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Blue Care Network will continue to offer 19 products for individual marketplace in 2019

Blue Care Network is offering 19 products on the Marketplace for 2019 coverage. We are offering six products in 63 rural counties, 19 products in three southeast Michigan counties and 13 products in 17 urban counties.

- **Blue Cross® Preferred HMO** – This is the standard BCN network which is used for six individual health plans in the gold, silver and bronze coverage levels.
- **Blue Cross® Select HMO** – This is the PCP Focus network that is available in 20 counties. Kent and Muskegon were recently added for individual product purchase. The other counties are: Bay, Calhoun, Clinton, Eaton, Genesee, Ingham, Kalamazoo, Livingston, Macomb, Monroe, Oakland, Ottawa, Saginaw, Shiawassee, St. Clair, Van Buren, Washtenaw and Wayne. Seven plans are offered in the silver, bronze and value coverage levels.
- **Blue Cross® Metro Detroit HMO** – This is a special network available to Oakland, Macomb and Wayne county residents. Six plans are offered in the silver and bronze coverage levels.

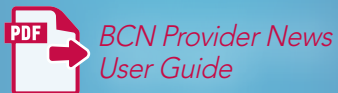
Please see [Marketplace](#), continued on Page 2

Award recognizes providers' roles in star-ratings success

Providers who have made outstanding contributions to the BCN AdvantageSM and Blue Cross Medicare Plus BlueSM PPO plans' star ratings for the 2016 calendar year were recently honored with Provider Distinction Awards.

The Centers for Medicare & Medicaid Services uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system. Achieving star-ratings success is crucial for our Medicare health plans. The Provider Distinction Awards recognize our partner providers who help us achieve success in the CMS star program.

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



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Marketplace, continued from Page 1

BCN has modified some plans and made deductible and out-of-pocket changes for the majority of plans. The Silver Extra plans, which previously had separate prescription and medical deductibles, will change to having one integrated deductible including both medical and prescription drugs.

As always, check member eligibility and benefits at every visit before providing services. You can do this through web-DENIS or by calling our **Provider Automated Response System**.

Ask to see the latest member ID card

January is the time when many patients change health care plans. You should always ask to see the latest member ID card and make sure it matches the coverage listed on web-DENIS.

Award, continued from Page 1

To qualify for the award, providers:

- Have achieved a quality score (star measure screenings: diabetes care, colorectal cancer screening, breast cancer screening and other measures) of 87 percent or above either with their patients who have Medicare Plus Blue PPO only, BCN Advantage only, or jointly with patients from both plans. Providers must have a minimum of five services that count toward the star rating (for example, a diabetes test, colorectal screening.) The number of services completed divided by the number of eligible services equals the quality score.
- Must be currently credentialed and contracted with Medicare Plus Blue PPO or BCN Advantage, and in good standing.
- May not be in the low-quality score rating program. (Those providers with low quality scores will be eligible for future awards once they have completed the QSR program.)

The plaque awarded is a perpetual plaque. Each year the physicians and physician groups achieve impressive scores, we will add a star to the plaque.

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We'll begin granting board certification exceptions for certain practitioners designated as Patient-Centered Medical Home providers

Blue Cross Blue Shield of Michigan will continue to verify board certification statuses of practitioners in our Blue Cross Blue Shield of Michigan and Blue Care Network managed care networks.

Effective Jan. 1, 2019, the status of family medicine, internal medicine or pediatric practitioners' board certification will be reviewed annually. If their board certification status has lapsed and they are a designated patient centered medical home physician, Blue Cross will grant an exception and allow the practitioner to remain in our Blue Cross and Blue Care Network managed care networks. This exception does not apply to new practitioner enrollments. Blue Cross and BCN will continue to require all practitioners to have board certification upon initial enrollment for affiliation with us.

Family medicine, internal medicine and pediatric practitioners who are not board certified and are not designated as PCMH physicians will be required to complete their applicable specialty's maintenance of certification requirements within a two-year timeframe. Failure to meet these requirements will result in termination from our managed care networks.



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Use in-network laboratories for toxicology, drug-of-abuse testing

Providers affiliated with Blue Cross Blue Shield of Michigan and Blue Care Network have a contractual obligation to use in-network providers when referring our members for services. This includes referring members for toxicology and drug-of-abuse testing services. This applies for members covered by all Blue Cross and BCN products:

- Blue Cross' PPO plans
- Blue Cross Medicare Plus BlueSM PPO
- BCN HMOSM
- BCN AdvantageSM

A significant number of contracted providers refer members to out-of-network laboratories. This puts members at risk of having to pay higher costs. Since the tests are available at in-network labs, these costs are unnecessary. Please follow the conditions of your provider agreement and the directions in our provider manuals, which require you to refer these members to in-network labs.

Our goal is to:

- Give your patients convenient access to high-quality, cost-efficient toxicology testing services that properly meet their clinical needs
- Help our members avoid higher copayments and other out-of-pocket costs that may result from using out-of-network labs

After confirming member benefits using the automated system, you can speak to someone in Provider Inquiry to get help finding an in-network lab.

Confirm which labs are in-network or out-of-network with these resources

Blue Cross' PPO plans

For salaried employees covered through Ford, General Motors and the Michigan Public School Employees' Retirement System, call: Quest DiagnosticsTM — 1-866-697-8378.

For all other PPO members, use the Blue Cross [online provider directory](#).

Medicare Plus Blue PPO

Call either of the following resources:

- Joint Venture Hospital Laboratories — 1-800-445-4979
- Quest Diagnostics — 1-866-697-8378

BCN HMO and BCN Advantage

Call Joint Venture Hospital Laboratories at 1-800-445-4979.

If you need more help locating an in-network lab or want to discuss specific lab testing needs you may have, please call one of the following Provider Automated Response System numbers during normal business hours:

Blue Cross' PPO plans, BCN HMO or BCN Advantage

- Professional providers in Michigan, call 1-800-344-8525.
- Facility providers in Michigan, call 1-800-249-5103.

Medicare Plus Blue PPO, call 1-866-309-1719.

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Learn about the features in Provider Secured Services

We're making it easier for you to learn how to use our online tools. See our **presentation** that gives you an overview of the features and tools in Provider Secured Services.

Learn how to use popular features like:

- Web-DENIS
- Provider Enrollment and Change Self-Service
- BCN Health e-BlueSM
- BCBSM Health e-BlueSM
- Electronic funds transfer

You'll also learn how to request access to these tools and where to find important contact information.



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Use our self-service tools to get claims information and more

When you call Provider Inquiry, you may notice we've expanded our self-service offerings to help meet your business needs. This includes changes to the Provider Automated Response System, or PARs, and Provider Secured Services.

About PARS

PARS is a telephone system that provides patient eligibility, benefits and claims information for health care providers.

- Benefit information: PARS provides high-level benefit information that's not specific to a procedure or revenue code.
- Claims information: PARS provides detailed claims data, including information about ICN number, date of service, charged amount, allowed amount, cost-sharing applied, amount paid to provider, check number, check date and check status.

The system has both touchtone and voice recognition capabilities including an option that allows you to request that a hard copy of the benefits or general claims information be sent to your fax or email address.

Using PARS is:

- Quick (inquiry answered within a few minutes)
- Convenient (available 24 hours a day, seven days a week)
- Personalized (caller controls the information they want to hear or skip)
- Accurate (receipt of a fax or email provides documentation of the information received on a given day)

PARS provides information for:

- Blue Cross and Blue Care Network commercial
- Medicare Advantage
- Federal Employee Program®
- Professional, facility, vision and hearing

When calling with questions about the determination of a claim, our customer service representatives will encourage you to use PARS to retrieve your information. They'll help you navigate through the system or find the detailed information you need.

About Provider Secured Services

Provider Secured Services is a secure site on bcbsm.com/providers that gives you patient information and the resources you need to do business with us. Depending on the kind of provider (or facility) you are, you can:

- Get patient eligibility, benefits and claims status using **web-DENIS**
- **Sign up for EFT** for direct deposit of claims payments and view online vouchers
- Get **medical drug prior authorization** if you're a doctor practicing in an office or a hospital
- Use **Health e-BlueSM** to generate reports about patient health. Primary care physicians can also use it to fill out Healthy *Blue LivingSM* HMO qualification forms.

Please see [Self-service tools](#), continued on Page 7

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Self-service tools, *continued from Page 6*

Providers and facilities outside of Michigan may qualify for access based on the following two questions:

Do you only get payment from us for Medicare crossover claims?

You can use Provider Secured Services to:

- Register for electronic funds transfer, or EFT
- View your online vouchers

First you'll need to enroll with us using the **Out-of-State/EFT New Provider Enrollment form (PDF)**. The form includes a section for signing up for access to Provider Secured Services.

You'll also need to fill out the **Use and Protection Agreement (PDF)**.

Do you get payment from us for Medicare and non-Medicare claims?

If you're one of the allied provider types listed below, you can use secured services for EFT and online vouchers, plus patient eligibility, benefits and claims status.

- Clinical independent laboratory
- Durable medical equipment supplier
- Freestanding radiology center
- Hearing
- Independent diagnostic testing facility
- Physiological laboratory
- Vision

You need to be enrolled with us first to use Provider Secured Services even if you don't participate with Blue Cross.

Our enrollment forms have a section for signing up for Provider Secured Services, where you can also list staff members who need access and what they can access.

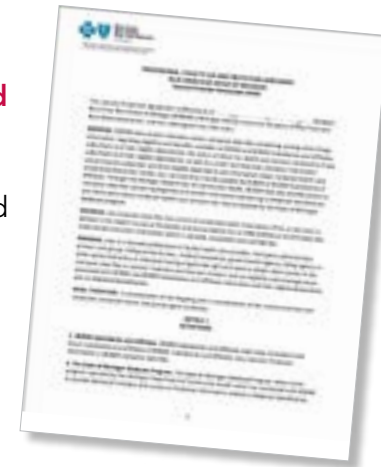
Get started here.

Allied providers should fill out the *Professional Secured Access Application* if they:

- Already use Provider Secured Services and need to make changes such as adding or removing staff members
- Skipped the Provider Secured Services section on the enrollment form:
 - **Provider Secured Access Application (PDF)**

If you've never used Provider Secured Services before, you'll also need to fill out the **Use and Protection Agreement (PDF)**.

If you have a change in staff and an ID that can be reassigned, fill out the **Provider Secured Services ID Reassignment form (PDF)**.



If you need assistance, call the Web Support Help Desk at 1-877-258-3932 from 8 a.m. to 8 p.m. Monday through Friday.



We've made improvements to Provider Inquiry

Over the past year, we've been updating Provider Inquiry's automated response system to better serve you. With the increase in usage, we've also received a lot of great feedback and suggestions. Based on your feedback, we've made several updates.

Inquiries about eligibility (August updates)

When you call for eligibility and benefits, and the system doesn't find any active coverage, you will hear the following:

1. The date the policy became inactive
2. You will be asked if your inquiry is about a claim:
 - If your response is "yes," the system will ask for more information related to the claim so the call can be handled appropriately and routed correctly.
 - If the response is "no," the system will tell you to check with the member to determine their medical coverage.
3. The option to request information on another contract

September updates

Old automated response	New automated response	How will it help?
"Are you calling on behalf of a Michigan member?"	"Are you calling on behalf of a member who has a Blue Cross Blue Shield of Michigan ID card? Please say 'yes' or 'no'."	<ul style="list-style-type: none"> • It will give you clearer understanding of the question • It will route your call correctly
"Are you calling for a status on your claim?"	"If you know the outcome of your claim, but have additional questions about the determination, say 'yes' otherwise, say 'no'."	<ul style="list-style-type: none"> • It will give you clearer understanding of the question • It will lessen the amount of time you need to spend in the automated response system

Call Provider Inquiry at 1-800-344-8525.

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

Blue Cross Blue Shield of Michigan and Blue Care Network corporate offices are closed as follows:

- Tuesday, Nov. 6 for Election Day
- Thursday, Nov. 22 and Friday, Nov. 23 for Thanksgiving
- Monday, Dec. 24 and Tuesday, Dec. 25 for the Christmas holidays
- Monday, Dec. 31 for the New Year

During holiday closures, BCN's inpatient utilization management area remains available to accept inpatient authorization requests for BCN HMOSM (commercial) and BCN AdvantageSM members.

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

Acute initial inpatient admissions

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

Note: These requests may also be submitted through the X12N 278 Health Care Services Review – Request for Review and Response electronic standard transaction.

Post acute initial and concurrent admission reviews

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

Other authorization requests

The requests listed below must be submitted by fax:

- Acute inpatient concurrent reviews and discharge dates, but only for facilities reimbursed on the basis of DRGs (Effective Nov. 1, acute inpatient concurrent reviews and discharge dates, for facilities reimbursed on the basis of DRGs, can only be sent via e-referral. See the article on Page [46](#))
- Authorization requests for sick or ill newborns
- Requests for enteral and total parenteral nutrition

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

Additional information

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

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

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

Refer to the document [Submitting acute inpatient admission requests to BCN](#) for additional information.

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

BCN Advantage



Premiums are lower for five of our eight BCN AdvantageSM products in 2019. We still have two \$0 premium plans and we did have to raise the rate slightly on our MyChoice Wellness partnered product that is available in four western Michigan counties.

We also either lowered member cost-sharing amounts and out-of-pocket maximums for 2019 or held them steady. Plus, we added new package choices for our popular Optional Supplemental Dental, Vision and Hearing plan, with two packages for BCN AdvantageSM HMO-POS members and two for our HMO members. (See separate article on Page 11.)

In other important news ...

- There is now no cost-sharing for observation care.
- An Enhanced Disease Management program was added for members in certain areas of west Michigan.
- A Readmission Prevention program will begin in part of southeast Michigan.
- Coinsurance has been eliminated for bathroom safety bars. (The allowance remains \$100).
- A new Select Care Tier 6 has been added for members to receive commonly used diabetes and cholesterol medications at \$0 copay when prescriptions are filled at a preferred pharmacy.
- Online visits will be offered for all of our members. (See article on Page 14.)

Plans available in 2019

The BCN Advantage plans available in 2019 are unchanged. They are:

- BCN AdvantageSM HMO-POS Elements
- BCN AdvantageSM HMO-POS Basic
- BCN AdvantageSM HMO-POS Classic
- BCN AdvantageSM HMO-POS Prestige
- BCN AdvantageSM HMO MyChoice Wellness
- BCN AdvantageSM HMO ConnectedCare
- BCN AdvantageSM HMO HealthySaver
- BCN AdvantageSM HMO HealthyValue

We're telling BCN Advantage members they don't need referrals

We're letting BCN Advantage members know they don't need a referral from their primary care physician for covered services with a specialist who's in the provider network for the member's health plan. This isn't a change. We're just making sure members know.

We're also reminding members that:

- Their primary care physician is the best resource for coordinating their care and can help them find a specialist in their provider network.
- Their primary care physician will coordinate care with the specialist.
- Some specialists may still want to confirm with the primary care physician that the member needs specialty care.
- Authorizations are still required for certain services with any provider and for all services with a provider who's outside the network for the member's health plan.

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BCN Advantage adds dental, vision and hearing benefits for 2019

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For several years now, BCN AdvantageSM has offered members the ability to purchase dental, vision and hearing coverage above the benefits that are part of their health plan for a nominal additional premium. For 2019, there are choices in the amount of coverage — two coverage options for HMO-POS members and two coverage options for HMO members.

For BCN Advantage HMO-POS Elements, Basic, Classic and Prestige members

- Higher benefit allowances for dental, vision and hearing
- Dental and vision allow out-of-network benefits
- HMO-POS members who previously had BCN Advantage Optional Supplemental Dental, Vision and Hearing coverage will automatically be enrolled in Package 1 unless they choose to enroll in Package 2 or cancel.

Package 1: includes increases over our previous optional supplemental plan for \$21.50 per month.

- Increased dental allowance from \$1,000 to \$1,500
- Increased vision allowance for glasses or contacts from \$200 to \$300*
- Allowance for hearing aids increased from \$500 (\$250 per ear) to \$1,200 (\$600 per ear)
- Also eliminated the coinsurance for a hearing exam every three years

Package 2: an enhanced package choice, which provides even more for just \$32.50 per month.

- \$2,500 dental allowance
- Dental allowance includes coverage for oral surgery, dentures, bridges, onlays (in-network only)
- \$400 vision allowance*
- Vision includes Lasik discount (in-network only)
- \$2,500 hearing aid allowance (\$1,250 per ear)
- No coinsurance for annual hearing exam and hearing aid fitting every three years

*Benefits may vary across plans.

For BCN Advantage HMO ConnectedCare, MyChoice Wellness, HealthySaver and HealthyValue members

- Package 1 has a lower premium than current plan
- Higher benefit allowances for dental, vision and hearing
- Lower coinsurance for Package 2
- HMO members who previously had BCN Advantage Optional Supplemental Dental, Vision and Hearing coverage will automatically be enrolled in Package 1 unless they choose to enroll in Package 2 or cancel

Package 1: includes increases over our previous optional supplemental plan for a lower premium of \$13.50 per month.

- Increased dental allowance from \$1,000 to \$1,500
- Increased vision allowance from \$200 to \$300
- Allowance for hearing aids increased from \$500 (\$250 per ear) to \$1,200 (\$600 per ear)
- Also eliminated the coinsurance for an annual hearing exam and hearing aid fitting every three years

Package 2: an enhanced package choice, which provides even more for \$25.50 per month.

- \$2,500 dental allowance
- Dental allowance includes coverage for oral surgery, dentures, bridges, onlays
- \$400 vision allowance
- Vision includes Lasik discount (in-network only)
- \$2,500 hearing aid allowance (\$1,250 per ear)
- No coinsurance for an annual hearing exam and hearing aid fitting every three years

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Reminder: Starting Oct. 1, additional specialty medications required authorization for BCN AdvantageSM members

For dates of service on or after Oct. 1, 2018, additional specialty medications covered under the Medicare Part B medical benefit require authorization for BCN Advantage members.

We first communicated about this in an **article** on Page 28 of the July-August 2018 *BCN Provider News*. Please review this article to see which drugs required authorization starting October 1.

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

These medications require authorization when billed as a professional service (via the paper HCFA 1500 claim form or electronically as an 837P transaction) or as an outpatient facility service (via the UB-04 or electronically as an 837I transaction) and one of the following place of service codes is used:

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

We also published an update in the article **Clarification: Vivaglobin does not require authorization**, on Page 8 of the September-October 2018 *BCN Provider News*.

In addition, an updated list of drugs requiring authorization for BCN Advantage members is now online. To see the list, visit ereferrals.bcbsm.com, click *BCN* and then click **Medical Benefit Drugs — Pharmacy**. Finally, click *Requirements for drugs covered under the medical benefit – BCN Advantage*.

Note: This communication updates earlier ones, including the newsletter articles, which incorrectly stated that 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. We apologize for this error.

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BCN Advantage initiating step therapy to certain Part B specialty drugs on the prior authorization program beginning in January

For dates of service on or after Jan. 1, 2019, BCN Advantage will implement step therapy for certain Part B specialty drugs that are already on the prior authorization list. You can quickly submit a prior authorization request for specified drugs through a web tool called Novologix®, which you can access within Provider Secured Services.

For drugs subject to step therapy, the questions you'll answer when you submit authorization requests will be different from the ones you currently answer.

Some of the major drugs that will be targeted and may require prior therapy include:

- Prolia® for osteoporosis
- Eylea®, Lucentis® and Macugen® for neovascular age-related macular edema
- Botox® for migraines and overactive bladder

A comprehensive list of all drugs and further program details will be provided in the November 2018 issue of *The Record*.

How does step therapy work?

Step therapy requires that treatment for a medical condition begin with the most preferred drug therapy and progress to other drug therapies only if necessary. The goal of step therapy is to encourage better clinical decision-making.

Background

As part of a patient-centered care coordination program, the Centers of Medicare & Medicaid Services released a memo on Aug. 7, 2018, allowing the use of step therapy for Part B drugs, beginning Jan. 1, 2019.

Renflexis requires authorization for BCN Advantage starting Oct. 1

For dates of service on or after Oct. 1, 2018, Renflexis® requires authorization for BCN AdvantageSM members.

This medication is not self-administered. It must be given by injection or infusion by a physician or health care professional in the office, home or outpatient facility setting.

This medication requires authorization when it is billed on either a professional HCFA 1500 claim form (or submitted electronically using an 837P transaction) or on a facility claim form such as the UB-04 (or submitted electronically using an 837I transaction), for the following places of service:

- Physician office (Place of Service code 11)
- Home (Place of Service code 12)
- Outpatient facility (Place of Service codes 19 and 22)

Submit authorization requests for this medication through the Novologix online tool. Authorization must be obtained prior to the medication being administered.

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BCN Advantage members get added support with online visits

Blue Cross Blue Shield of Michigan's BCN AdvantageSM and Medicare Advantage PPO plans will begin offering Blue Cross Online VisitsSM beginning Jan. 1, 2019.

Beneficiaries will be able to virtually connect with a physician, therapist or other health care provider with a two-way, real-time communication using:

- A mobile phone
- A laptop
- A tablet
- A video conferencing device

Telemedicine is becoming more popular as a way for people to get treatment for non-emergency concerns when their doctor is unavailable. This services provides our members with a real-time alternative for non-emergency care. Members can also use these medical and behavioral health services while traveling; online visits are available in all 50 states.

We encourage members who take advantage of this service to inform their primary care physician of the online visit and are provided a visit summary to share with their doctor.

- Let your patients know how they can access this benefit
 - BCBSM Online VisitsSM app
 - Visit bcbsmonlinevisits.com
 - Call 1-844-606-1608
- PCP or behavioral health copayment applies

Blue Cross Online Visits is powered by American Well®, an independent company that provides online visits for Blue Cross Blue Shield of Michigan and Blue Care Network members.

Online visits through American Well are not intended to replace a member's relationship with his or her primary care physician. These visits are an alternative way to seek treatment for acute illness when the member's primary care physician is not available or when it is not convenient for the member to visit an urgent care center. Members are encouraged to follow up with their primary care physician after an online visit with American Well.

Providers: If you'd like to offer online visits, and have the technology to do so, BCN Advantage will have the ability to support online visits after the first of the year. For providers and provider groups that are interested in offering this service, we'll include instructions in an upcoming update of the *BCN Provider Manual*, including the appropriate policies and billing codes.



Diabetes education available to Medicare Advantage members

We've mailed letters to eligible Blue Cross Medicare Plus BlueSM PPO and BCN AdvantageSM members to let them know about our new Fit4D diabetes education program if they meet these requirements:

- Must be fully insured Medicare Advantage PPO or BCN Advantage members
- Must be 18 or older
- Must have an A1C equal to or greater than 8.0

The Fit 4D program provides personalized education and coaching services to support members with diabetes as they self-manage their condition and follow treatment and care plan recommendations. Services are delivered primarily over the phone, as well as by email and text messages with links to educational content. The program also offers optional online group webinars. There's no cost to the member.

If a patient would like to learn more about the Fit4D program, have them call the Fit4D 24-hour message line at 1-800-422-9875.

What your patients can expect

A Fit4D certified diabetes educator will coach your patients by telephone, text or email. Coaching is available in English and Spanish, and will include the following topics:

- Monitoring blood sugar
- Understanding how medication works
- Recognizing the importance of regular doctor visits
- Achieving healthy eating and exercise goals

A new GM plan has a similar name to BCN Advantage ConnectedCare

Effective, Jan. 1, 2019, General Motors will offer a new medical plan option that has a similar name to an existing BCN AdvantageSM plan.

The plan is called ConnectedCare: Henry Ford Health System. Please note that this plan is **not** affiliated with our existing plan, BCN AdvantageSM ConnectedCare HMO.

January is the time when many patients change health care plans. You should always ask to see the latest member ID card and make sure it matches the coverage listed on web DENIS. You can also check member eligibility and benefits through web DENIS or by calling our **Provider Automated Response System**.



Battling the opioid epidemic: A roundup of recent news and information

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Surgeon General publishes report on opioid addiction, recommends actions

In September, the Surgeon General published a **report**, *Facing Addiction in America: The Surgeon General's Spotlight on Opioids*, which called for a cultural shift in the way Americans talk about the opioid crisis and recommended actions that can prevent and treat opioid misuse.

Through this report, the Surgeon General calls on individuals to:

- **Talk about opioid misuse.** Have a conversation about preventing drug misuse and overdose.
- **Be safe.** Only take opioid medications as prescribed, make sure to store medication in a secure place, and dispose of unused medication properly.
- **Understand pain and talk with your health care provider.** Treatments other than opioids can be effective in managing pain.
- **Understand that addiction is a chronic disease.** With the right treatment and supports, people do recover.
- **Be prepared.** Get and learn how to use naloxone, an opioid overdose reversing drug.

This report follows preliminary data from the Centers for Disease Control and Prevention, which indicates that overdose deaths rose by almost 10 percent in 2017 to claim the lives of more than 70,000 Americans — 48,000 of those deaths were attributable to opioids. The report highlights that while effective treatment for opioid use disorder exists, only one in four people with the disorder will receive any type of treatment. Through recommendations to patients indicated above, the Surgeon General is trying to close that coverage gap.

Opioid laws hit physicians, patients in unintended ways

New state laws on opioids that were intended to save lives have some physicians concerned about unintended consequences, according to article in **Crain's Detroit Business** on July 29. None of the doctors interviewed by *Crain's* objected to the laws' intent: Reducing misuse of the powerful painkillers that have contributed to rising deaths and addictions. But they say regulations have added unnecessary administrative headaches, led to a climate of fear for doctors and left some patients unable to get medications when they really need them.

Limited number of providers authorized to prescribe buprenorphine

Delays in getting admitted to an outpatient program that uses buprenorphine — considered by many specialists to be the gold standard in the treatment of opioid addiction — are the norm rather than the exception, the **Detroit Free Press** reported Aug. 10. And while the shortage of prescribers is a national problem, Michigan appears to be especially hard hit.

Michigan pharmacies filled more orders for drug that reverses opioid overdoses

Michigan pharmacies filled twice as many orders for naloxone, the drug that reverses opioid overdoses, during the second quarter of the year than it did the first, according to report from Lt. Gov. Brian Calley, the **Detroit Free Press** reported July 20. "While we have made great progress [in addressing the addiction epidemic], we have a long way to go and equipping people with naloxone is a great step," Calley said.

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Substance use, continued from Page 16

Heroin deaths surpass gun homicides for first time

Deaths from heroin, an opioid, spiked in 2015, rising by more than 2,000 cases, according to Centers for Disease Control and Prevention data, as reported in *The Washington Post*. For the first time since at least the 1990s, there were more deaths due to heroin than traditional opioid painkillers like hydrocodone and oxycodone.

Get free, customizable brochures about opioids for your patients

The Michigan Opioid Prescribing Engagement Network, or Michigan OPEN, has developed **brochures** that can be customized with your institution's logo and printed for you for free.

Blue plans make progress in addressing opioid epidemic

In July, the Blue Cross and Blue Shield Association issued an update to last year's report on the opioid epidemic. The report, titled, *The Opioid Epidemic in America: An Update*, indicated that Michigan is making significant progress in efforts to combat the epidemic. Last year's report, titled *America's opioid epidemic and its effect on the nation's commercially-insured population*, examined opioid prescription rates, opioid use patterns and opioid use disorder among commercially insured Blue plan members.

Opioid use before knee or hip replacement may increase patient's risk of repeat surgery and hospitalization

Prolonged use of opioid painkillers before total knee or hip replacement may greatly increase a patient's risk of repeat surgery and hospitalization, according to a new study in the *Journal of Bone & Joint Surgery*.

In the study of 233,000 patients in the U.S. who had total knee replacement, and 91,000 who had total hip replacement, more than half of patients had one or more opioid prescriptions filled in the six months before surgery and rates of prolonged opioid use before surgery approached 20 percent.

Hospital readmission rates in the knee replacement group were 1.4 percent higher among those who used painkillers for more than 60 days and 2.2 percent higher within the hip replacement group. After one year, rates of repeat knee surgery were twice as high in the long-term opioid group compared to those who were not on long-term opioids; in the new hip group, repeat surgery rates were more than double for the opioid group.

CDC releases study on opioid use disorder in labor and delivery

The Centers for Disease Control and Prevention recently released the first-ever multi-state **analysis of trends** in opioid use disorder (OUD) in labor and delivery. These data indicate the number of pregnant women with OUD at labor and delivery more than quadrupled from 1999 through 2014, with significant increases in every one of the 28 states with available data.

OUD during pregnancy has been associated with a range of negative health outcomes for both mothers and their babies including maternal death, preterm birth, stillbirth and neonatal abstinence syndrome.

Reducing the burden of OUD on pregnant women and infants is a key component of CDC's response to the opioid crisis. For additional information about CDC's work in this area, please see this new **infographic** highlighting strategies to address opioid use disorder and improve maternal and infant health.



Blue Cross plans are working together nationwide to improve addiction treatment

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Blue Cross is working with doctors and other experts nationwide to make sure our members have access to the most effective addiction treatment centers to get the care they need. A new Blue Cross Blue Shield Association program, which will include a new designation for effective treatment programs, builds upon the existing **Blue Distinction®** system that evaluates and identifies the highest quality doctors and hospitals.

The Blue Distinction program is one of the many ways that Blue plans are working together to ensure patients are given the most effective and appropriate treatments through value-based and patient-centered care.

And to help connect people with these top-ranked treatment centers, Blue Cross is creating a national hotline, which will make access much easier.

A new system to designate treatment centers using proven methods – and a hotline to locate them — are two more critical and proactive steps to help individuals and families nationwide and, most importantly, save more lives.

Find more information in our **MI Blues Perspectives** blog.



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Screen kids early to avoid cardiovascular disease

Atherosclerosis can begin in childhood and progress slowly into adulthood, leading to coronary heart disease. Children are also at risk for developing hypertension, metabolic syndrome and Type 2 diabetes.

The American Academy of Pediatrics recommends that all children be screened for high cholesterol at least once between the ages of 9 and 11 and again between 17 and 21*.

Michigan Quality Improvement Consortium **guidelines** recommend screening for children older than 2 who are at increased risk for genetic forms of hypercholesterolemia. The best method for testing is a fasting lipid profile. If the child has values within the normal range, testing should be repeated in three to five years.

Children 8 years and older with abnormal cholesterol readings may be considered for cholesterol-reducing medications. Younger children with abnormal readings should focus on weight reduction, healthy eating habits and an active exercise program.

For younger patients who are overweight or obese and have a high triglyceride concentration or low HDL concentration, weight management is the primary treatment.

During the office visit, the primary care physician should address the following risk factors with the child and his or her family:

- Family history of heart disease
- Family history of obesity
- Family history of high blood pressure
- Family history of diabetes
- Child's height and weight and body mass index
- Blood pressure measurement at age 3, then yearly if normal
- Lipid screening if indicated
- Review of child's diet and daily physical activity
- Tobacco use by parents and the child beginning at age 12, including second hand smoke exposure; counseling for smoking cessation

Our Care Management team provides parents and caregivers of overweight children with information about hypertension, nutrition and other factors related to cardiovascular disease. Call the Care Management nurse line at 1-800-392-4247.

*Guidelines sponsored by the National Heart, Lung and Blood Institute

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Help prevent Type 2 diabetes in children

While Type 2 diabetes is usually diagnosed in adults, it's increasingly diagnosed in children and adolescents, particularly in American Indians, African-Americans and Hispanics and Latinos, according to the Centers for Disease Control and Prevention.

Obesity is a major risk factor for Type 2 diabetes in children. Type 2 diabetes mellitus can remain asymptomatic for a long time. According to the National Institutes of Health, obesity in children may be attributed to the following modifiable habits:

- High-calorie food choices
- Lack of physical activity
- Parental obesity
- Irregular eating habits that include skipping meals and overeating
- Parents with poor nutritional habits and sedentary lifestyles

The Michigan Quality Improvement Consortium guidelines recommend that physicians assess children at each periodic health exam. These key components should be addressed:

- Education of parents with children younger than 2 about obesity risk and prevention
- Assessment of body mass, risk factors for being overweight and excessive weight gain relative to linear growth in children age 2 or older
- Education to promote healthy weight in children age 2 years or older with a body mass index less than the 85th percentile for age

For children 2 years or older, guidelines recommend that the general assessment include:

- Performing a history (including focused family history) and physical exam
- Measuring and recording weight and height on CDC BMI-for-age growth chart
- Assessing risk factors, including pattern of weight change (watch for increases of three to four BMI units per year.)
- Assessing dietary patterns (for example, frequency of fast-food meals, skipping breakfast, frequency of fruit and vegetable intake, portion sizes)
- Physical activity level

For additional information about prevention and identification of children who are overweight and obese, refer to the updated MQIC **guidelines**.

Overweight or obese children may benefit from weight loss supervision from their health care practitioners. Studies in adults have indicated that if an individual can reduce his or her body weight by 5 to 7 percent and maintain at least moderate activity for 30 minutes most days of the week, he or she can reduce the risk of diabetes.

Physicians should provide counseling about nutrition, weight control and physical activity to young people and their families, as well as an individualized plan of care. Some children may also need treatment for hypertension and hyperlipidemia, including follow-up every three months. Pharmacologic therapy for weight loss isn't recommended for children until more safety and efficacy data is available.





Diabetes patients require certain tests

Blue Care Network is commemorating American Diabetes Month in November by reminding physicians about the assessment and treatment of their diabetic patients.

The Michigan Quality Improvement Consortium guidelines recommend periodic medical assessments, laboratory tests and education to guide effective self-management in patients with Type 1 and Type 2 diabetes mellitus.

The following tests are recommended:

- Hemoglobin A1C (two to four times annually based on individual therapeutic goal)
- Urine microalbumin measurement (annually)
- Serum creatinine and calculated glomerular filtration rate (annually)
- Fasting lipid profile (annually)
- Dilated eye exam by ophthalmologist or optometrist or digiscope evaluation (annually, or every two years in absence of retinopathy)
- TSH and LFTs

For more information about treating diabetic patients, refer to the [MQIC guidelines](#).

The level of HbA1c may be reduced with lifestyles choices of diet, weight loss and physical activity. Members who continue to be challenged with HbA1c levels greater than 9 percent may benefit from working with a BCN nurse case manager.

Our Chronic Condition Management program provides tools to help members make informed health choices and manage their conditions. To refer members, call Chronic Condition Management at 1-800-392-4247; TTY 1-800-257-9980. Specialists are available from 8:30 a.m. to 5 p.m. Monday through Friday.

DIABETES
AWARENESS
MONTH

YOU SPOKE

WE LISTENED

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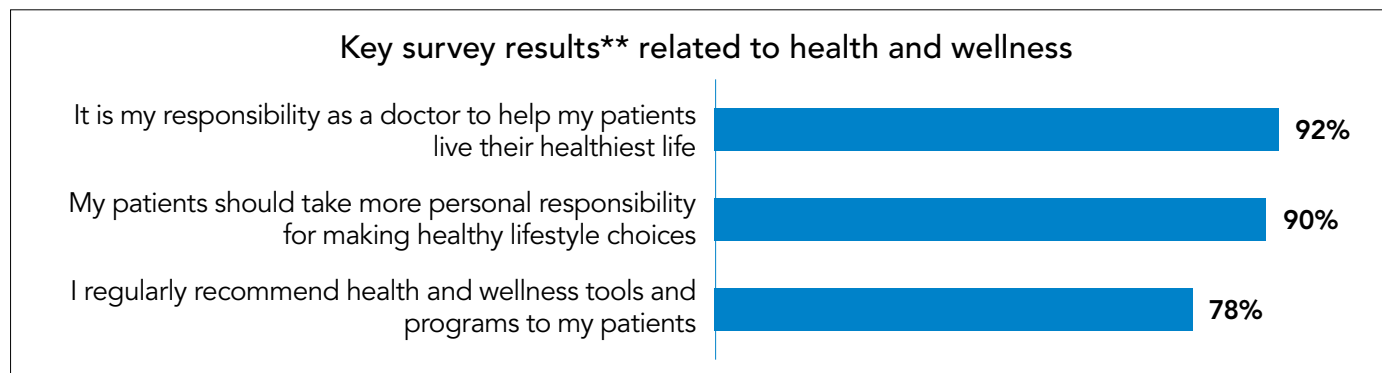
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Physicians, Blue Cross and BCN agree that healthy lifestyles are key to living well

In October 2017, Blue Cross Blue Shield of Michigan commissioned an independent market research firm, Gongos Research, to conduct an online survey of Blue Cross and Blue Care Network physicians. The objective? To obtain their opinions about patient care, health and wellness programs, the health care industry and more. Over the next year, we'll be running a series of articles that examine how we're responding to their attitudes and concerns. This is the first article in the series.

Doctors want their patients to take steps toward a healthier lifestyle by making good decisions about nutrition, physical activity and overall wellness. That was a key finding of a recent survey conducted by Blue Cross. See the chart below for other findings related to health and wellness.



** Results show top-two box percent "agree" responses on a five-point scale.

"Blue Cross and Blue Care Network value our relationship with physicians and share in the belief that healthy lifestyles are important for everyone," said Sherri Dansby, market research manager with Corporate Marketing and Customer Experience. "As part of that belief, Blue Cross strives to give our members the tools they need to succeed in living well."

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Health and wellness tools

Here's an overview of some of these tools and programs:

- The Blue Cross® Health and Wellness website, powered by WebMD® gives members 24-hour access to current health information and tools, including digital health assistant programs, health trackers and a personal health record.
- The Blue365® program offers health and wellness deals and discounts exclusively to our members. Blue365 categories include healthy eating, fitness, lifestyle and wellness. Personal care and financial deals are also available to members. Members can access these deals at bcbsm.com and through the Blue Cross mobile app.
 - Blue365® discounts on groceries and healthy meal programs give members nutritious food options, such as discounts at Better Health stores, Weight Watchers, Jenny Craig and Nutrisystem. Private weight-loss coaching, nutrition educational resources and discounts on vitamins and supplements are also available.
- Fitness Your Way™ by Tivity Health™ allows members the flexibility to work out at any of its locations nationwide for only \$29 per month. More than 10,000 fitness locations participate, including LA Fitness, Snap Fitness and Anytime Fitness, as well as many local fitness centers. Deals are also offered on mindfulness courses, wearable health devices and fitness equipment.

In addition to providing wellness tools directly to members, Blue Cross and BCN provide health and wellness resources to employer groups through the Blue Cross® Health and Wellness benefit. Examples of resources offered include:

- Lifestyle coaching and stress management tools designed to help improve health risks
- Smoking and tobacco cessation support programs
- Health assessments and coaching
- Wellness challenges for motivation to improve healthy behaviors

Nine in 10 physicians responding to the survey seek to help their patients live healthy lives. And nearly eight in 10 physicians frequently recommend health and wellness tools to their patients.

Blue Cross and BCN encourage health care providers to consider our health and wellness programs when making lifestyle recommendations to their patients.

WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network members by providing health and wellness services.

Blue Cross and BCN encourage health care providers to remind their patients to create an account at bcbsm.com and download the BCBSM mobile app to access health and wellness resources.

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BCN continues to follow AAP palivizumab guidelines

Blue Care Network follows guidelines from the American Academy of Pediatrics for the use of Synagis®, also known as palivizumab. Palivizumab, approved in 1998, has reduced respiratory syncytial virus hospitalizations. AAP consistently updates its Synagis guidance for prevention of respiratory syncytial virus. The guidance was developed to implement palivizumab in the most cost-effective way.

Palivizumab is a monoclonal antibody given monthly to prevent RSV during the RSV season in pre-term or high-risk infants. RSV season in Michigan generally starts around October 1 and continues for four to five months.

High-risk infants were previously defined as infants with bronchopulmonary dysplasia, those born at or before 35 weeks gestation and children with hemodynamically significant congenital heart disease. In addition, it was indicated for children undergoing cardiopulmonary bypass.

Due to the advancement in neonatal care since 1998, there has been a steady decline in RSV hospitalization both with and without prophylaxis. This has changed the need for palivizumab. Because high-risk infants are no longer at such a risk, AAP has stated criteria to identify those high-risk infants: Palivizumab is recommended for infants born before 29 weeks, 0 days gestation, who are younger than 12 months at the start of RSV season.

Palivizumab is no longer recommended for infants born at 29 weeks, 0 days gestation or later, but may be indicated for:

- Infants younger than 12 months with hemodynamically significant congenital heart disease
- Infants younger than 12 months with chronic lung disease — defined as birth at before 32 weeks, 0 days, and greater than 21 percent oxygen for at least 28 days after birth
- Infants younger than 24 months who are profoundly immunocompromised during the RSV season, children who required at least 28 days of oxygen supplementation after birth and those who require medical intervention (oxygen, chronic corticosteroids, diuretic therapy)
- Infants younger than 12 months with pulmonary abnormalities or neuromuscular disease that impairs the ability to clear secretions from upper airways
- Infants younger than 12 months of age with cystic fibrosis with clinical evidence of chronic lung disease (as defined above) and/or nutritional compromise

The AAP also emphasizes that the risk of RSV disease is higher in Alaskan Native American patients, and use has been broadened in these individuals as well as other selective American Indian populations.

Please see [Palivizumab](#), continued on Page 25



The guidance states a maximum of five monthly doses may be given to infants in the first year of life. This differs from the previous recommendations, where certain infants required fewer doses. Although those born within the season may require fewer doses, palivizumab is no longer recommended for infants in their second year of life as it was in certain populations in the past. It is no longer recommended for prevention of health care-associated RSV disease and should be discontinued in any child who has a breakthrough RSV hospitalization.

A publication and commentary published in *Pediatrics* in the August 2016 issue demonstrated additional support for the current recommendations. As of August 1, 2018, no additional changes have been noted to the AAP guidance.

RSV **seasonal trends** and **surveillance data** are available at the Centers for Disease Control and Prevention.

References:

Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection. *Pediatrics* 2014; 134:415; originally published online July 28, 2014.

Palivizumab Prophylaxis for Healthy Preterm Infants: More Data Supporting AAP Guidelines. *Pediatrics* 2016; 138(2):e20161494

Observed Effectiveness of Palivizumab for 29–36-Week Gestation Infants. *Pediatrics*. 2016;138(2):e20160627

BCN requires prior authorization for Synagis

We require prior authorization for the coverage of Synagis (palivizumab), in accordance with the American Academy of Pediatrics guidance.

For a full list of drugs in the prior authorization program, and how to request an authorization go to **ereferrals.bcbsm.com** and click on *Medical Benefit Drugs – Pharmacy* link on the Blue Care Network homepage. You can also call the Blue Care Network Specialty Pharmacy Help Desk at **1-800-437-3803** from 8 a.m. to 4:30 p.m., Monday through Friday, to initiate a prior authorization request.

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

- Allografts for nerve repair
- CPT category III codes—noncovered
- Lymphedema — Surgical treatments
- Sphenopalatine ganglion block for headache

Covered services

- Cytoreductive surgery and hyperthermic perioperative intraperitoneal chemotherapy for select intra-abdominal and pelvic malignancies
- Esophageal function tests
- Genetic testing — *BRAF* mutation in selecting melanoma or gliomas patients for targeted therapy
- Genetic testing for heterozygous familial hypercholesterolemia
- Intensity modulated radiation therapy of the breast and lung
- Pneumatic compression pumps (Flexitouch™ System) for lymphedema
- Transcatheter mitral valve repair
- Transcatheter aortic valve implantation for aortic stenosis
- Wireless capsule endoscopy to diagnose disorders of the small bowel, esophagus and colon


[Medical Policy Updates](#)



Educate patients about the dangers of smoking

The American Cancer Society marks the **Great American Smokeout** on the third Thursday of November each year to encourage smokers to quit.

By quitting even for one day, smokers and smokeless tobacco users take an important step toward a healthier life, one that can reduce cancer risk. Oral or smokeless tobacco products also cause cancer and can lead to nicotine addiction. The use of any smokeless tobacco product isn't considered a safe substitute for quitting.

Tobacco use is the most preventable cause of death in the U.S., yet approximately 40 million Americans or one in every five adults still smokes cigarettes. According to the American Cancer Society, cigarette smoking rates have dropped (from 42 percent in 1965 to 17 percent in 2014). However, cigar, pipe, and hookah are very much on the rise.

The dangers of secondhand smoke

According to the Surgeon General's Report, there have been more than 20 million smoking-related deaths in the United States since 1964; 2.5 million of those deaths were among nonsmokers who died from exposure to secondhand smoke. Secondhand smoke exposure is also known to cause strokes in nonsmokers.

Second hand smoke is a mixture of two forms of smoke that come from burning tobacco:

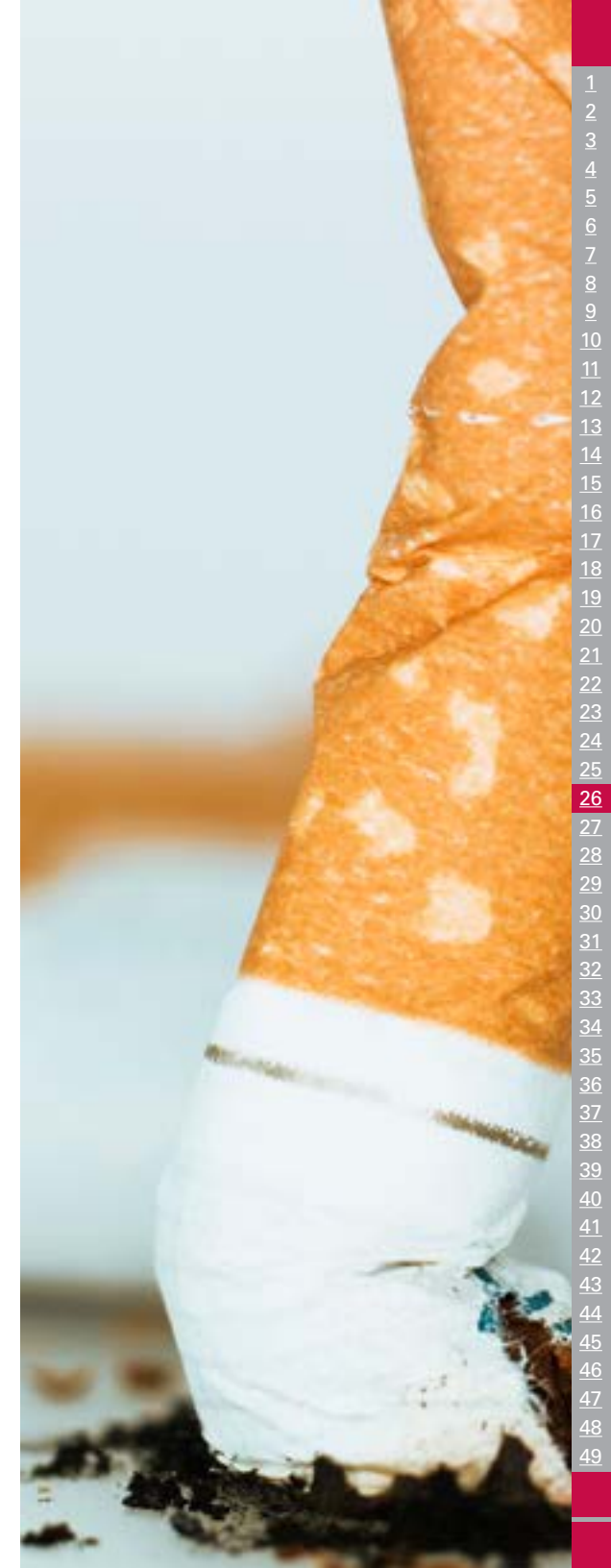
- Side stream smoke: Smoke from the lighted end of a cigarette, pipe, cigar or tobacco burning in a hookah.
- Mainstream smoke: The smoke exhaled by a smoker

While it is generally known that mainstream smoke can be detrimental, side stream smoke is also very toxic. Side stream smoke has higher concentrations of carcinogens and is more toxic than mainstream smoke. It has smaller particles than mainstream smoke. These smaller particles make their way into the lungs and the body's cells more easily. When nonsmokers are exposed to second hand smoke, it's called involuntary, or passive, smoking.

Nonsmokers who breathe in secondhand smoke take in nicotine and toxic chemicals by the same route smokers do. Quitting smoking alleviates exposure to second hand smoke that is harmful to others.

Blue Care Network has partnered with WebMD to provide a telephone-based tobacco cessation and lifestyle coaching program.

We encourage physicians to counsel all patients who smoke or use smokeless tobacco to quit at each visit until they are successful.



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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 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.

If you have any questions, please contact your provider consultant.

*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.



Behavioral Health

Recent events turn nation's attention to suicide awareness and prevention

By William Beecroft, M.D.



Suicide deaths have climbed dramatically in the U.S. — 30 percent over the past decade and a half, according to data from the Centers for Disease Control and Prevention. Nearly 45,000 Americans died by suicide in 2016, making it the most common cause of death that year. These findings were released in two separate CDC reports in June, coinciding with the suicides of two celebrities — TV host and chef Anthony Bourdain and designer Kate Spade.

While suicide is most common among adults middle-aged and older, it's on the rise in other age groups and among women.

- The CDC reported that the number of women who died by suicide has nearly doubled since 2000 — from less than 6,000 to more than 10,000 in 2016.
- Nearly twice as many children were hospitalized for thinking about or attempting suicide in 2015 as in 2008, according to a study published in May in the journal *Pediatrics*.

The psychiatric community is particularly distressed about the increase in teen suicide. The suicide rate for girls ages 15 to 19 doubled from 2007 to 2015 to about five per 100,000 — the highest point in 40 years, according to the CDC. The suicide rate for boys ages 15 to 19 increased by 30 percent over the same time period, reaching 14 per 100,000 in 2015.

What's behind these dramatic increases?

There are many reasons young people are particularly vulnerable. They include:

- The increase in social media use
- Exposure to violence
- Bullying and cyberbullying
- Sleep deprivation
- Depression

According to an **article** on huffingtonpost.com, teen depression is on the rise, yet the stigma surrounding mental health treatment often prevents people from asking for and getting the help they need. And untreated mental health conditions are among the leading causes of suicide.

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Dr. William Beecroft is the medical director of behavioral health for Blue Care Network. He's a board-certified psychiatrist with added qualifications in geriatrics and psychosomatic medicine.

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From the medical director, continued from Page 28

What can a doctor do to help prevent suicide?

Research has shown that **most people who attempt suicide** make some type of health care visit in the weeks or months before the attempt. That's one reason why it's so important to screen patients for depression and suicidal tendencies. One good assessment tool is the **Columbia Suicide Severity Rating Scale**. There are three versions of the scale, including one targeted to children.

Even after someone receives help for depression, anxiety or suicidal tendencies, their doctor still needs to remain vigilant. People often become quiet — and don't express their suicidal thoughts or anxiety — a couple of weeks before they commit suicide.

It seems that once they formulate a plan to commit suicide, their anxiety decreases and they are likely to move forward with the plan. Also, after beginning antidepressant medication, their energy levels may increase, giving them the impetus to put a plan in place.

Most seasoned psychiatrists and psychologists have encountered hundreds of people who are suicidal. When one of our patients commits suicide despite our best efforts, we experience a sense of failure, and want to do all we can to help other health care providers to prevent suicide among their patient populations.

Some other suggestions

I try to impress upon my patients that suicide is a permanent solution to a temporary problem. It may be wiser to consider temporary solutions until the cause of the symptoms leading to suicidal thoughts can be identified and resolved. Many people — particularly young people — don't seem to grasp the permanency of death.






There are many nonpermanent options they can choose from to distract themselves from loneliness, depression or other problems. I call this the smorgasbord of life. Taking a walk eating a nice meal, going for a bike ride, doing some type of volunteer work, visiting a friend or trusted confidant, or seeking out treatment are some examples. They need to realize that if they can keep busy for a time — even if they don't feel like it — life may not look quite so bleak in a day or two.

I also like to recommend that families sit down for 15 minutes each day to talk about their day and ask each family member if there's anything they'd like to discuss. Families have become so fragmented and busy these days that they may not be aware that a family member is at risk.

Talking about things that are causing emotional pain, removing the stigma surrounding mental health and encouraging people to seek psychiatric or behavioral health care when they're depressed or suicidal are absolutely essential to reversing this dangerous trend.

Please see [From the medical director](#), continued on Page 30

Suicide by the numbers

-  **30%** increase in suicide rates from 2000 to 2016
-  Nearly **45,000** Americans died by suicide in 2016
-  Suicide ranked as **second** leading cause of death for people ages 10 to 34 in 2016
-  **70%** increase in suicide rate among girls from 2010 to 2016
-  **60%** increase in suicide rate for women ages 45 and 64 from 2010 to 2016.

Source: CDC, National Center for Health Statistics

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From the medical director,

continued from Page 29








Want to learn more?

September was Suicide Awareness Month. We've posted an array of suicide awareness and prevention resources on our "Engage" page at bcbsm.com/engage in the "Mental Health Awareness" section. Also, the sidebar below includes a list of articles and other resources that may be of interest.



Resources for doctors

The following resources and articles may assist you in your efforts to create awareness of the rising suicide rate help prevent this tragedy:

-  **CDC: [Suicide rising across the U.S.](#)**
-  **American Academy of Family Physicians: [A tool to help your practice assess suicidal patients](#)**
-  **Sentinel Event Alert: [Detecting and treating suicide ideation in all settings](#)**
-  **American Academy of Pediatrics: [Suicide prevention policy, publications and tools](#)**
-  **MSMS Medigram e-News: [Local efforts to push suicide training results in new nationwide policy](#)**
-  **Psychiatric News: [Suicide deaths climb dramatically in U.S., nearly double for women](#)**
-  **The Wall Street Journal: [New CDC director targets opioids and suicides](#)**

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

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Providers can refer patients to BCN facility partners for addiction treatment

We'd like to remind providers that they can refer Blue Care Network members to either of two hospital partners in our pilot project for substance abuse treatment.

The two hospital partners are Maplegrove Center (part of Henry Ford Behavioral Health Services) and Pine Rest Christian Mental Health Services. As part of the pilot, the hospitals have agreed to a specific treatment protocol for all patients with opioid use disorders during the cohort year. The one-year pilot began in May 2018.

The treatment protocol consists of key phases:

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

See the article in the May-June 2018 issue of *BCN Provider News* or the flyer (PDF) for details about the program.



Whom to contact

Here's information on the areas the facilities cover and how to refer for treatment:

Pine Rest

The BCN member can call Pine Rest at 1-800-678-5500 to speak to an intake coordinator, who will connect them with services.

Pine Rest serves clients from all over Michigan at its detox facility in Grand Rapids. Outpatient services are located on the west side of the state: greater Grand Rapids area, Traverse City and Kalamazoo.

Additional information can be found on the Pine Rest [website](#).

Henry Ford Health System/Maple Grove

The member can call 1-800-422-1183 or 248-641-4100 to obtain services from Maple Grove. The contact person is Christine Reeves, clinical manager.

Maple Grove, located in West Bloomfield, serves patients throughout the state of Michigan. Most patients reside in Macomb, Oakland and Wayne counties.

See the Henry Ford/Maple Grove [website](#) for more information about the facility.

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Best Practices

Ann Arbor physician discusses risks of not getting the flu vaccine

An interview with Dr. Jack Billi, an internist at the University of Michigan

How do you maintain a high rate of patients who get the influenza vaccine?

It takes a system to improve quality. Our system includes my medical assistant, our nurses, our front desk staff, and our electronic health record. We rely on our EHR to prompt us when a patient hasn't had his or her flu vaccine, or has any other gap in care. Because the flu vaccine is recommended for almost everyone, our medical assistant offers it to every patient we see. It's one of the most cost-effective techniques in all of health care.

A lot of credit goes to my medical assistant, Todd Nelson. He has a great approach with patients and his own technique for giving vaccines. He comes up with ideas on how to approach patients who haven't agreed to get a flu vaccine before. I tap into his creativity when we're coming up with ways to improve our vaccination rates.

What are the challenges to making sure everyone gets vaccinated, and how do you overcome them?

We see several reasons why our patients decline the flu vaccine. We work with them to counteract the misinformation and incorrect beliefs. Some say they never get the flu. We explain that three-quarters of all influenza



Dr. Billi, Todd Nelson and patient Robert Donnellan

cases have no symptoms, but can infect others. Or they say they always get a mild case (that might not have been flu). Others are skeptical of vaccines in general.

Some of my patients see me less than once a year. There are a small number of what I call healthy indestructible males who don't ever come see me. We send reminders to those patients through our patient portal and try to reach healthy people we rarely see. We also make it easy. Patients can schedule their flu shot without having a physician office visit. Some want to delay until the perfect time for the vaccine, but I usually convince them it is better to get it while they can. They could be exposed early or they might get another infection, which would delay their vaccination further.

Many people who resist at first change their minds and get the flu shot. We tell them powerful stories about the risks of not vaccinating, including risks to them, to their family members, and to people who can't be vaccinated.

It helps to share a personal story. In my second year as resident, I got influenza. I was a very healthy 27-year-old and was bedridden for over a week, unable to stand.

So, we continue to work on these resistant patients and their numbers grow smaller each year.

Please see [Best Practices](#), continued on Page 33

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Best Practices, *continued from Page 32*

What about pharmacies? How do you record that your patients got a flu vaccine elsewhere?

I used to ask all our patients to get their flu shots from us, but I realize it's sometimes inconvenient to come to our office. Often pharmacies have the vaccine before we do. We ask patients to let us know they were vaccinated elsewhere, or else we'd waste time tracking down people who were already vaccinated.

In the past, pharmacies were inconsistent entering the vaccine into MCIR. What's helped us is the medication reconciliation information in our electronic health record. Our record shows meds "prescribed" outside our system, and often it's a flu shot at a pharmacy. So we know they got the vaccine.

Is there anything you'd like to add that you feel is important?

We use the resources that come through value-based reimbursements, such as BCN incentive payments or the Blue Cross PGIP program, to support our office systems for improving quality. They help support the infrastructure and our whole team – medical assistants, call center staff, front desk staff. We use the whole team to their maximum potential to help us do the right things for our patients and create a good patient-centered medical home.

New blood pressure measures from NCQA

The National Committee for Quality Assurance has made some important changes to the measures related to controlling blood pressure. These changes apply to BCN AdvantageSM and Medicare Plus BlueSM PPO members.

The current measure requires two outpatient visits with a diagnosis in the current or prior year.

Controlled blood pressure thresholds are now **less than 140/90 for the entire population** of hypertensives. The BP reading must be on or after the date of the second diagnosis of hypertension.

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HEDIS 2018 Results

The Healthcare Effectiveness Data and Information Set, or HEDIS®, is the most widely used set of performance measures in the managed care industry, has been submitted to the National Committee for Quality Assurance accreditation process.

HEDIS is part of an integrated system to establish accountability in managed care organizations. It was originally designed to address private employers' needs as purchasers of health care and has been adopted for use by public purchasers, regulators and consumers and is now used by Centers for Medicare & Medicaid Services for their star ratings. Areas of improvement were noted in the following measures:

Commercial

- Adult BMI Assessment
- Antidepressant Medication Management – Effective Continuation Phase Treatment
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection (Inverted Rate)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Childhood Immunizations – Combo 2
- Comprehensive Diabetic Care – HbA1c Screening & Poorly Controlled >9.0%
- Follow-up Care for Children Prescribed ADHD Medication – Continuation & Maintenance Phase
- Immunization for Adolescents – Combo 2
- Initiation and Engagement of Alcohol and other Drug Dependence Treatment – Initiation and Engagement Phases
- Pharmacotherapy Management of COPD – Bronchodilators
- Use of Imaging Studies for Low Back Pain (Inverted Rate)
- Weight Assessment & Counseling for Children/Adolescents – BMI %, Nutrition Counseling, and Physical Activity Counseling
- Well-Child Visits in the First 15 Month of Life – Six or more visits
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Marketplace or qualified health plan

- Adult BMI Assessment
- Annual Monitoring for Patients on Persistent Medications
- Antidepressant Medication Management – Effective Continuation Phase Treatment
- Appropriate Testing of Children with Pharyngitis
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Breast Cancer Screening
- Chlamydia Screening in Women
- Comprehensive Diabetes – HbA1c Screening
- Comprehensive Diabetes – HbA1c Control < 8.0%
- Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase, and Continuation and Maintenance Phase
- Immunization for Adolescents – Combo 2
- Initiation and Engagement of Alcohol and other Drug Dependence Treatment – Initiation and Engagement Phases
- Medication Management for People with Asthma
- Postpartum Care
- Pharmacotherapy Management of COPD – Bronchodilators
- Use of Imaging Studies for Low Back Pain (Inverted Rate)
- Weight Assessment & Counseling for Children/Adolescents – BMI %
- Well-Child Visits in the First 15 Months of Life – Six or more visits
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life



*HEDIS Results
Commercial*



*HEDIS Results
Marketplace*

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Medicare

- Antidepressant Medication Management – Effective Acute Phase
- Colorectal Cancer Screening
- Comprehensive Diabetic Care – HbA1c Screening
- Comprehensive Diabetic Care – HbA1c Control < 8.0%
- Comprehensive Diabetic Care – HbA1c Poor Control > 9.0% (Inverted Rate)
- Comprehensive Diabetic Care – Medical Attention for Nephropathy
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Initiation and Engagement of Alcohol and other Drug Dependence Treatment – Initiation and Engagement Phases
- Follow-up Care After Hospitalization for Mental Illness – Seven days
- Hospitalizations for Potentially Preventable Complications
- Medication Reconciliation Post-Discharge
- Persistence of Beta-Blocker Treatment After Heart Attack
- Pharmacotherapy Management of COPD – Systemic Corticosteroid
- Pharmacotherapy Management of COPD – Bronchodilators



We'd like to thank all our affiliated practitioners for their contributions toward providing quality care to our members and allowing the BCN staff to conduct medical record reviews for HEDIS and various audits.

Primary care practitioners can still find opportunities to provide aggressive intervention in the management and care of our members with diabetes, controlling high blood pressure, and in ordering procedures for breast, cervical and colorectal cancer screening.

BCN is actively involved in activities throughout the year that positively impact our HEDIS rates, including:

- Physician Quality Rewards Program which is tied to some of the HEDIS measures
- Health e-BlueSM website
- Member gaps in care letters
- Member outreach reminder telephone calls
- Member and physician education via publications
- Member health fairs
- Care Management calls and letters
- Member incentive programs
- HEDIS interventions
- HEDIS/CAPHS Summit Meetings
- MedXM, Home Access and BCN at home services (BMDs)

We look forward to working with you to promote continued improvement in all areas of patient care and services.

If you would like more information about HEDIS, contact Blue Care Network, Quality Management & Population Health Department at 1-855-228-8543.

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Specialty pharmacy program helps you care for your patients

Blue Cross Blue Shield of Michigan and Blue Care Network have partnered with AllianceRx Walgreens Prime to become the exclusive provider of specialty pharmacy services for all individual business PPO and HMO members.

If your patient is affected by this change, you'll need to write a new prescription for his or her medication before Jan. 1, 2019 or the patient may be responsible for the full cost of the drug. If your patient is not affected, no action is required.

This specialty pharmacy service will help patients with complex health conditions who take medications that:

- Require injections
- Need to be taken on a strict schedule
- Require special storage needs



The AllianceRx Walgreens Prime Care Team of pharmacists, nurses and patient care coordinators, will be available to help provide your patients with clinical excellence. They can assist with convenient access to the specialty medication you've prescribed. The patient care coordinators will regularly contact your patients to offer helpful information and provide direction that can enhance their medication compliance and adherence by:

- Helping patients better understand their complex health condition
- Working with Blue Cross to coordinate and verify pharmacy benefits, when necessary
- Assisting patients when a new or existing prescription needs to be filled
- Encouraging patients to take medications exactly as prescribed
- Helping patients manage medication side effects
- Evaluating a patient's response to the prescribed medication therapy
- Calling the patient's prescriber, when necessary
- Offering telephone access to a pharmacist, 24 hours per day, seven days a week
- Delivering a patient's specialty medication to the most clinically appropriate site that meets his or her needs (prescriber's office, clinic, treatment center, or the patient's home)
- Scheduling a patient's next refill

AllianceRx Walgreens Prime is committed to reducing the demands on your time and helping simplify the referral process by providing insurance verification, prior authorization and financial assistance coordination and other resources necessary to help ensure your patients get the specialty pharmacy care they deserve.

For additional information, visit the AllianceRx [website](#).



We've stopped covering Clindagel effective Sept. 1

We've stopped covering Clindagel® as of Sept. 1, 2018 because there are safe, effective and less-expensive choices. Members can continue to fill their prescriptions through Nov. 15.

If a member fills his or her prescription on or after this date, he or she will be responsible for the full cost.

Our goal is to provide members with safe, high-quality prescription drug therapies while also controlling costs. To accomplish this, we're making some changes to the drugs we cover.

The following table includes available alternatives that have similar effectiveness, quality and safety but at a fraction of the cost.

Drug not covered 9/1/2018	Generic name	Available formulations	Average cost per package
Clindagel	Clindamycin	1% gel	\$2133
Covered generic alternative	Generic name	Available formulations	Average cost per package
Cleocin-T	Clindamycin	1% gel	\$115
		1% lotion	\$83
		1% solution	\$38
		1% swabs	\$22

Changes to your Pharmacy Prior Authorization Helpdesk are coming

Changes will be made to the Pharmacy Prior Authorization Helpdesk toll-free number for all commercial and Medicare products under both Blue Care Network and Blue Cross Blue Shield of Michigan contracts, effective Dec. 14, 2018. These changes should make the provider experience more user friendly.

Here are some of the changes:

- Providers *must* have a member contract to authenticate and speak with a live agent. This helps us identify contracts by line of business and eliminates the need for the provider to specify whether the contract is commercial or Medicare. Without an eligible contract (including inactive), providers will not be able to reach a live agent.
- Providers will need to choose which drug benefit they are calling about: Pharmacy or Medical
 - The pharmacy benefit covers drugs that are self-administered and picked up by the member in a retail pharmacy. These can be taken orally, topically, or self-injected
 - The medical benefit covers drugs that are administered by a health care professional, often in a home, office or outpatient facility.
 - The provider will hear the following prompt to make the correct choice:
- "There are two options for drug prior authorizations. For medications that are taken by the patient themselves and billed to the pharmacy benefit say 'pharmacy'. For infusions or injectable drugs given by a health care professional, billed to the medical benefit say 'medical'."

Please note it is crucial for fast and accurate servicing that you choose the correct option.

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FluMist approved and other vaccine updates

Blue Cross Blue Shield of Michigan and Blue Care Network are announcing an update about various vaccines. This update applies to BCN commercial HMO and Blue Cross Blue Shield of Michigan (commercial) PPO members.

Flu vaccines

FluMist[®], also called Live Attenuated Influenza Vaccine, has been approved for use in nonpregnant individuals, ages 2 through 49 years. The following people with certain medical conditions shouldn't receive the nasal spray flu vaccine:

- Children younger than age 2
- Adults age 50 and older
- Pregnant women
- People with a history of severe allergic reaction to any component of the vaccine or to a previous dose of any influenza vaccine
- Children ages 2 through 17 who are receiving aspirin- or salicylate-containing medications
- People with weakened immune systems (immunosuppression)
- Children ages 2 through 4 who have asthma or a history of wheezing in the past 12 months
- People who've taken influenza antiviral drugs within the previous 48 hours

- People who care for severely immunocompromised persons who require a protected environment (otherwise avoid contact with those persons for seven days after getting the nasal spray vaccine)

Quantity limits

Quantity limits have been placed on the following vaccines effective Sept. 1 unless otherwise noted. Quantity limits will help prevent billing vaccines for greater quantities than recommended. The dosage for each vaccine is based on the recommended standard.

- Menactra[®]
- Pneumovax[®] 23
- Boostrix[®] and Boostrix[®] TDAP
- Gardasil[®] and Gardasil[®] 9
- Havrix[®] (adolescent dose)
- Vaqta[®] (adolescent dose)
- Havrix[®] (adult dose)
- Vaqta[®] (adult dose)
- Prevnar[®]
- Adacel[®] TDAP
- Menveo[®] (effective Aug. 1)

Renflexis requires authorization for BCN Advantage starting Oct. 1

For dates of service on or after Oct. 1, 2018, Renflexis[®] requires authorization for BCN AdvantageSM members. See the article on Page 13 for details.

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Coding Corner

Myocardial infarction

It's estimated that 1.5 million people are affected by a myocardial infarction (or MI) every year in the United States. Updates to the 2018 ICD-10-CM now require MI to be coded by type. MI codes have now been expanded to reflect clinical classifications, as defined by the Task Force for the Universal Definition of Myocardial Infarction.

The five types of MI classifications and corresponding codes:

- **Type 1 Acute myocardial infarction (AMI)** represented by codes from **I21.0-I21.4**, is spontaneous myocardial necrosis caused by a blockage of blood flow in the heart for a prolonged period. This most frequently occurs due to a plaque rupture or thrombotic occlusion.
- **Myocardial infarction Type 2** is represented by code **I21.A1**, pertains to a demand ischemia or ischemic imbalance that is "supply-demand mismatch", an imbalance between oxygen demand and supply (e.g., coronary spasm, anemia or hypotension). Since a type 2 MI is always caused by an underlying condition or disease process a "code also" note is included, instructing you to code this condition as well, if it's known and applicable.
- **Types 3-5**, represented by code **I21.A9**, generally apply to an MI associated with a revascularization procedure and are all "other myocardial infarction type." They are described as follows:
 - **Type 3** - MI that results in sudden cardiac death (when biomarker values are unavailable)
 - **Type 4a** - MI associated with percutaneous coronary intervention (PCI)
 - **Type 4b** - MI associated with stent thrombosis
 - **Type 4c** - MI due to restenosis > 50% after an initially successful PCI
 - **Type 5** - MI related to coronary artery bypass graft (CABG)

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Clarification related to coding these new classifications (1-5) of MI can be found in ICD-10-CM guideline I.C.9.e, Acute Myocardial Infarction (AMI). Subsequently, you'll find the official guidelines we were accustomed to using now only apply to a Type 1 MI.

The guideline includes the following directions for coding MI:

- Don't assign code I22 for subsequent myocardial infarctions other than Type 1 or unspecified
- For subsequent Type 2 AMI assign only code I21.A1
- For subsequent Type 4 or Type 5 AMI, assign only code I21.A9

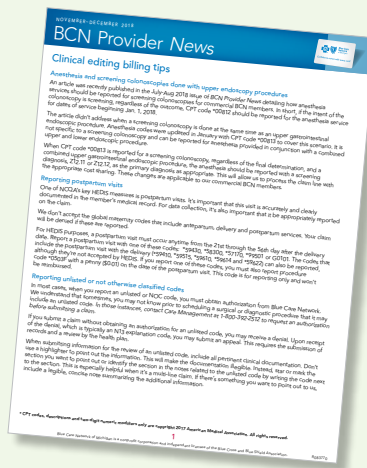
Clinical editing billing tips

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:

- Anesthesia and screening colonoscopies done with upper endoscopy procedures
- Reporting postpartum visits
- Reporting unlisted or not-otherwise-classified codes

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



Clinical editing billing tips

Specificity within provider documentation is essential when choosing the correct MI code to represent the patient's condition. **Only when the documentation doesn't specify the type of MI, the code I21.9, Acute myocardial infarction, unspecified, should be assigned.** If further clarification is needed on a patient's condition the physician should be queried.

Some important points when coding an MI:

- AMI described as acute or with duration of four weeks (28 days) or less, is classified and coded as an acute myocardial infarction.
- For encounters after the four-week time frame, with the patient still receiving care related to the myocardial infarction, the appropriate aftercare code should be assigned, not a code from category I21.
- If an AMI is documented as non-transmural or subendocardial, but the site is provided, it's still coded as a subendocardial AMI.
- For old or healed myocardial infarctions not requiring further care, code I25.2, old myocardial infarction, may be assigned.**
- Old myocardial infarction is a history code and should be reported to identify a "healed or old MI" whether the patient is currently experiencing problems or not. This history code for a myocardial infarction is significant because an old, or "healed" MI, typically requires ongoing monitoring to address any long-term complications or new symptoms that can arise as a result of the damage caused by the myocardial infarction.

The note under the code I25.2 mentioning "currently presenting no symptoms" refers to symptoms specifically related to the old/healed MI, **not cardiac symptoms in general (*AHA Coding Clinic for ICD Detail; Year: 2003; Second Quarter*).

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

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Billing Q&A

Question:

We bill for anesthesia services and have several claims that are not paying for the 22 modifier. I can't find a policy that states this isn't a covered modifier.

Answer:

Modifier 22 can be reported on procedure codes when the work required for that service markedly exceeded what is normally expected. Modifier 22 is accepted by Blue Care Network, but only as an informational modifier. This means we accept the modifier, but it will not result in additional reimbursement.

Modifier 22 will not override or prevent clinical edits from occurring on a code or between procedure codes. The appropriate modifiers must be reported in these instances when supported by documentation.

Question:

When I send in an appeal for clinical editing, I have had them returned for no documentation. I have included a copy of the CPT book where it says the code is payable. I have also included examples showing where Medicare has paid it, along with a letter from our physician requesting the appeal be reviewed. Can you advise what information you need?

Answer:

First, you *must* send all clinical editing appeals with a Clinical Editing Appeal Form.

- Any appeals received without the form will be sent back. The form is required for appeals to be scanned into our system.
- If any of the required sections on the form are not completed or are inaccurate, we may send the appeal back.

Second, you *must* include appropriate clinical documentation to support the appeal. What we require depends on what's being appealed, but may include any or all of the following (or more):

- Medical office notes
- Radiology reports
- Operative (surgical) notes
- Previous records (depending on edit received)
- Anesthesia notes
- Other pertinent medical records

Third, if you're contesting the edit overall, submit the following:

- Peer-reviewed literature
- Documentation from professional societies
- Medicare/CMS transmittals

Fourth, you don't need to submit basic coding information, for example, CPT manual pages. If you do have information from specialty manuals, we'd be glad to review, but we have access to most of that information. As always, if there is something you think we are missing, feel free to submit. We'd rather make sure you get all your information in and not miss any key points.

Lastly, make sure to look at the explanation (EX) code for the edit the claim line received. That will give you the most information about what documentation to provide to support your appeal.

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Question:

I have seen several articles published on TCM in different publications, including from Medicare. What is most confusing, though, is when a patient needs more than one visit during the TCM period, how are we supposed to report it? Can we get paid for more than just the TCM visit?

Answer:

We're in the process of updating our provider manual to include information about transitional care management services. Blue Care Network follows the guidelines set forth by American Medical Association CPT and Medicare for both commercial and BCN AdvantageSM members.

Depending on the level of care required by the member, either CPT code *99495 or *99496 may be reported to represent TCM care. This service may be appropriate for members when they are being discharged from an inpatient facility setting, partial hospitalization, observation care or a skilled nursing facility to a community setting, such as their home. The care members require is considered of moderate or high complexity due to their medical or psychological conditions.

You should report the TCM visit code using the date of the initial face-to-face contact. If you're reporting the high complexity code, this visit should occur within seven days of discharge. If you're reporting the moderate complexity code, the initial face-to-face visit should occur within 14 days of discharge. The TCM service can be reported on a claim as soon as it is provided. You don't need to wait until the end of the 30-day TCM period to report. If the patient requires additional evaluation and management visits for dates of service after the initial visit, you can report them separately; they're not considered bundled in the TCM service.

Refer to the updated information in the provider manual for additional information. Here are some key points to keep in mind:

- TCM services can be reported for members discharged from select facility locations to help the transition to the community setting and prevent readmission.
- TCM services cover a 30-day period beginning with the discharge day and continue for the next 29 days.
- Criteria must be met to report TCM services including, but not limited to:
 - An interactive contact must be made with the patient within two business days of discharge. Documentation of contact or the attempts must be in the medical record.
 - Non face-to-face services identified as appropriate and necessary for the management of the patient should be documented in the medical record.
 - A face-to-face visit is required within seven days for a member requiring high complexity TCM, and within 14 days for a member requiring moderate complexity TCM.

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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We're continuing to make enhancements to our clinical editing system

As we've noted in past issues, Blue Care Network is moving from ClaimCheck to ClaimsXten by mid-December. As we work on this implementation, we are constantly looking for opportunities to improve.

Our edits are based on national coding standards, including AMA CPT and CMS/Medicare guidelines, as well as our health plan policies, such as our medical policies.

The primary goal is to facilitate correct coding and reimbursement. This serves multiple purposes, including:

- Making sure you get paid timely and appropriately for the services you perform
- Helping us make sure that we are paying only once for the services performed
- Allowing accurate collection of data through correct coding, an enormous key to health care management
- Allowing for appropriate benefit administration

As we enhance our system, you may see new or different edits. While they may be new in our system, it's likely that these edits were already effective, but our ability to enforce them has been limited by system capabilities.

For example, we do plan additional edits related to the surgical global period. In the past, office visits provided in the global period were not subject to an edit if a modifier indicated it wasn't related to the surgical procedure. In a future update, if the diagnosis is found to be related to the surgical procedure, even if the modifier is reported, an edit may be applied. As with any clinical edit, you'll have the opportunity to appeal by submitting clinical records.

Another example in which editing may be enhanced is the review of unspecified diagnosis and procedure codes. Receiving a diagnosis for treatment of wound infection or fracture care, with site unspecified will most likely not be accepted in the future. In situations where there is a more specific diagnosis or procedure, we'd expect more specific information to be reported.

Additionally, if a diagnosis and procedure-modifier combination are in conflict, that could result in an edit. It's our goal to ensure that the information reported on claims provides the most accurate information. This assists in data collection and helps ensure appropriate utilization of services.

When you receive a clinical edit, it's important to look at the explanation (EX) code. As we update our system, there will be additional EX codes. Many of you are familiar with our current list that begins with the letters N, Q, a or d. This will be much expanded, and you should refer to the *BCN Provider Manual* for the most current list.

Due to the expansion of the EX codes, we'll remove the drop-down list from the Clinical Editing Appeal form. It is still important to add the procedure code and the EX code for the services you are appealing, as well as complete all required fields. The Clinical Editing Appeal form must be completed and submitted with any appeal, as well as all related and supporting medical documentation.

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Reminder: AIM Specialty Health manages cardiology and high-tech radiology for Blue Care Network

As a reminder, for dates of service on or after Oct. 1, 2018, AIM Specialty Health manages the authorization process for cardiology and high-tech radiology procedures for BCN HMOSM (commercial) and BCN AdvantageSM members. We first communicated about this in the **article** AIM Specialty Health to manage cardiology and high-tech radiology procedures for BCN starting October 1 in the July-August 2018 issue of *BCN Provider News*, on Page 33.

Here are some important things to know:

- AIM started accepting authorization requests on Sept. 17, 2018, for dates of service on or after Oct. 1. You can submit these requests either through the AIM provider portal 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. eviCore will handle all requests for dates of service prior to Oct. 1, including postservice requests.

Information about what AIM manages for BCN

Look on the new **AIM-Managed Procedures** page at ereferrals.bcbsm.com to find:

- Link to the **AIM provider portal**
- **Procedures that require authorization** by AIM Specialty Health — A list of codes representing the procedures AIM manages for BCN for dates of service on or after Oct. 1, 2018
- **Cardiology and radiology procedures** managed by AIM and eviCore — A list comparing the cardiology and radiology procedure codes AIM manages for BCN for dates of service on or after Oct. 1, 2018, and those managed by eviCore healthcare for dates of service prior to Oct. 1
- **Frequently asked questions** about AIM — Answers to some questions about working with AIM
- **More frequently asked questions** about AIM — Additional questions and answers about working with AIM

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Updated authorization criteria and e-referral questionnaires in effect

We made updates to the authorization criteria and questionnaires in the e-referral system, for the following services:

- Cervical spine surgery
- Endovascular intervention, peripheral artery
- Ethmoidectomy, endoscopic
- Hammertoe correction surgery
- Sacral nerve stimulation
- Sinusotomy, frontal endoscopic
- Sleep studies, outpatient facility and clinic-based

We use these criteria and questionnaires when making utilization management determinations for the following members:

- BCN HMOSM
- BCN AdvantageSM
- Blue Cross Medicare Plus BlueSM PPO

Note: The criteria and questionnaires for cervical spine surgery and sleep studies apply to BCN HMO and BCN Advantage members only.

The updated authorization criteria and preview questionnaires are available at ereferrals.bcbsm.com. Here's where to find them:

- **For BCN documents** — Click *BCN*, then click *Authorization Requirements & Criteria*. Next, look in the "Authorization criteria and preview questionnaires" section.
- **For Medicare Plus Blue documents** — Click *Blue Cross*, then click *Authorization Requirements & Criteria*. Next, look in the "For Blue Cross Medicare Plus Blue PPO members" section.

You can look over the preview questionnaires to see what questions you'll need to answer in the actual questionnaire that opens in the e-referral system for each service. Once you know what questions you'll need to answer, you can prepare your answers ahead of time. This can cut down on the time it takes to submit the authorization request.

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BCN now accepts inpatient continued stay reviews and discharge notifications through the e-referral system

You can now submit inpatient continued stay reviews and discharge notifications for BCN HMOSM (commercial) and BCN AdvantageSM members through the e-referral system. This started in September and applies to members admitted for non-behavioral health services.

Currently, these requests are faxed in to BCN. However, **starting Nov. 1, 2018, we will no longer accept faxed requests.**

This change means that BCN HMO (commercial) and BCN Advantage inpatient discharge notifications and continued stay reviews will be processed through the e-referral system, just like they are for Blue Cross PPO (commercial) and Blue Cross Medicare Plus BlueSM PPO members.

To request additional days on an inpatient admission

To request additional days, follow the instructions in the **e-referral User Guide** for extending an inpatient authorization. Here's what it says:

- To extend service on an existing Inpatient Authorization, begin by locating your authorization.
- Click the *Edit* button on the right side of the details page.
- Scroll down to the Confinement Extension(s) section, click the *Create New* button to enter your new dates and the number of days.

You must also submit clinical information related to the continued stay. To do that, follow the instructions 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 issue of *BCN Provider News*.

To submit a discharge notification

To notify us of a member's discharge, enter the discharge date in the e-referral Case Communication field. As an alternative, you can record the discharge date on a discharge summary form and attach it to the case in e-referral.

Sign up for e-referral

If you don't currently have access to the e-referral system, we encourage you to sign up for it now so you'll be ready to use it before November 1, when faxes are no longer accepted. Follow the instructions on the **Sign Up or Change a User** page on our **ereferrals.bcbsm.com** website.



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Fax authorization requests for BCN members moving to a SNF, rehabilitation facility or LTACH

Fax all authorization requests to BCN for post-acute care services for BCN HMOSM (commercial) and BCN AdvantageSM members. This applies to members transitioning to a skilled nursing facility, a rehabilitation facility or a long-term acute care hospital.

Here's what you should know

- Fax authorization requests to 1-866-534-9994. We accept faxed requests 24 hours a day, seven days a week.
- Normal business hours for BCN post-acute care staff are Monday through Saturday, 8 a.m. to 5 p.m.
- The on-call nurse is available to assist with admissions on Sundays and holidays and at other times outside of normal business hours. During those times, call the on-call nurse at 1-800-851-3904 and fax the documentation to 1-866-534-9994.

Here's what to fax

For skilled nursing facility and rehabilitation admissions, fax these documents:

- A completed **Rehabilitation Assessment Form**
- History and physical from the hospital admission
- Physical medicine and rehabilitation consultation notes, as appropriate

For long-term acute care hospital admissions, fax these documents:

- A completed **LTACH Assessment Form**
- History and physical from the hospital admission
- Physical medicine and rehabilitation consultation notes, as appropriate
- Last two days of practitioner progress notes (admission and concurrent)
- Current intravenous and subcutaneous medication lists

The forms are available at ereferrals.bcbsm.com, on the **Forms** page in the BCN section of the website.

A summary of these instructions is available at ereferrals.bcbsm.com. Click *BCN* and then click *Authorization Requirements & Criteria*. Finally, click **Post-acute care admissions: Submitting authorization requests to BCN**.

The Care Management chapter of the *BCN Provider Manual* is being updated to reflect this information.

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eviCore to handle BCN initial and follow-up authorization requests for PT, OT and ST in 2019

In 2019, providers who currently submit their initial authorization requests for physical, occupational and speech therapy, or for physical medicine services by chiropractors, through the e-referral system or by calling BCN, will submit these requests through eviCore healthcare's provider portal instead.

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

We communicated earlier this year that the change would occur later in 2018 but the change has been postponed until sometime in 2019.

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

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

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

Look for more details about these changes in the coming months.



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