyclic neutropenia

#### Acquired immunodeficiency

This can occur in one of two ways:

1. As a side effect or adverse effect of a medication that's correctly prescribed and properly administered. The medicine is used to treat an underlying disease without the intent to alter the immune state, such as antineoplastic chemotherapy drugs or radiation.\*\*  
**Example:** The physician documents that the patient is immune deficient due to chemotherapy used for treating cancer. The correct code assignment would be T45.1X5-, adverse effect of antineoplastic and immunosuppressive drugs. The required 7th digit is dependent on whether the patient is receiving active treatment (A), routine care during the healing or recovery phase (D) or treatment for complications or conditions that arise directly from the condition (S).
2. As the result of a disease or disorder, such as:
  - Cancer
  - A human immunodeficiency virus infection leading to acquired immunodeficiency syndrome, or AIDS

### Immunosuppression

Immunosuppression is caused by medications prescribed to intentionally suppress the immune system. These medications are used to treat various autoimmune diseases, including:

- Rheumatoid arthritis
- Sjogren's syndrome
- Psoriasis
- Crohn's disease

By suppressing the overreactive immune system in patients with these conditions, the immune response triggering the disease process is weakened. Weakening the immune response helps promote remission in afflicted patients.

Immunosuppressant medications are also required for patients who have had an organ transplant. The immune system is designed to attack anything foreign within our body; transplanted organs are no exception. By suppressing the immune system, the body is less likely to reject the transplanted organ.

**Example:** A physician documents that a patient has an immune deficiency and is taking immunosuppressants. The doctor should use code Z79.899 to represent the patient's long-term immunosuppressant medication therapy. The ICD-10-CM code for immunodeficiency doesn't provide a specific code to identify these drugs. **Since this patient is taking the immunosuppressant medication, with the intent to suppress the immune system, codes for immunodeficiency that's caused by an adverse effect of drug treatment or from an underlying disease should not be assigned.\*\***

\*\*AHA Coding Clinic for ICD; 2015; third quarter

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

# Billing Bulletin

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

### Question:

When we report transitional care management, what dates are we to report when we see the patient for the face-to-face visit? Do we wait and report the date at the end of the 30 days, or do we report the date of the actual visit?

### Answer:

In reporting these services for both BCN commercial and BCN Advantage members, we follow the guidelines documented by Medicare. The **Medicare FAQ** dated March 17, 2016, states the date of service reported should be the required face-to-face visit. The claim can be submitted at any time once the face-to-face visit has taken place. It doesn't need to be held for the 30-day period.

## 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.

### Question:

I do billing for an OB-GYN office. How do I report prenatal visits?

### Answer:

When antepartum care is reported by the same provider or provider group and more than four visits are billed, it's important to report the CPT code that best describes the service provided and the number of visits: \*59425 or \*59426. It's also important not to span the dates in the "From" and "To" fields. Report the date of the first prenatal visit in both fields. Report the total number of visits in field 24G.

Reporting claims information other than as noted may result in errors and delays processing your claims. Please refer to the Maternity and delivery services section in the Claims chapter of the *BCN Provider Manual* for additional information on billing antepartum care services, as well as claim examples.



# Referral Roundup

Cover Story

Network Operations

BCN Advantage

Patient Care

Behavioral Health

Quality Counts

Pharmacy News

Billing Bulletin

Referral Roundup

Index



## AIM Specialty Health to manage cardiology and high-tech radiology procedures for BCN starting October 1

Effective with dates of service on or after Oct. 1, 2018, AIM Specialty Health® will manage the authorization process for cardiology and high-tech radiology procedures for BCN HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members. Currently, these procedures are managed by eviCore healthcare.

AIM will accept authorization requests starting Sept. 17, 2018. You can submit these requests either through the AIM provider portal or by calling AIM at 1-844-377-1278.

These one-hour webinars are for providers and their staff.

August 2018	September 2018	October 2018
Wednesday, Aug. 22, 10-11 a.m. Thursday, Aug. 23, 2-3 p.m. Wednesday, Aug. 29, 10-11 a.m. Thursday, Aug. 30, 2-3 p.m.	Wednesday, Sept. 5, 10-11 a.m. Thursday, Sept. 6, 2-3 p.m.	Wednesday, Oct. 3, 10-11 a.m. Thursday, Oct. 4, 2-3 p.m.

### How to sign up for a webinar

To register, complete the **AIM webinar registration form** and submit it in one of the following ways:

- Fax it to 1-866-652-8983
- Email it to [providerinvitations@bcbsm.com](mailto:providerinvitations@bcbsm.com)

The instructions for logging in and calling in to the webinar will be emailed to you a day or two prior to the webinar.

### Additional information

Additional information about submitting authorization requests is available on the **AIM Specialty Health** website, including:

- AIM's **clinical guidelines**
- **Frequently asked questions** about the AIM provider portal
- **Additional information** about the AIM provider portal

### Webinars offered in August, September and October

We're scheduling training webinars so you can learn how to use the AIM provider portal, an online tool to request authorization from AIM:

- Get an overview of the AIM provider portal.
- Learn how to create and submit an order request, update an existing request and retrieve your order summary.
- Learn how to check the status of your requests.
- Get tips and shortcuts for navigating the AIM system.

Once you're registered to use the AIM provider portal, you'll also be able to access AIM's **tutorials** about using their provider portal.

Watch for additional information about this upcoming change in web-DENIS messages, in news items at **ereferrals.bcbsm.com** and in the September-October 2018 issue of *BCN Provider News*.

# 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](#)

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

Later this year, providers will submit initial authorization requests for physical, occupational and speech therapy, or for physical medicine services by chiropractors, through eviCore healthcare’s provider portal. They’ll no longer use the e-referral system or call Blue Care Network.

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 HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> 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 corePath<sup>SM</sup> 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 Blue<sup>SM</sup> PPO authorization requests starting Jan. 1, 2018.

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

[Provider Portal Login | eviCore](#)



LOGIN: [PROVIDERS](#) | [PLANS](#)

[Clinical Guidelines and Forms](#) [PROVIDER SHORTCUTS](#) ▾

[HOME](#) [ABOUT](#) [APPROACH](#) [SOLUTIONS](#) ▾ [RESOURCES](#) ▾ [INSIGHTS](#) [CAREERS](#) [CONTACT](#)



# Providers Delivering Medical Solutions That Benefit Everyone.

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

# 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](#)

# What's new about authorization criteria and e-referral questionnaires for certain services

The authorization criteria and the questionnaires in the e-referral system have been updated for certain services. Click the PDF to see which services have revised authorization criteria and questionnaires.

In addition, you'll see a questionnaire in the e-referral system for the following services:

- Blepharoplasty and repair of brow ptosis – starting June 25, 2018 for any date of service
- Hyperbaric oxygen therapy – for dates of services on or after July 1, 2018

These procedures already require authorization, but now you'll need to complete a questionnaire in the e-referral system. This applies to procedures for BCN HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members.

### How the questionnaires work

If your responses indicate that the procedure meets criteria, the authorization request will automatically be approved. If the criteria aren't met, we'll hold the request for clinical review by BCN's Utilization Management staff.

For cases that aren't automatically approved by e-referral after you complete the questionnaire, you must include additional clinical information. You can type the information directly into the Case Communication section in the e-referral system or attach it to the case. The instructions for attaching clinical information to the case are outlined in the article "[How to attach clinical information to your authorization request in the e-referral system](#)," on page 44 in the November-December 2016 *BCN Provider News*.

### Where to find authorization criteria and preview questionnaires

The updated authorization criteria are available at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Click *BCN* and then click **Authorization Requirements & Criteria**.

You'll also find new and updated preview questionnaires at that location to help you prepare in advance and reduce the time it takes to submit the authorization request.



*Authorization criteria and questionnaires*

## Reminder: Starting June 1, Northwood manages diabetic shoes and inserts

For dates of service on or after June 1, 2018, Northwood, Inc., manages diabetic shoes and inserts for Blue Care Network HMO<sup>SM</sup> (commercial), BCN Advantage<sup>SM</sup> and Blue Cross Medicare Plus Blue PPO members. This applies to HCPCS codes A5500 through A5513 and code K0903.

J&B Medical Supply managed these items for dates of service on or before May 31, 2018.

Call Northwood at 1-800-393-6432 to identify a contracted supplier near you. The supplier submits the request to Northwood for review.

Northwood representatives are available weekdays from 8:30 a.m. to 5 p.m. Northwood's on-call associates are available after normal business hours at the same number.

We've updated the BCN and Blue Cross Medicare Plus Blue PPO provider manuals to reflect the changes related to diabetic shoes and inserts.

# 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: July–August 2018

## BCN Advantage

What you need to know about Medicare fraud, waste and abuse . . . . . **Page 8**

Notice of Medicare Noncoverage for BCN Advantage members . . . . . **Page 9**

Some important facts about the NOMNC . . . . . **Page 10**

Blue Care Network’s Care Transition program helps BCN Advantage patients transition to home . . . . . **Page 11**

Starting Aug. 7, Fasenra and Luxturna require authorization for Medicare Advantage members . . . . . **Page 11**

Starting Oct. 1, additional specialty medications require authorization for BCN Advantage members . . . . . **Page 12**

## Behavioral Health

BCN offers incentive for primary care physicians to provide medication-assisted treatment . . . . . **Page 23**

We’re making important changes to the Behavioral Health Incentive Program . . . . . **Page 23**

Drs. Beecroft, DiFranco honored by American Psychiatric Association . . . . . **Page 24**

Reminder: Starting June 1, no authorization required for BCN routine outpatient behavioral health therapy . . . . . **Page 25**

Blue Care Network now gives members access to in-home long-acting injectable program . . . . . **Page 25**

## Billing Bulletin

BCN reviews inpatient readmissions that occur within 14 days of discharge . . . . . **Page 30**

Clinical editing billing tips . . . . . **Page 30**

Coding Corner: Here’s how to accurately code for immunosuppression and immunodeficiency . . . . . **Page 31**

Billing Q&A . . . . . **Page 32**

Have a billing question? . . . . . **Page 32**

## Network Operations

Best Practices: Partnering with patients helps them adopt healthier lifestyles . . . . . **Page 1**

BCN is updating its clinical editing system . . . . . **Page 1**

Healthy *Blue* Living reminders . . . . . **Page 4**

Blue Care Network updates professional fees July 1 . . . . . **Page 4**

Helpful hints to expedite your Provider Secured Services application . . . . . **Page 5**

How to submit inpatient authorization requests to BCN during upcoming holiday closures . . . . . **Page 7**

## Patient Care

It’s not too early to prepare for next flu season . . . . . **Page 13**

SAMHSA publishes clinical guidance to help broaden health care professionals’ understanding of medications to treat opioid use disorder . . . . . **Page 15**

State opioid commission releases prescribing guidelines . . . . . **Page 15**

NIH doubles funding for scientific solutions to opioid crisis . . . . . **Page 16**

Blue Cross develops opioid resource guide for employers . . . . . **Page 16**

Consider patient’s alcohol use when screening for opioid use disorder . . . . . **Page 17**

Emergency room data show increase in opioid overdoses . . . . . **Page 17**

Michigan requires health care professionals to provide opioid education before prescribing . . . . . **Page 18**

AHIP responds to senate Democrats on opioid issues . . . . . **Page 18**

Case management program helps you care for patients . . . . . **Page 19**

Back-to-school tips for children with asthma, diabetes . . . . . **Page 20**

Medical policy updates . . . . . **Page 21**

COPD diagnosis should include spirometry . . . . . **Page 22**

## Pharmacy News

We’ve added Humira to the pharmacy benefit drug prior authorization program . . . . . **Page 27**

Correction: Brineura won’t be added to the site of care program . . . . . **Page 27**

BCBSM and BCN drug lists updated, available online . . . . . **Page 27**

Starting Oct. 1, additional specialty medications require authorization for BCN Advantage members . . . . . **Page 28**

Starting Aug. 7, Fasenra and Luxturna require authorization for Medicare Advantage members . . . . . **Page 29**

## Quality Counts

Quality improvement program information available upon request . . . . . **Page 26**

Quality corner: Clinical Quality Corner tip sheets updated for 2018 . . . . . **Page 26**

## Referral Roundup

AIM Specialty Health to manage cardiology and high-tech radiology procedures for BCN starting October 1 . . . . . **Page 33**

Reminder: eviCore to handle BCN initial and follow-up authorization requests for PT, OT and ST starting later in 2018 . . . **Page 34**

What’s new about authorization criteria and e-referral questionnaires for certain services . . . . . **Page 35**

Reminder: Starting June 1, Northwood manages diabetic shoes and inserts . . . . . **Page 35**

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