SEPTEMBER–OCTOBER 2018

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BCN Provider News User Guide

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Check to see if you have a new professional provider consultant

Professional provider consultants have been reassigned as part of our new provider outreach reorganization that we told you about in the **May-June** issue.

Your consultant may have changed. We've posted new contact lists to help you find the correct person. There are two lists:

- **Primary care physicians and medical care groups**
- Specialists and other professional providers – To find your list:
  - Go to **bcbsm.com/providers**.
  - Click on *Contact Us* in the upper right corner.
  - Under Physicians and professionals, click on *Blue Care Network provider contacts*.
  - Click on *Provider consultants* and select your geographic region. If you don't know which region you're in, you can view our **map**.

Please see Consultants, continued on Page 2

Blue Cross and BCN program reduces doctor shopping

Blue Care Network and Blue Cross Blue Shield of Michigan have reduced the number of opioid pills dispensed by more than 600,000 pills due to doctor shopping. Doctor shopping occurs when a member visits multiple physicians to obtain multiple prescriptions.

When we identify members that meet certain criteria, we send a fax notifying providers about their patient's behavior. We also share reports with provider organizations. Providers are encouraged to check the Michigan Automated Prescription System, or MAPS, when prescribing. State monitoring programs allow a provider to see if a patient is also receiving prescriptions written by other doctors.

We've been monitoring members since 2012, but changed the program criteria in 2016. Since the changes, we've shown a 65 percent reduction of members identified (through May 2018). Members who continue to meet criteria are reviewed by Blue Cross and BCN's controlled substance workgroup for further intervention, which may include referral for treatment of substance use disorder.

Inside this issue…

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Consultants, *continued from Page 1*

Please remember the first point of contact for claim questions is still Provider Inquiry:

- 1-800-344-8525 for medical providers
- 1-800-482-4047 for vision and hearing providers

If your issue isn't satisfactorily resolved, ask the customer service representative to escalate your inquiry to a manager. By directing issues through standard methods such as Provider Inquiry, we can better identify problems, prioritize efforts and fix problems impacting many providers simultaneously versus one practice at a time.

The **Blue Cross** and **BCN** resource guides include contacts for questions related to laboratory, pharmacy, behavioral health and other areas.

With current investments being made in our standard processes, we expect you will see incremental improvements resulting in higher satisfaction over time when you reach out to us for information or assistance.

Only minor changes to hospital and facility consultant assignments

There have only been minor changes to the provider consultant assignments for hospitals and facilities. Here's how you can find the hospital and facility consultant lists:

- Go to **bcbsm.com/providers**.
- Click on *Contact Us* in the upper right corner.
- Under Hospitals and facilities, click on either *Blue Cross Blue Shield of Michigan provider contacts* or *Blue Care Network provider contacts*. Both take you to the same location.
- Click on *Provider consultants* and select the provider's geographic region. If you're not sure of the region, view our **map**.

We're continuing to work out details of our reorganization to help serve you better. If you have specific comments or suggestions, contact us at provideroutreach@bcbsm.com.

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Here's an update on Blue Distinction Specialty Care

We want to remind you about this important Blue Cross and Blue Shield Association designation program and let you know how it's changed over the past year.

About the program

Blue Distinction® Specialty Care recognizes health care facilities and providers that demonstrate proven expertise in delivering high-quality, effective and cost-efficient care for select specialty areas.

The goal of the program is to help members find quality specialty care on a consistent basis nationwide and encourage health care providers to improve the overall quality and delivery of specialty care. The program currently includes the following seven areas of specialty care:

- Bariatric surgery
- Cardiac care
- Knee and hip replacement
- Spine surgery
- Maternity care
- Cancer care
- Transplants

Blue Cross Blue Shield of Michigan awards health care facilities and providers with two levels of designation:

- **Blue Distinction Centers** are providers recognized for their expertise in delivering safe, effective, high-quality specialty care.
- **Blue Distinction Centers+** are providers recognized for their expertise and cost-efficiency in delivering specialty care. Only those providers that first meet Blue Distinction Centers' nationally established, objective quality criteria are considered for designation as a Blue Distinction Center+.

About selection criteria

Blue Distinction Center and Blue Distinction Center+ designations are awarded to facilities and providers based on a thorough, objective evaluation of their performance in the areas that matter most, including quality care, treatment expertise and overall patient results. Selection criteria are developed with the help of expert physicians and medical organizations. Blue Distinction Centers and Blue Distinction Centers+ have a proven history of delivering better quality and results, such as fewer complications and lower readmission rates, than those without these recognitions.

Recent program changes

- The new complex and rare cancer care program launched Jan. 1, 2018, replacing the program that ended Dec. 31, 2017. Here are features of the new program:
  - There's no restriction on cancer type.
  - Hospitals, physician groups and individual physicians can be designated.
  - The provider must be engaged in a value-based payment arrangement with a Blue plan to be designated.
  - There's no BDC+ designation; only BDC.
- As of Jan. 1, 2018, the bariatric surgery program went from a type of service designation (stapling versus banding) to a place-of-service designation (comprehensive center versus ambulatory surgery center). This means that an entity can either be designated for bariatric surgery as a comprehensive center or an ASC.

Program refreshes

- The Blue Cross and Blue Shield Association refreshes criteria for designation in each specialty area of the program about every two years to provide meaningful quality and cost differentiation to employers, employees and providers. To remain designated, facilities must reapply for Blue Distinction Center designations during each re-evaluation cycle.
- The spine surgery and knee and hip replacement programs are being refreshed this year. In the new cycle, ASCs can earn BDC designation in addition to hospitals. This August, Blue Cross Blue Shield of Michigan will be sending a letter to each facility and ASC that performs these procedures, inviting them to apply for designation by submitting a provider survey. The refreshed programs are tentatively scheduled to be effective July 1, 2019.

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BDSC, *continued from Page 3*

Coming next

- A new fertility care program will launch Jan. 1, 2019.
- A new gene therapy program is tentatively scheduled to launch Jan. 1, 2019.
- A new cellular immunotherapy program is tentatively scheduled to launch Jan. 1, 2019.
- A new substance use disorder program is tentatively scheduled to launch Jan. 1, 2020.

Finding a center

The Blue Distinction Specialty Care program provides broad national access to facilities and providers by delivering better quality specialty care, making them easy to find wherever you work and live across the U.S. You can easily locate a Blue Distinction Center using the **Blue Distinction Center Finder** or by using our **Find a Doctor** feature at **bcbsm.com**.

Did you know?

Today, more than 3,600 Blue Distinction Center and Blue Distinction Center+ designations have been awarded to more than 1,900 health care facilities in 48 states.

Getting results

As you may have read in the **2017 Value Partnerships Annual Report**, Blue Distinction Specialty Care is helping members find high-quality, cost-efficient facilities nationwide. The program is a key tool in our efforts to manage health care costs. Analysis confirms that, overall, patients treated at Blue Distinction Centers and Blue Distinction Centers+ have better outcomes, such as fewer complications and lower readmission rates. Overall, Blue Distinction Centers+ are also more cost-efficient than non-Blue Distinction Centers+, with episode savings of nearly 20 percent on average.

Here's an overview of national savings in six areas for providers receiving the Blue Distinction Center+ designation:

- Bariatric surgery — 29 percent savings
- Cardiac care — 23 percent savings
- Knee and hip replacement —24 percent savings
- Maternity care — 23 percent savings
- Spine surgery —22 percent savings
- Transplants — 31 percent savings

Note: Savings, calculated from Blue Cross and Blue Shield Association data, are based on total episode cost, and compare Blue Distinction Center+ facilities versus a relevant comparison group.

Important information about the new audit process

Blue Cross Blue Shield of Michigan and Blue Care Network have partnered with Health Management System to assist with various post pay audits.

- For Blue Cross, HMS will conduct selective professional and non-hospital facility audits.
- For both Blue Cross and BCN, HMS will conduct the diagnosis-related group audits.
- Inpatient high dollar audits will remain as they are.

DRG audits are a retrospective review of paid claims. The review ensures that billed and paid services were ordered, medically necessary, documented, and reported correctly. For these audits, medical records will be requested for review. Once the review has been completed, HMS will send the findings letter and information on how to request an appeal, if necessary.

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How to request peer-to-peer review of inpatient admissions

Blue Cross Blue Shield of Michigan and Blue Care Network allow onsite physician advisors at contracted facilities to discuss reviews of inpatient admissions with a Blue Cross or BCN medical director. According to our policy, facilities should start peer-to-peer conversations only through their employed physician advisors, and not through third-party advisors or organizations.

This applies to members with coverage with commercial Blue Cross PPO and BCN HMO℠, Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠ products.

The purpose of the peer-to-peer discussion is to exchange information about the clinical nuances of the member's medical condition and the medical necessity of the inpatient admission, not to discuss InterQual® criteria or Blue Cross and BCN local rules.

Use the following guidelines to request a peer-to-peer review with a Blue Cross or BCN medical director.

Non-behavioral health inpatient admissions

For BCN HMO and BCN Advantage members:

1. Call 248-799-6312
2. Select prompt 3 for a *peer-to-peer discussion*
3. Leave a message that includes:
   - Reason for requesting a peer-to-peer review
   - Member's name, date of birth and contract number
   - Physician advisor or physician's name and phone number
   - Best date and time to reach the physician advisor or physician

For Blue Cross PPO and Medicare Plus Blue members:

1. Call 1-866-346-7299
2. Select prompt 2 for the *Facility Precertification department*
3. Select prompt 1 to request a *provider peer-to-peer review*
4. Wait for the prompt to leave a message, then provide:
   - Reason for requesting a peer-to-peer review
   - Member's name, date of birth and contract number
   - Physician advisor or physician's name and phone number
   - Best date and time to reach the physician advisor or physician

Behavioral health inpatient admissions

For BCN HMO, BCN Advantage and Medicare Plus Blue members:

1. Call 1-877-293-2788
2. If a live operator doesn't answer the call, leave a message that includes:
   - Name of the person calling and a call-back number
   - Member's name, date of birth and contract or case number
   - Specific times the provider is available to discuss the case
   - Physician advisor or physician's name and phone number

For Blue Cross PPO members, call the behavioral health number on the back of the member's ID card.

The peer-to-peer phone lines are open Monday through Friday, from 8 a.m. to 5 p.m. Eastern time, except for holidays. We'll return your call within 48 business hours.

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Talk with your patients about osteoporosis

Many people don't know they have osteoporosis until they suffer a fracture. That's why it's important to maintain ongoing conversations with your older patients about the risks of falls and the benefits of osteoporosis screening.

Starting the conversation

- Proactively evaluate the risk of falls with older patients at each office visit:
  - Ask your patients if they've fallen or had issues with balance and walking.
  - As appropriate, suggest:
    - » A cane or walker
    - » An exercise program
    - » Vision testing
  - Assess the potential causes such as medications.
  - Consider the need for vitamin D supplementation.
- For women ages 65 and older, reinforce the importance of screening for osteoporosis with bone mineral density testing. This test is the only one that can diagnose osteoporosis.
- For women ages 67 and older who've already incurred a fracture, order a bone mineral density test and prescribe an osteoporosis medication within six months of the fracture. Do this unless BMD testing was done within two years of the fracture or osteoporosis treatment has occurred 12 months before the fracture.

Checking on osteoporosis care

HEDIS® star measures, including the Health Outcomes Survey, evaluate osteoporosis care and the risk of falls.

- **HEDIS measures:**
  - The Osteoporosis Management in Women Who Had a Fracture measure assesses the percentage of women ages 67 and older who had a bone mineral density test or treatment for osteoporosis within six months of a fracture.
    - » Patients who had bone mineral density testing two years prior to a fracture or osteoporosis treatment 12 months before the fracture are excluded.
  - The Risk of Falls measure assesses the percentage of members 65 and older who:
    - » Were seen by a practitioner in the past 12 months
    - » Discussed falls or problems with balance or walking with their current provider
- The Health Outcomes Survey asks patients:
  - Have you ever had a bone mineral density test to check for osteoporosis?
  - Has your doctor discussed the risk of falls, how to prevent falls or treat problems with balance or walking?

For more information

The U.S. Preventive Services Task Force **webpage on osteoporosis** indicates that doctors should screen all women age 65 and older for osteoporosis.

The American College of Physicians published evidence-based **osteoporosis treatment guidelines** in the *Annals of Internal Medicine* on May 9, 2017. The group recommends that doctors offer pharmacologic therapy to reduce the risk for hip and vertebral fractures in women with known osteoporosis.

You can also check out the Centers for Disease Control and Prevention's **Older Adult Falls** webpage.

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Physicians should recommend physical activity to older patients

One in three older adults fall every year and these falls threaten the lives, independence and health of these adults. Twenty to 30 percent of those adults who suffer moderate to severe injuries after experiencing a fall will find it harder to get around, or live independently. Falls also increase the risk of an early death.

One out of every five falls causes a serious injury such as a broken bone or head injury. The most common cause of traumatic brain injury is a fall.

People who fall but don't experience an injury may develop a fear of falling which may cause many to limit their activities. This can lead to reduced mobility and loss of physical fitness, which increases their actual risk of falling.

One of the most important things providers can recommend to their older patients is physical activity.

There are four types of exercise that encompass all the benefits of physical activity: Endurance, strength, balance and flexibility. It's important to remind patients to start out slowly and build up to more activity and intensity of activity. Exercising shouldn't cause pain or tiredness. Many local fitness centers, hospitals, churches, religious groups, senior and civic centers, parks, recreation associations, YMCAs, YWCAs and shopping malls have exercise, wellness or walking programs.

Here are some groups you can recommend to older patients looking for information about physical activity:

- American College of Sports Medicine
  1-317-637-9200
  www.acsm.org
- Centers for Disease Control and Prevention
  1-800-232-4636 (toll-free)
  1-888-232-6348 (TYY/toll free)
  www.cdc.gov
- National Library of Medicine
  Medline Plus
  Exercise for Seniors
  Exercise and Physical Fitness
  www.medlineplus.gov
- President's Council on Fitness, Sports and Nutrition
  1-240-276-9567
  www.fitness.gov

For more information contact:

National Institute on Aging Information Center
1-800-222-2225 (toll-free)
1-800-222-4225 (TTY/toll-free)
www.nia.nih.gov
www.nia.nih.gov/Go4Life

References:
http://www.cdc.gov/physicalactivity/basics/older_adults/index.htm
http://www.cdc.gov/HomeandRecreationalSafety/index.html
https://www.nlm.nih.gov/medlineplus/falls.html
http://www.niams.nih.gov/Health_Info/Bone/Osteoporosis/Fracture/prevent_falls_ff.asp
https://www.nia.nih.gov/health/publication/exercise-and-physical-activity
http://www.cdc.gov/features/activity-older-adults/index.html

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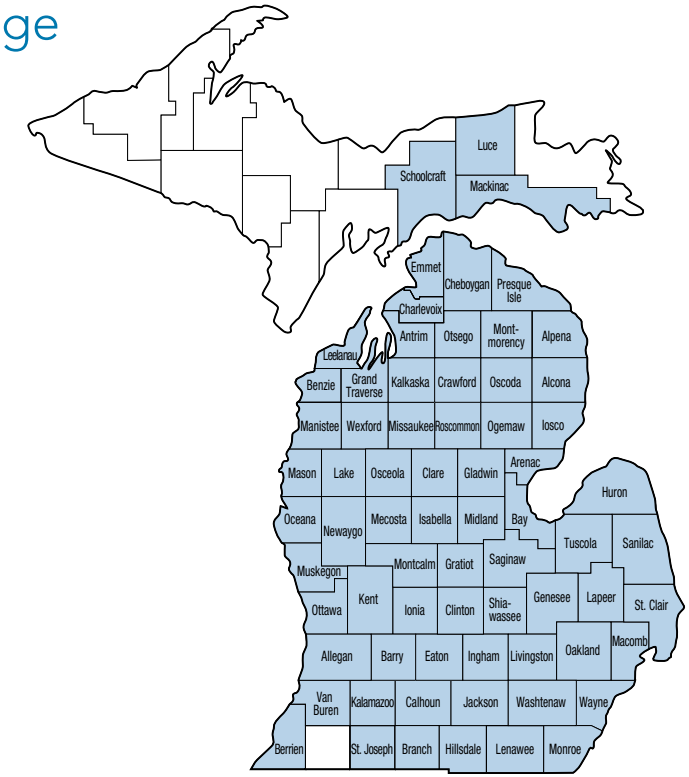
We've expanded BCN Advantage coverage area

We've expanded services for BCN Advantage℠ HMO-POS products to Berrien County and added new ZIP codes that enable us to provide full access in St. Joseph county. This brings BCN Advantage coverage into 70 Michigan counties.

The expansion applies to the HMO-POS products – Elements, Basic, Classic and Prestige.



Clarification: Vivaglobin does not require authorization

We published an article in the **July-August issue** announcing that additional specialty medications covered under Medicare Part B medical benefit require authorization for BCN Advantage members, starting Oct. 1.

Vivaglobin® (HCPCS code J1562) won't require authorization because it's being discontinued. This is a change from what we communicated in the newsletter article.

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

- Physician office (Place of Service code 11)
- Outpatient facility (Place of Service codes 19, 22 and 24)

Note: In the July-August 2018 newsletter article, we mentioned only Place of Service codes 19 and 22 for outpatient facilities, but authorization is also required for Place of Service code 24.

Authorization is not required for these medications when they are billed on a facility claim form (such as the UB 04) or electronically via an 837I transaction

Substance use disorders: How primary care physicians can be part of the treatment team

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By Michael L. Fox, D.O., DFASAM

Dr. Fox is board-certified in addiction medicine. He serves as medical director, chemical dependency unit, at St. Mary Mercy Hospital, Livonia and is an associate clinical professor at Michigan State University, Wayne State University and the University of Detroit.

When it comes to treating substance use disorders, a primary care physician is an integral part of the treatment team.

Typically, a primary care physician can make a diagnosis, or a suspicion of a diagnosis, using some simple measures. Those measures include using the Michigan Automated Prescription System, a urine drug screen and a patient history.

Using MAPS is now required by the state of Michigan when prescribing opiates. It allows you to see if your patient is visiting other physicians to obtain prescriptions, sometimes known as doctor shopping.

Periodic drug screens are useful because they might be a clue that your patient may be using illicit substances or prescription medicines that aren't prescribed by you. This is a red flag, especially when a person is requesting a medication refill.

As we all know, a history is critical. When doing a history, one should always include three things:

- Alcohol use
- Street drug use (most patients will not classify cannabis as a street drug)
- Prescription drug use

When taking a history, it's also important to ask about present and past use. It's critical to ask the frequency of use and the typical amount. Ask patients if their use is past or present; is it regular or somewhat regular? What is the amount (the most) they can or have consumed? This applies to alcohol, illicit substances and prescription medicine.

Providers can easily assess whether a patient is participating in high-risk drinking. Using readily available information, you can determine:

- How much a female can drink in one sitting
- How much a 70-year-old can drink
- How much a male can drink before he passes the threshold of what is known as high-risk drinking

It's always important to ask when your patient first used a substance. Typically, their first use would have been in middle or high school and, typically it would have been alcohol or cannabis.

You should also discuss problems that may be related to the patient's substance use. Patients don't always realize the problems caused by their disorder.

The following are indications that the patient may be have problem related to substance use disorder:

- A physician is concerned about the patient.
- A psychiatrist has expressed concern about the patient.
- The patient has a history of driving under the influence or some other legal problem.
- The patient has an issue on his or her job or a problem with family relationships.

Sometimes there are other significant problems, or the patient may have an inkling that their substance use has a causal relationship or other issues in their lives.

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Substance use, *continued from Page 9*

When you're treating a patient who has already been diagnosed

If a primary care physician is on the other end of the care spectrum (after the disorder has been diagnosed) and a patient tells you he or she has been in treatment for substance use disorder, it's important to know a few things.

The first thing is what not to prescribe. Typically, benzodiazepines are a big problem in the country and, for the most part, should never be prescribed for more than two weeks.

This class of medication should also never be prescribed for a patient taking an opiate for pain.

Consequently, PCPs wouldn't want to use any prescription medications that are problematic. I stress stimulants, such as Adderall, benzodiazepines and opiates. There are alternative medications that can be prescribed for ADD. And there are many medications that can be prescribed as alternatives for benzodiazepines.

If the patient has a past use disorder with opiates, he or she will always have a tolerance, always be at risk and will be very difficult to treat for pain without high risk relapse.

You can consult with an addiction specialist if you're uneasy with a pain issue in a patient who has a history of opiate dependency. Typically, those patients do better when they're on medication-assisted treatment, which could be buprenorphine or vivitrol, the latter of which would block any use of opiates. (Some people don't think Tramadol is an opiate.)

The primary care physician is a big player as addiction specialists often refer people back to their primary physician. Often, we like to let the primary doctor know we don't want them to prescribe benzodiazepines, stimulants or opioids when the patients allow continuity of care.

When the PCP is the main provider of care, he or she should be sure that patient is attending support groups, counseling and psychiatric care, if indicated.

Approximately 50 percent of people with substance use disorders have a co-occurring mood disorder. However, that doesn't give the psychiatrist who is the treating provider a green light to use inappropriate medicines, such as benzodiazepines or stimulants.

If the patient isn't on medication-assisted treatment and has a pain issue, it's high risk to use these opiates; using them for longer than three or four days places this patient at great risk. This patient again should be followed with urine drug screens and MAPS.

These days, it's going to be harder for physicians to prescribe medication for acute pain for longer than seven days. To continue it in these patients is high risk.

I can't stress enough how problematic benzodiazepines are; these aren't indicated for anything more than detoxification from alcohol and for no longer than about five days.

There are many medications we can use for anxiety and ADD. Some SSRIs are "on label" for this purpose and work well as do other classes of antidepressants. Strattera and Intuniv work well for ADD. Gabapentin, trazodone, propranolol and other anticonvulsants can be used off label for anxiety, along with some alternative compounds such as valerian and chamomile for anxiety and protracted anxiety after treatment for alcohol withdrawal. Mirtazapine can be used for anxiety symptoms, especially if accompanied by a co-occurring mood disorder.

Remember that anxiety can manifest itself not only from post-traumatic stress syndrome, which is often treated with SSRIs, but also bipolar disorder, which is a diagnosis that is often missed for at least 10 years with failed response to medications. Mood stabilizers are indicated to reduce anxiety for patients with bipolar, but benzodiazepines are essentially contraindicated.

When in doubt, contacting a certified expert in addiction medicine is your best route; addiction specialists can be found at treatment centers. These doctors want to help you help these patients. They'd prefer not to have them readmitted to their facilities because their relapse begins with a provider's prescription.

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BCN Chronic Condition Management Program overview

Blue Care Network delivers an innovative chronic condition management and registry program for our members and their physicians. Chronic condition management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions.

Chronic condition management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based guidelines and patient empowerment strategies such as self-management. We continuously evaluate clinical, humanistic and economic outcomes with the goal of improving overall health.

BCN's chronic condition management programs focus on improving the health status of members with certain chronic conditions. These programs teach members how to manage certain diseases, empower members and families on self-management and how to avoid exacerbation and complications of the diseases. We also remind members when to have important exams, tests and immunizations. BCN's chronic condition management programs are an opt-out design. Eligible members must elect not to receive chronic condition management services to decline participation.

BCN offers chronic condition management programs for:

- Asthma
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Heart failure
- Ischemic heart disease
- Kidney health management

The primary goals of the chronic condition management programs include:

- Increase member adherence to their treatment plan through education on their chronic condition and associated self-management tools
- Increase practitioner awareness of current treatment modalities and maximizing use
- Improve the rate of appropriate pharmaceutical use according to current clinical practice guidelines
- Decrease unnecessary inpatient admissions and emergency department visits
- Decrease workplace absence
- Assist practitioners in tracking and monitoring services needed by members
- Educate members on the purpose and importance of advance directives
- Encourage member communication with their practitioner about their health condition and treatment

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Chronic condition management, *continued from Page 11*

Chronic condition management program content addresses:

- Condition monitoring (including self-monitoring and medical testing)
- Patient adherence to the treatment plan (including medication compliance)
- Medical and behavioral health comorbidities and other health conditions
- Health behaviors
- Psychosocial issues
- Depression screening
- Information about the member's condition provided to caregivers that have the member's consent
- Additional resources external to BCN

BCN uses the following sources to identify members who qualify for chronic condition management programs:

- Claims data
- Pharmacy data
- Health assessment results
- Laboratory results
- Data collected through the utilization management and case management processes
- Data from health management, wellness or health coaching programs
- Information from electronic health records, if available
- Member and practitioner referrals

Gaps in care initiatives

BCN also delivers targeted outbound calls for diabetic members with no A1C and diabetic members with high A1C. Nurses also deliver targeted outreach for beta blocker after a cardiac event.

WebMD

We maintain a partnership with WebMD Health Service that facilitates member engagement. Members with chronic conditions can easily take advantage of a plethora of electronic resources.

Members with chronic conditions who register on the site can read health articles and watch videos specific to health conditions, check symptoms and learn about medications, access and use a personal health record and sync fitness and medical devices with apps to keep information in one convenient place. Interactive quizzes, tracking monitors and professionally-monitored message boards are also included. Finally, upon completion of the health assessment, members can receive emails about specific preventive and care gap reminders.

Follow MQIC blood lead testing guidelines

Michigan Quality Improvement Consortium guidelines recommend blood lead level testing at ages 9 months and 18 months. The **guidelines** can be found at the Michigan Quality Improvement Consortium website.

The Michigan Department of Community Health has a Lead Poisoning Prevention Program. Michigan's Childhood Lead Poisoning Prevention Program provides education and outreach regarding lead hazards and the effects of lead poisoning. Prevention strategies are included in a state work plan for preventing childhood lead poisoning. It also offers information on the number of children with elevated blood lead levels and the percentage of children tested. The program includes training on in-office lead level testing and a questionnaire on lead exposure.

For more information on this program, visit the **Michigan Department of Health and Human Services** website.

The Centers for Disease Control and Prevention offers a **fact sheet** for parents and information on their **website** for providers.

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2018 InterQual® criteria became effective Aug. 6

Blue Care Network's utilization management and behavioral health staffs use Change Healthcare (formerly called McKesson) InterQual criteria when reviewing requests for Blue Care Network and BCN Advantage℠ members.

InterQual criteria have been a nationally recognized industry standard for more than 20 years. BCN may use other criteria resources for appropriate levels of care, including BCN medical policies, the member's specific benefit certificate and clinical review by the BCN medical directors.

Change Healthcare (McKesson Corporation's CareEnhance™) solutions include InterQual clinical decision support tools. Change Healthcare (McKesson) is a leading provider of supply, information and care management products and services designed to manage costs and improve health care quality.

BCN began using the following criteria on August 6, 2018. The 2018 Local Rules in the PDF below are effective in October.

Criteria/Version	Application
InterQual® Acute – Adult and Pediatrics	• Inpatient admissions • Continued stay discharge readiness
InterQual® Level of Care – Subacute and Skilled Nursing Facility	• Subacute and skilled nursing facility admissions
InterQual® Rehabilitation – Adult and Pediatrics	• Inpatient admissions • Continued stay and discharge readiness
InterQual® Level of Care – Long-Term Acute Care	• Long-term acute care facility admissions
InterQual® Level of Care – Home Care	• Home care requests
InterQual® Imaging	• Imaging studies and X-rays
InterQual® Procedures – Adult and Pediatrics	• Surgery and invasive procedures
Medicare Coverage Guidelines *Applies to BCN Advantage only*	• Services that require clinical review for medical necessity and benefit determinations
Blue Cross/BCN medical policies	• Services that require clinical review for medical necessity
BCN-developed imaging criteria	• Imaging studies and X-rays
BCN-developed Local Rules	• Exceptions to the application of InterQual criteria that reflect BCN's accepted practice standards
Behavioral Health Utilization Management Clinical Criteria	• Behavioral health services that require clinical review for medical necessity

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Intimate partner screening is part of MQIC preventive service guidelines

Domestic violence, also referred to as intimate partner violence, is a repetitive pattern of behaviors used to maintain power and control over an intimate partner. These are behaviors that physically harm, arouse fear, prevent a partner from doing what he or she wishes or force him or her to behave in unwanted ways. Abuse includes the use of physical and sexual violence, threats and intimidation, emotional abuse and economic deprivation. Many of these different forms of abuse can be going on at one time.

Domestic violence is an epidemic that affects individuals in every community, regardless of age, economic status, sexual orientation, gender, race, religion or nationality. It can result in physical injury, psychological trauma and even death.

Domestic violence often intensifies gradually over time so it isn't always easy to determine in the early stages of a relationship if a person is abusive. Often the abusive behaviors are dismissed or downplayed in the beginning of a relationship. It's important to note that domestic violence doesn't always manifest as physical abuse. Emotional and psychological abuse can often be just as damaging to the victim as physical abuse.

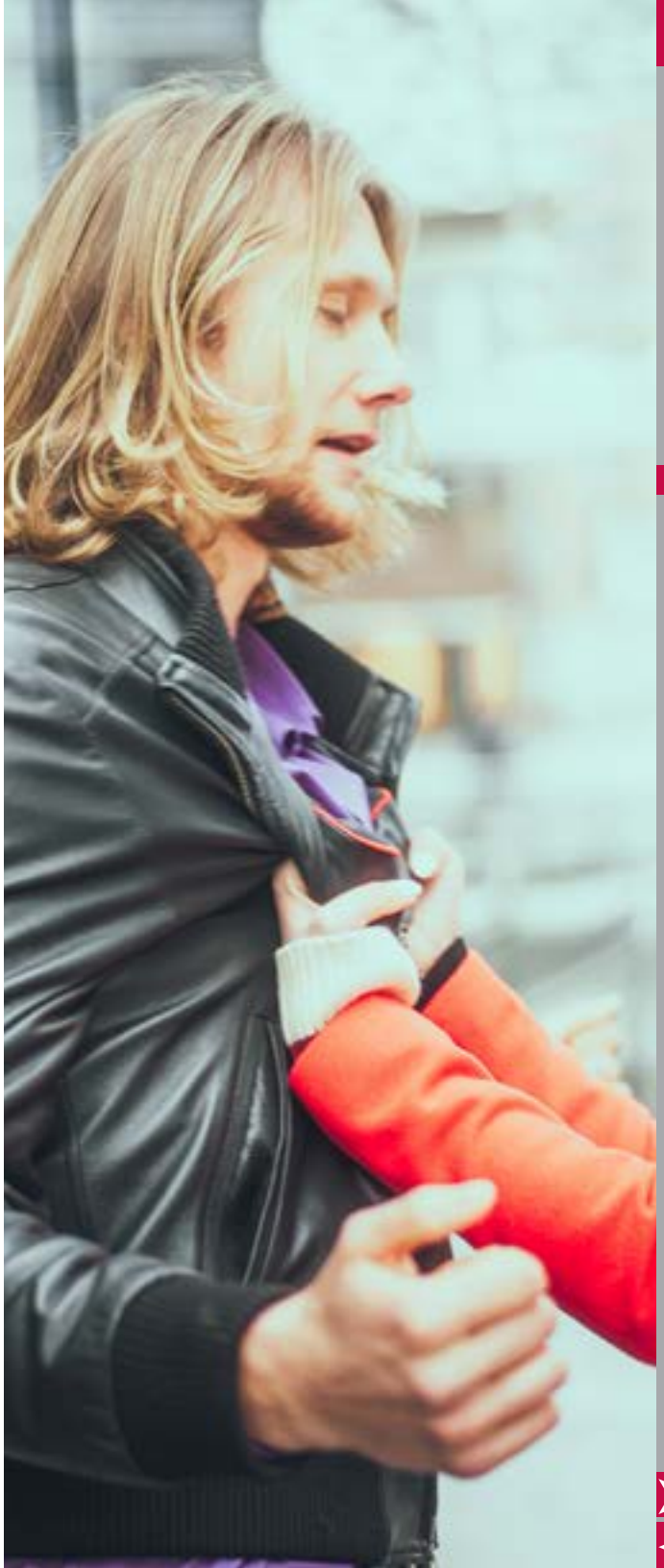
Many times, domestic abuse intensifies when the victim attempts to escape the abuser, terminate the relationship or seek help as the abuser feels a loss of control over the victim.

Anyone can be a victim of domestic violence.

The same can be said of abusers – there is no typical abuser. It's important to note that most abusers are only violent with their current or past intimate partners. One study found that 90 percent of abusers don't have criminal records, and are generally law-abiding outside of the home.

Intimate partner violence screening is part of the **Michigan Quality Improvement Consortium Adult Preventive Services (ages 18-49)** guideline.

If you think one of your patients is a victim of domestic violence, encourage the patient to talk to someone he or she trusts or call the National Domestic Violence Hotline, which is available 24 hours a day, seven days a week, 365 days a year. Online chat is available every day from 8 a.m. to 3 a.m. Eastern time at 1-800-799-7233 (SAFE).



Opioid roundup

Here's a roundup of articles about the opioid crisis, including general information, statistics and Blue Cross efforts.

Impacts from the $570,000 Blue Cross Blue Shield of Michigan opioid grant partnership

The MI Blues Perspective blog features three articles about how the impact of the $570,000 in Blue Cross Blue Shield of Michigan opioid grants are affecting the state.

- **Taking Action: Prevention Driving U.P. Coalition Efforts to Combat Opioids**
- **Taking Action: Multi-prong approach fighting opioids in Northern Michigan**
- **Taking Action: The Power of Putting "Hope Before Handcuffs"**

CEO Loepp discusses opioid crisis with business leaders

Blue Cross Blue Shield of Michigan President and CEO Daniel J. Loepp shared some of the results of the company's efforts in battling the opioid epidemic during the state's Mackinac Policy Conference in late May. This annual event is sponsored by the Detroit Regional Chamber, and gathers prominent state and national speakers to discuss topics important to Michigan.

Loepp was a featured panelist in a discussion titled "Opioids in the Workplace: Impacting Michigan." He was joined by Penske Corp. President Bud Denker Gallagher Benefit Services Health Management Director Jenny Love and former U.S. Attorney Barbara McQuade. For more information, see the article, **Opioid in the workplace**, on our MI Blues Perspective blog.

New Michigan law limits amount of opioids doctors can prescribe

A new state law limits the amount of opioids that doctors are allowed to prescribe patients who have acute pain, the Detroit Free Press reported June 28. Effective July 1, 2018, doctors are prohibited from prescribing more than a seven-day supply of opioid medication for patients in acute pain — pain from broken bones, bad backs, short illnesses and most surgeries — pain that's relatively short term.

Doctors can't write refills for the medications until the seven-day period has elapsed. To read more, see the *Detroit Free Press* **article**.

Study says number of opioid overdose deaths undercounted

According to a University of Pittsburgh study, 216 opioid overdose deaths likely went unreported in 2015. That brings the total up to 1,402 accidental opioid overdose deaths in 2015, 14th in the nation. For more about the study, see the *Detroit Free Press* **article**.

Blue Cross efforts to reduce opioid use

Blue Cross Blue Shield of Michigan is expanding access to resources and treatment for individual and families. Through statewide partnerships, Blue Cross saw a 34 percent decrease in opioid prescriptions per 1,000 members between 2013 and 2017.

For more information, see the **MI Blues Perspectives blog**.

How Blue Cross plans are working to improve addiction treatment

A recent article by our CEO Dan Loepp features what Blue Cross plans are doing to improve treatment for addiction.

One initiative includes a new designation for effective treatment programs. It builds on the existing Blue Distinction system that evaluates and identifies the highest quality doctors and hospitals.

See the complete **article** on MI Blues Perspectives blog.

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Campaign created to raise awareness of prescription drug abuse

Blue Cross Blue Shield of Michigan, the Michigan Health & Hospital Association, Michigan Osteopathic Association, the Michigan Open Prescribing Engagement Network and the Michigan State Medical Society recently teamed up to announce the "Be Rx SAFE" opioid awareness campaign. The campaign was created to raise awareness about the dangers of prescription drug abuse and overuse and encourage prescribers and patients to do their part in addressing the opioid crisis.

To learn more, read the **MI Blues Perspective blog**.

SAMHSA offers opioid prevention toolkit

The Substance Health and Mental Services Administration, or SAMHSA, has a toolkit that offers strategies to health care providers, communities and local governments for developing practices and policies to help prevent opioid-related overdoses and deaths.

Access reports for community members, prescribers, patients and families and those recovering from opioid overdose at the **SAMHSA website**.

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Talk with your patients about importance of complying with statin therapy

Several modifiable risk factors for cardiovascular disease are well-known and can be treated, including hyperlipidemia, or high cholesterol. Although treatments for hyperlipidemia, such as statin therapy, are effective and relatively inexpensive, many people aren't controlling their condition adequately.

Talk with your patients about their risk factors associated with cardiovascular disease and the importance of complying with their statin treatment.

To read more about the use of statin therapy for patients with cardiovascular disease, see the **article** in the July – August 2017 issue of *Hospital and Physician Update*.

Did you know?

According to the Centers for Disease Control and Prevention:

- Heart disease is the leading cause of death for men and women in the U.S.
- An estimated one in every seven U.S. dollars spent on health care goes toward cardiovascular disease.
- This expenditure totals more than $300 billion in annual health care costs and lost productivity from premature deaths each year.

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Tell us what you think about Blue Cross and BCN utilization management services – You could win a prize!

Blue Cross Blue Shield of Michigan and Blue Care Network want to know how satisfied you are with utilization management services and how we can improve to better meet your needs.

Your feedback is important to us. Please complete the 2018 Utilization Management **Survey** and encourage your office colleagues to do so as well, including physicians, nurses and referral coordinators. Your input will help us evaluate our efforts and determine other improvements to enhance our care management processes.

The survey will be available online October through Dec. 31, 2018.

As a token of our appreciation, those who respond and provide their contact information following the survey will be entered in a drawing to win one of two $250 gift certificates.* All survey responses must be submitted *no later* than Dec. 31, 2018, in order to be eligible for the random drawing.

*Two winners will be selected in a random drawing at the end of the survey from among all eligible entries. The winners will receive a $250 gift certificate. No participation is necessary. The drawing will take place approximately one month following the closure of the survey. The winners will be notified by telephone or email following the drawing.

This drawing is open to all contracted Blue Cross and BCN providers. If you do not wish to participate in the survey but want to be included in the drawing, you may enter by emailing BCBSMandBCNPhysicianSurvey@bcbsm.com with your entry request. Please include your name, phone number, office name and address. All requests must be emailed no later than Dec. 31, 2018.

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

- Autografts and allografts for nerve repair
- Interferon lambda 3 (IFNL3) testing to predict response to treatment of Hepatitis C virus (HCV) infection
- Molecular testing (proteomic and gene expression) in the management of pulmonary modules
- Urinary tumor markers for bladder cancer

Covered services

- Autografts and allografts in the treatment of focal articular cartilage lesions
- Genetic testing-molecular markers in fine needle aspirates (FNA) of the thyroid
- Intraoperative neurophysiologic monitoring
- Pulmonary rehabilitation
- Reconstructive breast surgery/management of breast implants

Medical Policy Updates

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Help male patients make informed decisions about prostate cancer screening

The Michigan Quality Improvement Consortium Guidelines recommends against prostate-specific antigen-based screening for prostate cancer. It's recommended that men make an informed decision with their health care providers about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks and potential benefits of the screening. Men shouldn't be screened unless they have received this information.

The discussion about screening should take place at:

- **Age 50 for men who are at average risk** of prostate cancer and are expected to live at least 10 more years
- **Age 45 for men a high risk** of developing prostate cancer, including African Americans and men who have a first degree relative (father, brother or son) diagnosed with prostate cancer at an early age (younger than 65)
- **Age 40 for men at even higher risk** (those with more than one first degree relative who have prostate cancer at an early age)

As new information about the benefits and risks of testing becomes available, the discussion about the pros and cons of testing should be repeated. It's also important to consider changes in the patient's health, values and preferences. Overall health status, and not age alone, is important when making decisions about screening.

Sources:
Michigan Quality Improvement Consortium: **http://www.mqic.org/pdf/mqic_adult_preventive_services_ages_50_to_65plus_cpg.pdf**
American Cancer Society: **https://www.cancer.org/cancer/prostate-cancer.html**

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Well-child visits present opportunities for physicians

A well-child visit is the perfect opportunity to monitor the physical, emotional and psychological well-being as a child grows and develops. From birth through early childhood, a child will have more frequent well-child visits offering excellent opportunities for physicians to communicate information about normal growth and development as well as education on immunizations, safety, exercise and nutrition with the parents.

Providers should record the child's weight, height, and head circumference on a growth chart and keep information in the child's medical record. Well-child visits also include opportunities to provide BMI screenings and discussions about many topics:

- Nutrition
- Sleep
- Safety
- Physical activity
- Violence, abuse and bullying
- Sexually transmitted infection prevention
- Suicide threats
- Alcohol and drug abuse
- Behavioral and other emotional problems
- Anxiety, stress reduction, coping skills
- Immunizations
- Skin cancer prevention
- Risk assessments including tobacco use and secondhand smoke exposure
- Poison prevention
- Burn prevention
- Injury prevention

Family relationships, school, and access to community services can also be discussed and documented at these visits.

The American Academy of Pediatrics **Bright Future guidelines** (includes three additional screenings):

- Autism screening at 18 and 24 months of age
- Cholesterol screening from ages 9 to 11
- Annual screening for high blood pressure beginning at age 3

Find recommended routine preventive services for infants, children and adolescents at **Michigan Quality Improvement Consortium** site. Also review the American Academy of Pediatrics **Bright Future** guidelines.

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Starting Aug. 6, updated utilization management criteria used for behavioral health

On Aug. 6, 2018, Blue Care Network and Blue Cross Medicare Plus Blue℠ PPO started using the 2018 InterQual® criteria for behavioral health utilization management determinations.

For certain services, we base utilization management decisions on modified 2018 InterQual criteria, local rules or medical policies, instead. These changes also began Aug. 6. The services affected by these changes are outlined in this table.

Line of business	Modified 2018 InterQual criteria for:	Local rules or medical policy for:
BCN HMO℠ (commercial) and BCN Advantage℠	Substance use disorders: partial hospital program and intensive outpatient program Residential mental health treatment (adult/geriatric and child/adolescent) – for BCN HMO only	Autism spectrum disorder / applied behavior analysis (local rules) Neurofeedback for attention deficit disorder / attention deficit hyperactivity disorder (medical policy) Transcranial magnetic stimulation (medical policy)
Medicare Plus Blue PPO	Substance use disorders: partial hospital program and intensive outpatient program	None

Note: Determinations on Blue Cross PPO (commercial) behavioral health services are handled by New Directions, a Blue Cross vendor.

Links to the updated versions of the modified criteria, local rules and medical policies are available on the **Blue Cross Behavioral Health page** and the **BCN Behavioral Health page** at **ereferrals.bcbsm.com**.

Reminder: 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. See the **article** in the July-August issue for details.

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Physicians can help prevent suicide

The recent tragic deaths of designer Kate Spade and chef and television host Anthony Bourdain by suicide have placed a spotlight on suicide prevention.

The U.S. Centers for Disease Control and Prevention issued a **report** in June showing suicide deaths have increased in nearly every state over the past two decades and across all ages, races, genders and ethnicities. The CDC also found suicide often happens without warning; 54 percent of people don't have a previously known mental health issue.

The CDC recommends, among other things, that states and communities identify and support people at risk of suicide and teach coping skills to help them manage challenges.

Providers are an important resource to help identify patients suffering from depression or considering suicide.

Below are some resources to help assess and treat your patients.

- The American Academy of Family Physicians offers a **tool** to help your practice assess suicidal patients.
- The Joint Commission has published an **Sentinel Alert** about detecting and treating suicidal ideation.
- The American Academy of Pediatrics provides **information** about suicide in teen and adolescent populations.

AMA adopts policy to increase suicide awareness among physicians and public

According to recently released data from the Centers for Disease Control and Prevention, suicide rates in the United States have risen nearly 30 percent since 1999. To help address this growing epidemic, the American Medical Association adopted a policy aimed at increasing awareness about the risks for suicide among the public, medical students, physicians and other health care professionals by using an evidence-based, multi-disciplinary approach. The new policy calls for providing training for physicians to help them assess suicide risk and conduct lethal means safety counseling.

Because suicides by firearms make up approximately 60 percent of all firearm deaths in the U.S. each year, the new policy aims to ensure physicians are aware of the significant role of firearms in suicides and are trained to assess whether a person at risk for suicide has access to a firearm. The policy encourages physicians to discuss firearm and lethal means safety and work with at-risk patients and their families to reduce access to lethal means of suicide.

More information is available at the **AMA website**.

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Best Practices

Flint physician makes cervical cancer screening a priority

An interview with Dr. Teresa Sherman

Standing: (from left) Teresa Sherman-Gach M.D., Denise Rogers, Samantha Leonard, Crystal Hill. Seated: Stacey Abram

Photo credit: James Butler

How do you make sure all your eligible patients are screened for cervical cancer?

We emphasize prevention in our office. We have lists that we review monthly of the screenings each patient needs. And we stay on top of contacting those patients – mostly by phone – to encourage them to get in. If we don't do the screening in office, we make sure we get the results from a gynecologist.

Do you have any challenges making sure your patients get regular screening?

The only challenge is making sure the results come back to us if the screening was done elsewhere. We've worked hard to educate patients about our Patient-Centered Medical Home designation and tell them to make sure their results are forwarded to our office. We also have good relationships with most area gynecologists.

If patients present an occasional challenge, we talk to them about why we do the screening and try to discover what their fears are.

Do you provide any patient education about cervical cancer screenings?

We have a lot of discussions in our office about screening tests, the reason we do them and what we're looking for. We also do a lot of one-on-one consulting. Our reinforcement with phone calls is also important.

If there's one thing you can point to that helps you stay on top of cervical cancer screenings what would it be?

We have put a lot of effort in building our database in our electronic medical records that tracks all health measures. We always know when a cervical cancer screening or other preventive test is due. It took some effort to get it done, but it's been helpful.

We also have a dedicated medical assistant and two front office staff who help with reminder calls. The medical assistant reviews the health maintenance grid for every patient.

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How to comply with HEDIS measure for controlling high blood pressure

Accurate blood pressure readings mean more personalized care, which can help patients better reach their goals for controlling high blood pressure.

The Centers for Medicare & Medicaid Services uses the Healthcare Effectiveness Data and Information Set to measure health care quality. The HEDIS® measure for controlling high blood pressure includes patients who:

- Are ages 18 to 85 as of Dec. 31 of the measurement year
- Have a diagnosis of hypertension, after at least two visits (Telehealth/telephone visit can count as **one** visit) on different dates of service during the measurement year or prior to the measurement year

A member is compliant if his or her last blood pressure reading of the year is in control.

How is a patient included in the measure?

The patient is included in the measure after at least two visits on different dates of service during the measurement year or prior to the measurement year.

Patients are excluded from the measure if they:

- Have evidence of end stage renal disease or had a kidney transplant or dialysis on or prior to Dec. 31 of the measurement year
- Have a diagnosis of pregnancy during the measurement year
- Have a non-acute inpatient admission during the measurement year
- Are in hospice or a skilled nursing facility at any point in the measurement year

What are the criteria for blood pressure control?

Although the American Heart Association and the American College of Cardiology have recently updated their blood pressure guidelines, the 2019 HEDIS measure for controlling blood pressure control is:

- < 140/90 mm Hg for patients ages 18 to 85

Readings may be higher at the beginning of the office visit, so take another reading at the end of the visit as it may be lower. It's important to not round up readings.

Blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider counts for numerator compliance.

Submit blood pressure CPT II codes on each office visit claim

HEDIS requires a medical record review to determine blood pressure compliance. However, when you submit blood pressure CPT Category II codes, it will help support member-facing programs and outcomes:

- 3074F — Most recent systolic blood pressure < 130 mm Hg
- 3075F — Most recent systolic blood pressure 130 – 139 mm Hg
- 3078F — Most recent diastolic blood pressure < 80 mm Hg
- 3079F — Most recent diastolic blood pressure 80 – 89 mm Hg

Questions about HEDIS compliance?

Visit **bcbsm.com/providers** for additional resources.

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Preventive services guidelines

The Michigan Quality Improvement Consortium updated the adult preventive guidelines for ages 18 and older for 2017-2018. Blue Care Network follows the MQIC guidelines that support several Healthcare Effectiveness Data and Information Set® measures. These HEDIS® measures are used by the National Committee for Quality Assurance and the Centers for Medicare and Medicaid Services to determine quality health care practices. You can download the guidelines from the Michigan Quality Improvement Consortium **website**.

The following preventive care guidelines were updated in 2017:

- Adult Preventive Services Ages 18-49
- Adult Preventive Services Age ≥ 50

The updated recommendations for ages 18 to 49 are listed below.

Immunizations:

- For up-to-date recommendations and vaccine indicators, consult Advisory Committee on Immunization Practices **website**.

The updated recommendations for age ≥ 50 are outlined below.

Immunizations:

- Pneumococcal before age 65: If risk factors present, consult ACIP website.
- Pneumococcal age 65 and older: Give PCV13 first and PPSV23 at least one year later. If the patient already received PPSV23, give PCV13 at least one year later.

These guidelines are based on several sources with levels of evidence provided for the most significant recommendations. The grade definitions used for these guidelines are defined by the United States Preventive Services Task Force.

Other MQIC guidelines updated in 2018 include:

- Advance Care Planning
- Management of Acute Low Back Pain in Adults
- Management of Uncomplicated Acute Bronchitis in Adults
- Primary Care Diagnosis and Management of Adults with Depression
- Management of Diabetes Mellitus
- Management and Prevention of Osteoporosis
- Prevention and Identification of Childhood Overweight and Obesity Treatment
- Routine Prenatal and Postnatal Care
- Prevention of Pregnancy in Adolescents 12-17 Years

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

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Effective Oct. 1, Prolia and Xgeva are subject to a site-of-care requirement for BCN HMO members

As a reminder, starting October 1, 2018, BCN is adding the following two medical benefit drugs to its site-of-care optimization program:

Brand name	HCPCS code	Generic name
Prolia®	J0897	Denosumab
Xgeva®	J0897	Denosumab

This requirement applies only to BCN HMO℠ (commercial) members. It does not apply to BCN Advantage℠ members. This information was first communicated in June, in a web-DENIS message and a news item at **ereferrals.bcbsm.com**.

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

Requests for Prolia and Xgeva must meet applicable authorization criteria in addition to the site-of-care requirement. This applies to first-time and current issues of these medications.

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

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

The new site-of-care requirement for Prolia and Xgeva have been added to the list.

Clarification: Vivaglobin does not require authorization

We published an article in the **July-August issue** announcing that additional specialty medications covered under the Medicare Part B medical benefit require authorization for BCN Advantage members, starting Oct. 1.

Vivaglobin® (HCPCS code J1562) won't require authorization because it's been discontinued.

See the article on **Page 8** for details.

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A dangerous duo: Understanding the risks associated with concomitant opioid and benzodiazepine use

While benzodiazepines have received less public attention than opioids, it's estimated that nearly 30 percent of fatal opioid overdoses also involved benzodiazepines. According to the Food and Drug Administration, concomitant use of these two medications increased by 41 percent from 2002 through 2014.

Benzodiazepines may be co-prescribed due to their anxiolytic and skeletal muscle relaxant effects, but combining these medications can be dangerous. Benzodiazepines potentiate the respiratory depressant effects of opioids which can lead to overdose and death. This drug class also carries similar risks of tolerance and dependence as opioids. Additional concern is that benzodiazepines can enhance the euphoric effects of opioids making them a prime candidate for misuse or abuse.

Due to the rise in prevalence and potentially fatal consequences of co-ingestion, the FDA and Centers for Disease Control and Prevention have taken action. Both drug classes now carry a "**boxed warning**" to caution patients and providers about the concomitant use of these medications which may result in profound sedation, respiratory depression, coma and death. The **CDC recommends** clinicians avoid prescribing opioids and benzodiazepines concurrently whenever possible.

Patients suffering from anxiety may be prescribed benzodiazepines due to their sedative effects and fast results. However, clinical guidelines recommend against their use for treatment of generalized anxiety disorder except in limited circumstances on a short-term basis. Antidepressants, specifically selective serotonin reuptake inhibitors and serotonin and norepinephrine reuptake inhibitors, are first-line treatments when medications are needed for anxiety.

First-line antidepressants for GAD

- SSRI (escitalopram and paroxetine)
- SNRI (duloxetine and venlafaxine)

If benzodiazepines are prescribed with opioids, limit dosages and durations to the minimum required, follow patients for signs and symptoms of respiratory depression and sedation and provide education about the increased risks of overdose, death and addiction. For questions or additional information, email RxOpioidTaskForce@bcbsm.com.

Benzodiazepines combined with opioids nearly quadruples the risk of an overdose-related death compared to opioid use alone.

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Drug exclusions effective Oct. 1, 2018

We have made some changes to the drugs we cover as detailed in the tables below.

Our goal at Blue Cross Blue Shield of Michigan and Blue Care Network is to provide our members with safe, high-quality prescription drug therapies. We continuously review prescription drugs to provide the best value for our members, control costs and make sure our members are using the right medication for the right situation.

Acne drugs

We'll stop covering the acne drugs listed below — and their generic equivalents — because there are safe, effective and less-expensive choices available:

Product	Drugs not covered as of October 1	Average cost of drugs not covered as of October 1	Covered alternatives	Average cost of covered alternatives
Topical	Evoclin®	$572 per package	Cleocin-T®	$22 to $115 per package
	Retin-A® Micro®	$500 to $950 per package	Atralin® Avita® Retin-A®	$110 to $200 per package
	Veltin®, Ziana®	$763 to $906 per package	Cleocin-T®	$22 to $115 per package
			Atralin® Avita® Retin-A®	$110 to $200 per package
Oral	Absorica®	$42 per capsule	Claravis® Myorisan® Zenatane®	$7.50 per capsule
	Acticlate®	$32 per tablet	Avidoxy® Monodox® Vibramycin®	$0.20 to $0.90 per tablet or capsule
	Solodyn®	$47 to $49 per tablet	Minocin®	$0.03 to $2.50 per tablet or capsule

Please see Drug exclusions, continued on Page 29

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Drug exclusions, *continued from Page 28*

Migraine, pain and skin condition drugs

We'll stop covering the various drugs listed below – and their generic equivalents -- because there are safe, effective and less-expensive choices available:

Drugs not covered as of October 1	Average cost per unit	Common uses	Covered alternatives	Average cost per unit
Cambia®	$83	Migraine	Ecotrin®	$0.03
			Voltaren®	$0.09
			Motrin®	$0.05
			Anaprox®, Naprosyn®	$0.23
			Relpax®	$15.25
			Imitrex®	$0.70
			Maxalt®, MLT®	$1.35
			Zomig®, ZMT®	$9.75
Naprelan®	$15 - $28	Pain	Cataflam®; Voltaren®, ER®	$0.53
			Lodine®	$0.95
			Motrin®	$0.04
			Toradol®	$1.25
			Mobic®	$0.03
			Relafen®	$0.26
			Anaprox®, Naprosyn®	$0.06 - $1.35
			Clinoril®	$0.19

Drugs not covered as of October 1	Average cost per package	Common uses	Covered alternatives	Formulation	Average cost per package
Prudoxin® Zonalon® cream	$711	Short-term treatment of itchy skin conditions	Elidel®	Cream	$185
			Protopic®	Ointment	$170
			Topical corticosteroids: Diprosone® Kenalog® Locoid® Elocon® Valisone®	-Cream -Ointment -Lotion -Solution -Foam	Multiple options for less than $10 per package

Please see Drug exclusions, continued on Page 30

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Drug exclusions, *continued from Page 29*

Cough and cold drugs not approved by the FDA

We'll also stop covering the cough and cold drugs listed below for members under the age of 18. These contain codeine or hydrocodone and have not been approved by the U.S. Food and Drug Administration for use in members under the age of 18.

Generic drug	Example brand name
Codeine/brompheniramine/pseudophedrine	M-End® PE, Poly-Tussin® AC
Codeine/chlorpheniramine	Tuzistra® XR
Codeine/chlorpheniramine/pseudophedrine	Capcof®
Codeine/guaifenesin	Cheratussin® AC, G Tussin® AC, Guaiatussin® AC, Guaifenesin AC, Virtussin AC
Codeine/dexclorpheniramine/phenylephrine	Pro-Red® AC
Codeine/phenylephrine/promethazine	Promethazine® VC w/codeine
Codeine/phenylephrine/triprolidine	Histex® AC
Codeine/pseudophedrine/guaifenesin	Cheratussin® DAC, Guaifenesin® DAC, Virtussin® DAC
Hydrocodone/chlorpheniramine	Tussionex®
Hydrocodone/chlorpheniramine/pseudophedrine	Zutripro®
Hydrocodone/guaifenesin	Obredon®
Hydrocodone/homatropine	Hycodan®, Hydromet®

Pulmozyme will require prior authorization, beginning Oct. 1

Effective Oct. 1, 2018, Blue Cross Blue Shield of Michigan and Blue Care Network will add Pulmozyme (dornase alfa) to the pharmacy benefit drug prior authorization program for commercial PPO and HMO members.

Pulmozyme is used to improve lung function in people with cystic fibrosis, in conjunction with standard therapies.

Members should have their prescribers submit a request for authorization from us before payment is approved for this medication.

Members who have an existing prior authorization for any of the following drugs aren't required to get a prior authorization for Pulmozyme:

- Orkambi®
- Symdeko®
- Kalydeco®

If we don't authorize this drug in advance, it may cost the member more or not be covered.

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Shingrix versus Zostavax: Preventing administration error

Joseph Galanto, a clinical pharmacist with Medical Drug Management, recently completed his residency at Blue Cross Blue Shield of Michigan. In his new role, he'll review requests for medical drugs that require prior authorization to determine if medication is clinically appropriate for our members. In this article, he shares information and recent recommendations about these vaccines.

The Centers for Disease Control and Prevention released a monitoring report on the approved recombinant zoster vaccine, Shingrix®, manufactured by GlaxoSmithKline. From October 2017 to February 2018, the Vaccine Adverse Events Reporting System received 155 reports involving RZV.[1] Of the reported events, 13, or 8 percent, were attributed to administration error. These errors include:

- Subcutaneous administration rather than intramuscular administration
- Inappropriate age
- Wrong vaccine information statement
- No instructions to return for the second RZV dose
- Administration of the wrong vaccine
- Administration without reconstitution of the vaccine

This early monitoring report shows that providers may be confusing the recombinant zoster vaccine, or RZV, with Zostavax®, or ZVL, the older live zoster vaccine that's manufactured by Merck. With supporting evidence of the efficacy of RZV and the Advisory Committee on Immunization Practices recommending RZV over ZVL, providers should familiarize themselves with the differences between the two vaccines and how they should be stored and administered to decrease errors.

ACIP recommendation[2]

The Advisory Committee on Immunization Practices, or ACIP, now recommends RZV over ZVL. Additionally, it recommends that RZV be used in immunocompetent adults:

- Age 50 or older
- Age 50 or older who were previously vaccinated with ZVL

Please see Shringrix vs. Zostavax, continued on Page 32

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Shringrix vs. Zostavax, *continued from Page 31*

Administration and storage[3,4]

Although both vaccines require reconstitution, there are some differences between the two. Unlike ZVL, which is a single-dose, live vaccine administered subcutaneously and stored in the freezer, the RZV dosing schedule requires two doses, is administered intramuscularly and kept in the refrigerator. After the initial dose of RZV, a second dose should be administered two to six months later. Confusion over the differences in dosing schedule, administration and storage may be the reason for many of the events that were reported to Vaccine Adverse Events Reporting System.

	Shingrix	Zostavax
Type	Recombinant adjuvanted	Live-attenuated virus
Storage location	Refrigerator (**do not** freeze)	Freezer
Dosage	0.5 mL IM x 2 doses (Two to six months apart)	0.65 mL SC x 1 dose
How supplied and administration	2 components: • Vial 1: Single-dose vial of adjuvant suspension component (blue-green cap) • Vial 2: Single-dose vial of lyophilized gE antigen component (brown cap) All of vial 1's contents (adjuvant) should be withdrawn and transferred in entirety to vial 2 (antigen). Gently shake until powder is completely dissolved. Withdraw 0.5 mL from vial 2 and administer intramuscularly.	Single-dose vial of lyophilized vaccine and a vial of sterile water diluent

References

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Medical drug prior authorization and site of care programs to expand

Blue Cross Blue Shield and Blue Care Network are expanding their medical drug management programs for commercial members. We encourage proper utilization of high-cost specialty medications administered by a health care provider.

For dates of service on or after Oct. 1, 2018, Trogarzo™ and Zilretta® will be added to the medical drug prior authorization program for BCN HMO℠ (commercial) and Blue Cross PPO (commercial) lines of business. Trogarzo will also be added to the site of care program for BCN HMO (commercial) members, effective Oct. 1, 2018.

Trogarzo is used to treat human immunodeficiency virus type-1 infection in heavily treatment-experienced adults with multi-drug resistant HIV-1 infection failing their current antiretroviral regimen. Zilretta is a single dose intra-articular injection. It is FDA- approved for the management of osteoarthritis knee pain.

Brand name	HCPCS code	Prior authorization requirement	Site-of-care requirement
Trogarzo (ibalizumab-uiyk)	J3590	Blue Cross PPO (commercial) and BCN HMO (commercial)	BCN HMO (commercial) only
Zilretta (triamcinolone acetonide extended release)	Q9993		No

Members currently on Trogarzo do not have to do anything.

Members currently on Zilretta need a prior authorization for dates of service on or after Oct. 1, 2018.

A prior authorization approval isn't a guarantee of payment. Health care practitioners must verify eligibility and benefits for members. Members are responsible for the full cost of medications not covered under their medical benefit coverage.

Refer to the opt-out list for the Blue Cross PPO (commercial) groups that don't require members to participate in the programs.

To access the list, follow these steps:

1. Log in to Provider Secured Services.
2. Click *BCBSM Provider Publications and Resources*.
3. Click *Newsletters & Resources*.
4. Click *Forms*.
5. Click *Physician administered medications*.
6. Click *BCBSM Medical Drug Prior Authorization Program list of groups that have opted out*.

These changes do not apply to BCN Advantage℠, Blue Cross Medicare Plus Blue℠ PPO or Federal Employee Program® members.

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

BCN

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

Blue Cross

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

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Coding Corner

Diabetic eye disease

Patients with diabetes require ongoing medical care and monitoring to reduce the risk of complications, such as diabetic retinopathy, and improve outcomes. Clinical interventions go far beyond glycemic control.

Diabetic retinopathy

Diabetic retinopathy is caused by persistent high blood sugar levels that, over time, cause damage to the blood vessels in the retina. The blood vessels can swell, leak or close, which impairs the blood supply to the retina. In advanced cases, abnormal new blood vessels can grow on the retina, a process known as neovascularization, which results in loss of vision.

What should primary care providers do?

Ensure your diabetic patients have an annual screening for diabetic eye diseases to prevent or delay blindness. Also, obtain a copy of the eye exam report from the optometrist or ophthalmologist and include it in the patient's medical record.

Stages of diabetic eye disease

- Non-proliferative diabetic retinopathy: In this early stage, the blood vessels leak, making the retina swell and resulting in blurred vision
  - Swelling of the macula (the central part of the retina) is known as macular edema; it's the most common reason for vision loss among diabetics.
  - Macular ischemia results when the blood supply to the macula is interrupted.
  - Stages of NPDR range from mild to severe, with or without macular edema.
- Proliferative diabetic retinopathy: This advanced stage includes neovascularization, where the retina grows new, abnormally fragile blood vessels, resulting in loss of vision.
  - These new blood vessels often bleed into the vitreous, causing floaters or varying degrees of vision loss.
  - The new blood vessels can also cause scar tissue to develop, resulting in problems with the macula and can lead to a detached retina.

Accurate documentation and coding

Health care providers should use the ICD-10-CM code Z13.5 (Encounter for screening for eye and ear disorders) until a definitive diagnosis has been determined by an eye care professional. Once definitively diagnosed, documentation and coding should be to the highest specificity of the disorder.

If primary care providers receive no communication from the eye care professional but are aware of the presence of diabetic eye disease, they should document and code the condition to the highest specificity known to them. See the chart below for some examples.

Condition	ICD-10 code
Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema	E11.311
Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema right eye	**E11.3211
Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema left eye	**E11.3492
Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula bilateral	**E11.3523
Type 2 diabetes mellitus with stable proliferative diabetic retinopathy unspecified eye	**E11.3559
Type 2 diabetes mellitus with diabetic cataract	E11.36
Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment bilateral	**E11.37X3

**The seventh character is required for subcategories E11.32, E11.33, E11.34, E11.35 and E11.37 to designate laterality.

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Coding Corner, *continued from Page 34*

2018 updates to *ICD-CM-10 Official Guidelines for Coding and Reporting*

In Chapter 7, "Diseases of the Eye and Adnexa, Disorders of the Globe," you'll see a change to H42, *Glaucoma in diseases classified elsewhere*. The manual deletes the "excludes 2" note for glaucoma in diabetes mellitus and replaces it with an instructional note for appropriate sequencing that follows familiar coding conventions. The new note reads: "Code first glaucoma (in) diabetes mellitus (E08.39, E09.39, E10.39, E11.39, E13.39)."

None of the information included in this article is intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with all applicable state and federal laws and regulations.

BCN clinic code policy clarified

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

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

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

Filing requirements

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

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

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Improve HEDIS scores, reduce medical record requests through proper claims coding

Submitting claims with CPT® Category II and ICD-10 codes can help Blue Cross Blue Shield of Michigan and Blue Care Network determine if certain HEDIS® measures are met without needing to review medical records. This lessens the administrative burden on office staff because it reduces the need for them to pull medical records for Blue Cross' review.

CPT II codes that support HEDIS measures include:

HEDIS measure	CPT II code	Description
Medication reconciliation post discharge	*1111F	Discharge medications reconciled with the current medication list in outpatient medical record
Comprehensive diabetes care – eye exam (The patient's eye exam report must be included in your medical record)	*2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
	*3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)
Comprehensive diabetes care – HbA1c control	*3044F	Most recent HbA1c level < 7.0%
	*3045F	Most recent HbA1c level 7.0-9.0%
	*3046F	Most recent HbA1c level > 9.0%
Comprehensive diabetes care – medical attention for nephropathy	*3066F	Documentation of treatment for nephropathy (includes visit to nephrologist, receiving dialysis, treatment for end stage renal disease, chronic renal failure, acute renal failure or renal insufficiency)
	*4010F	Angiotensin converting enzyme inhibitor or angiotensin receptor blocker therapy prescribed or currently being taken
Comprehensive diabetes care – controlling blood pressure**	*3074F	Most recent systolic blood pressure <130 mm Hg
	*3075F	Most recent systolic blood pressure 130 – 139 mm Hg
	*3077F	Most recent systolic blood pressure ≥ 140 mm Hg
	*3078F	Most recent diastolic blood pressure <80 mm Hg
	*3079F	Most recent diastolic blood pressure 80 - 89 mm Hg
	*3080F	Most recent diastolic blood pressure ≥ 90 mm Hg

**The National Committee for Quality Assurance requires medical record review for the controlling blood pressure measure. However, for the comprehensive diabetes care – controlling high blood pressure measure, CPT Category II codes can be used to identify compliant members through claims data when the member's latest blood pressure reading is compliant (<140/90).

Please see Claims coding, continued on Page 37

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Claims coding, *continued from Page 36*

ICD-10 codes that support HEDIS exclusion criteria include:

Patients won't be identified for certain HEDIS measures when ICD-10 exclusion codes are submitted on a claim. These include:

Measure	ICD-10 code	Description
Breast cancer screening Patients who have bilateral or two unilateral mastectomies	Z90.13	Acquired absence of bilateral breasts and nipples
	Z90.12	Acquired absence of left breast and nipple
	Z90.11	Acquired absence of right breast and nipple
Colorectal cancer screening Patients who currently have or with a history of colorectal cancer (cancer of the small intestine doesn't count)	Z85.038	Personal history of other malignant neoplasm of large intestine
	Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus

ICD-10 codes that support the adult BMI assessment measure include:

HEDIS measure	ICD-10 code	Description
Adult BMI	Z68.1	BMI of 19.99 or less
	Z68.20	BMI 20.0-20.9
	Z68.21	BMI 21.0-21.9
	Z68.22	BMI 22.0-22.9
	Z68.23	BMI 23.0-23.9
	Z68.24	BMI 24.0-24.9
	Z68.25	BMI 25.0-25.9
	Z68.26	BMI 26.0-26.9
	Z68.27	BMI 27.0-27.9
	Z68.28	BMI 28.0-28.9
	Z68.29	BMI 29.0-29.9
	Z68.30	BMI 30.0-30.9
	Z68.31	BMI 31.0-31.9

HEDIS measure	ICD-10 code	Description
Adult BMI	Z68.32	BMI 32.0-32.9
	Z68.33	BMI 33.0-33.9
	Z68.34	BMI 34.0-34.9
	Z68.35	BMI 35.0-35.9
	Z68.36	BMI 36.0-36.9
	Z68.37	BMI 37.0-37.9
	Z68.38	BMI 38.0-38.9
	Z68.39	BMI 39.0-39.9
	Z68.41	BMI 40.0-44.9
	Z68.42	BMI 45.0-49.9
	Z68.43	BMI 50.0-59.9
	Z68.44	BMI 60.0-69.9
	Z68.45	BMI 70.0 or greater

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You can now search clinical editing billing tips

Looking for a specific clinical editing billing tip? Now you can search all the billing tips that were published in *BCN Provider News* for a specific year. Previously, you'd have to open each *BCN Provider News* issue and look at the billing tips that were published in that issue.

We've included links to three years of clinical editing billing tips on BCN's Billing / Claims page within Provider Secured Services.

To find them:

- Visit **bcbsm.com/providers**.
- Log in to Provider Secured Services.
- Click *BCN Provider Publications and Resources*.
- Click *Billing / Claims*.

Under the Clinical Editing Resources heading, you'll see tips for 2016, 2017 and 2018. Open the tips for one of those years and search for the information you need.

To search, hold down the CTRL key on your keyboard and then press the "F" key. Enter the word you're searching for in the "Find" field and press "Enter" on your keyboard.

As more clinical editing billing tips are published in the upcoming 2018 *BCN Provider News* issues, we'll add those to the 2018 billing tips collection.

Clinical editing billing tips help ensure that Blue Care Network pays your claims accurately and that the procedure you performed is correctly reported to us. Remember, clinical editing billing tips are current as of the date published.

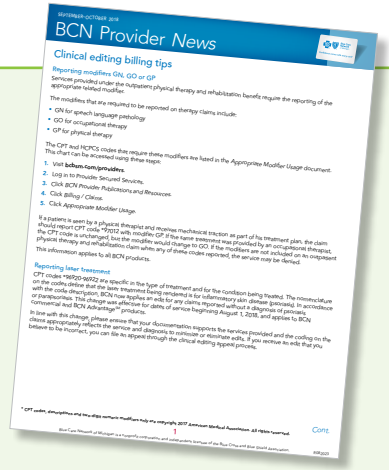
Clinical editing billing tips

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.

This issue's billing tips include:

- Reporting modifiers GN, GO or GP
- Reporting laser treatment
- Diagnosis requirements when reporting psychological and neuropsychological testing

To view the full content of the tips, click on the *Clinical editing billing tips* at the right.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BCN clinical editing system updates

As we noted in a previous issue, Blue Care Network is in the process of replacing the current Change Healthcare (previously McKesson) ClaimCheck® software with their enhanced clinical editing solution, ClaimsXten. We'll be continuing to implement the updated tool in the third quarter of 2018.

ClaimsXten help us to continue to meet the ever-changing needs in the health care industry, while aligning to national coding guidelines. The changes you will see won't affect how you submit claims or appeals. In fact, most of the clinical edits that you're familiar with will remain unchanged, as our processes are currently based on national coding guidelines.

Some of the changes you will notice include:

- **New explanation codes on your explanation of payment or remittance advice.** The current explanation codes, N01-N94, will remain for claims processed prior to the go live, but new ones, beginning with a variety of lower case letters, such as e, f, g, h, j, k, and l. As with the current explanation codes, a brief narrative will be provided giving the reason for the edit.
- **Professional reimbursement based on place of service.** Previously, the reimbursement was based primarily on the professional fee schedule in the office location, unless a manual adjustment was made. With ClaimsXten, the system will identify whether the location is outpatient or office as reported on the claim.
- **Multiple radiology reduction on the professional component.** BCN has been following CMS guidelines and reducing the technical component when multiple radiology procedures are reported on the same date of service. Due to system limitations, we haven't been able to implement the CMS professional reductions. Functionality within ClaimsXten will allow this.
- **Bundled procedures.** In line with CMS guidelines, BCN will consider most claims lines containing these procedure codes as bundled and not separately payable. There are some exceptions to this policy, such as with CPT code *99080 as it's required for reporting completion of the Healthy Blue Qualification form.

We'll continue to provide updates on the ClaimsXten implementation and ongoing clinical editing updates in future issues of *BCN Provider News* or on web-DENIS.

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How to submit a replacement or void claim

We're clarifying when and how to submit a replacement or void claim.

Filing a replacement claim, also known as a corrected, TOB XXX7 or Frequency 7 claim

A replacement, or corrected, claim replaces a previously submitted claim that contains changes or corrections to previously submitted charges, clinical or procedure codes or dates of service, for example.

When filing a replacement claim, submit a corrected claim with all line items that were billed on the original claim. It should never be filed with *only* the line items that are being corrected. In addition:

- If services previously billed are being deleted (that is, if the corrected claim has fewer lines than the original claim), include a note to confirm that the deleted codes were originally billed in error.
- If the member information needs to be updated, don't submit a replacement (corrected) claim. Instead, submit a void claim and then bill the services on a new claim that includes the correct member information.

Filing a void claim, also known as a TOB XXX8 or Frequency 8 claim

When filing a void claim, rebill all services that were billed on the original claim that's being voided. These include both paid and denied services that were on the original claim. Submit a TOB 8 (void) claim only when voiding the entire original claim.

Additional information

We've updated the Claims chapter of the *BCN Provider Manual* with these clarifications. To view the Claims chapter:

1. Visit **bcbsm.com/providers**.
2. Log in to Provider Secured Services.
3. Click *Provider Manuals*.
4. Click *BCN Provider Manual*.
5. Click *Claims (Billing)*.

You can also refer to the BCN page in the Claims Troubleshooting document to find additional information on submitting these types of claims.

To find the *Claims Troubleshooting* document:

1. Visit **bcbsm.com/providers**.
2. Log into Provider Secured Services.
3. Click *BCN Provider Publications and Resources*.
4. Click *Billing / Claims*.
5. Click *Claims troubleshooting*.

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Billing Q&A

Question:

When we report an evaluation and management service based on time in our office, our physicians document how much time they spend with the patient. Frequently we have been asked for additional information. What should we be documenting or sending for review?

Answer:

Billing evaluation and management services based on time seems like it should be simple. Just document the amount of time spent with the patient. Right?

More is needed, but it doesn't need to be overly complex or burdensome. Our response will focus on time based reporting in the office setting.

Time based reporting of E&M services is considered a key factor in those visits where counseling or coordination of care dominates (more than 50 percent of) the visit with the patient and family (face-to-face time in the office).

When the level of service reported is using time as a key component, documentation needed in the record should include:

- The total length of time of the encounter and percentage of time for counseling/coordination of care
- Description of the counseling and activities to coordinate care

The documentation for the time services does not eliminate or minimize the need to include the basic components typically noted in an E&M visit.

These components include the following, but the extent and amount of documentation may vary depending on the reason for the visit:

- Nature of presenting problem
- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Time

As with any medical record documentation, ensure that it is complete, accurate, clear and concise. Does it answer the question, "Does my documentation support the care I provided to the patient?"

Question:

If documentation supports a provider performing an EGD (*43235) then withdrawing the scope and performing a Maloney dilation (*43450), can you bill them both using the same diagnosis? The Maloney dilation is under a different section in the CPT book and I would bill it with a separate code.

Answer:

In situations where a patient has a diagnostic endoscopy and a dilation of the esophagus on the same day, they are typically performed for different and distinct clinical indications. In other words, it's not expected that the Maloney dilation is performed to gain access to a surgical site, which in the case of these codes could be for a brushing or biopsy. Therefore, an edit does not exist between these codes. As both codes are subject to a multiple procedure reduction, the procedure that is valued lower will receive a payment reduction in accordance with the multiple procedure payment guidelines.

Have a billing question?

If you have a general billing question, we want to hear from you. Click on the envelope icon to open an email, then type your question. It will be submitted to *BCN Provider News* and we will answer your question in an upcoming column, or have the appropriate person contact you directly. Call Provider Inquiry if your question is urgent or time sensitive. Do not include any personal health information, such as patient names or contract numbers.

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Where to get diabetic supplies for BCN members

We've received questions recently about where to order diabetic supplies. Providers can order diabetic supplies for BCN HMO℠ and BCN Advantage℠ members (except diabetic shoes and inserts) from J&B Medical Supply. Call 1-888-896-6233 or fax 1-800-737-0012.

For durable medical equipment, prosthetics, custom orthotics and diabetic shoes and inserts, contact Northwood to identify a contracted supplier near you. Call 1-800-393-6432 or fax 586-755-3878.

This information is available in the **BCN Provider Resource Guide At a Glance** and in the *BCN Provider Manual*.

You can also refer to the **BCN Provider Resource Guide**. See the DME, Medical Supplies and P&O page.

Where to submit appeals of eviCore healthcare's decisions

Providers must submit appeals of eviCore healthcare's decisions on BCN Advantage℠ authorization requests to the BCN Advantage Grievances and Appeals Unit and not to eviCore. This was effective June 22.

Here's where to submit:

By mail:
Blue Care Network
ATTN: BCN Advantage Grievances and Appeals Unit
P.O. Box 284
Southfield MI 48076-5043

By fax: 1-866-522-7345

BCN will process these appeals using the normal BCN Advantage appeal process for standard and expedited appeals. For information on that process, refer to the BCN Advantage chapter of the *BCN Provider Manual*. Look in the section titled "BCN Advantage provider appeals."

Appeals of eviCore decisions on BCN HMO℠ (commercial) authorization requests should continue to be submitted to eviCore.

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Reminder: Starting Oct. 1, AIM Specialty Health to manage cardiology and high-tech radiology services for Blue Care Network

As a reminder, for 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℠ (commercial) and BCN Advantage℠ members. We first communicated about this in the article **AIM Specialty Health to manage cardiology and high-tech radiology procedures for BCN starting Oct. 1** in the July-August 2018 issue of *BCN Provider News*, Page 33.

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

For dates of service prior to Oct. 1, continue to submit your authorization requests to eviCore healthcare.

Webinars still available in September and October

We've scheduled training webinars so you can learn how to register for and use the AIM provider portal, an online tool used to request authorization from AIM.

These training dates are still available:

September 2018	October 2018
• Wednesday, Sept. 5, 10-11 a.m.	• Wednesday, Oct. 3, 10-11 a.m.
• Thursday, Sept. 6, 2-3 p.m.	• Thursday, Oct. 4, 2-3 p.m.

To register for a webinar, 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

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

Codes for procedures AIM will manage

Click **here** for a list of the procedure codes AIM will manage. The list shows the following categories of procedures:

- **Category 1:** Procedures that require authorization by eviCore healthcare for dates of service through Sept. 30, 2018, and will continue to require authorization by AIM for dates of service on or after Oct. 1, 2018
- **Category 2:** Procedures that require authorization by eviCore healthcare for dates of service through Sept. 30, 2018, but will not require authorization by AIM for dates of service on or after Oct. 1, 2018
- **Category 3:** A few procedures that require authorization by eviCore healthcare for dates of service through Sept. 30, 2018, will require authorization by BCN for dates of service on or after Oct. 1, 2018. Submit authorization requests for these procedures directly to BCN through the e-referral system. Don't submit them to AIM.
- **Category 4:** Procedures that do not require authorization by eviCore healthcare for dates of service through Sept. 30, 2018, but will require authorization by AIM for dates of service on or after Oct. 1, 2018

You'll be able to find the list of codes on our **ereferrals.bcbsm.com** website by the end of September.

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

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.

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Gastric pacing / stimulation questionnaire updated in e-referral system

The gastric pacing / stimulation questionnaire in the e-referral system was updated in late June. The questionnaire opens when an authorization request for gastric pacing / stimulation for a BCN Advantage℠ or Blue Cross Medicare Plus Blue℠ PPO member is submitted.

How the questionnaire works

If your responses to the questionnaire 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*.

Preview questionnaire is available

The **gastric pacing / stimulation preview questionnaire** posted at **ereferrals.bcbsm.com** has been revised to reflect the questions in the e-referral questionnaire. We suggest using the preview questionnaire for this service and for other services to help you prepare in advance. This can reduce the time it takes to complete the authorization request in the e-referral system. To access the preview questionnaire for this or other services, visit **ereferrals.bcbsm.com**, click *BCN* and then click ***Authorization Requirements & Criteria***.

You'll also find the questionnaire on the **Authorization Requirements & Criteria** page in the Blue Cross section of that website.

List of updated preview questionnaires and authorization criteria

See the **list of other questionnaires** and authorization criteria that have been recently updated.

Tips for selecting a provider in e-referral

When populating the Servicing Provider field in e-referral, remember the following tips:

- Start by entering the group NPI for an exact match.
- If the NPI is unknown, you can search by the provider's name.
- If you choose to search for the provider by name, keep in mind the provider may be listed in the results several times. A provider may have several locations or addresses or multiple group affiliations.
  - If a provider has a group affiliation, select that listing not the individual. Use his or her NPI to ensure you're choosing the correct group affiliation.
  - If the provider has multiple locations and no group affiliation, choose the one with the correct NPI and that has a Preferred (Pref) or In status listed in the Network column.

Entering an incorrect servicing provider will result in a rejected claim.

For help using e-referral, see the user guides and online training available at **ereferrals.bcbsm.com** under *Training Tools*.

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Utilization management programs summary now available

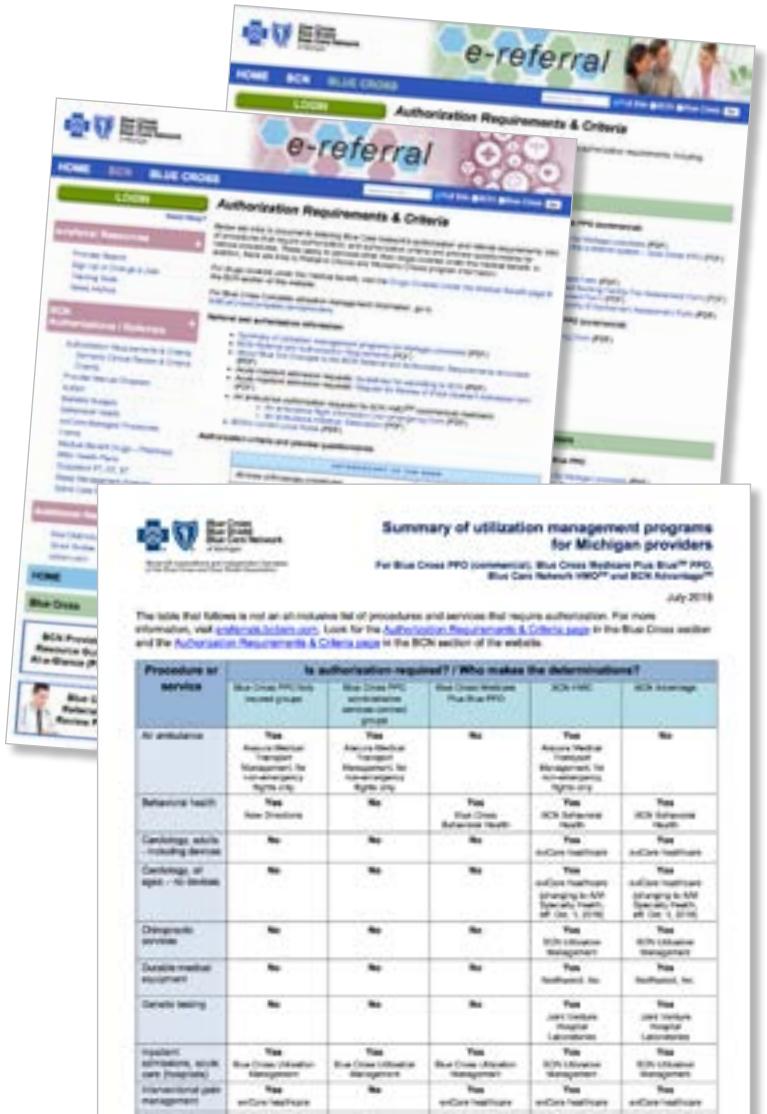
Do you ever get confused as to which products require authorization? We've put together a handy document that helps you find out whether a service you're providing requires an authorization and how to get it.

The document for Michigan providers includes all lines of business for Blue Cross Blue Shield of Michigan and Blue Care Network and lists who manages the authorizations. It will be updated from time to time.

The **utilization management programs summary document** has been posted online at these locations:

- At **ereferrals.bcbsm.com**
  - On the **BCN Authorization Requirements & Criteria** page
  - On the **Blue Cross Authorization Requirements & Criteria** page in both the Blue Cross PPO and Medicare Plus Blue PPO sections
- On the Blue Cross Clinical Criteria & Resources page within Provider Secured Services

The document is not an all-inclusive list of procedures and services that require authorization, but we hope it's a way to help you keep straight the requirements for some of the most frequently performed services.



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