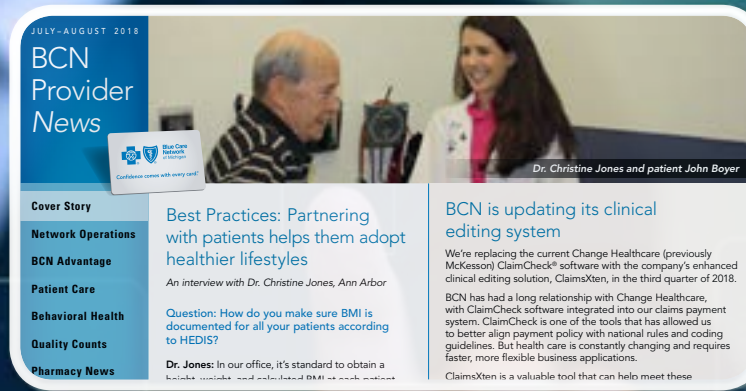


# BCN Provider News



## 2018 BCN Provider News Archives

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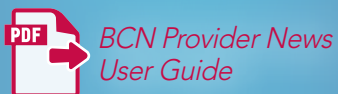
1. Hold down the "Ctrl" key on your keyboard and press the "F" key.
2. Open the drop-down menu in the "Find" field.
3. Select *Open Full Acrobat Search* (or *Open Full Reader Search*).

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## Blue Care Network offers 19 products for individual marketplace in 2018

Blue Care Network is offering 19 products for the 2018 Marketplace. We are offering six products in 63 rural counties, nine products in three southeast Michigan counties and 13 products in 17 urban counties.

BCN has modified some plans and made deductible and out-of-pocket changes for the majority of plans. We're closing 12 plans: Personal Plus, Preferred HMO Bronze, Select HMO Gold and Select HMO Bronze Extra, Metro Detroit HMO Bronze Extra and all Partnered HMO plans, effective Dec. 31, 2017. We are adding four new plans: Preferred HMO Bronze Saver HSA, as well as three off Marketplace-only plans in the Preferred, Select and Metro Detroit networks.

Please see [BCN products](#), continued on Page 3

## Direct reimbursement available to limited licensed psychologists and licensed marriage and family therapists beginning June 1, 2018

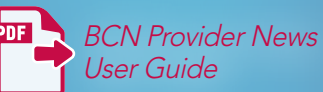
Starting June 1, 2018, limited licensed psychologists and licensed marriage and family therapists will have the opportunity to participate as Blue Care Network providers. Participating LLPs and LMFTs can receive direct reimbursement for covered behavioral health services within the scope of their licensure.

BCN is allowing LLPs and LMFTs to enroll as part of a group starting in March 2018.

In March, the enrollment forms and contract documents will be available at [bcbsm.com/providers](http://bcbsm.com/providers). Complete these steps:

1. Click *Join our network*.
2. Click **Provider Enrollment Forms**.

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



### Inside this issue...

**05** What you need to know about the new Healthy *Blue Living* HMO options

**07** Your patients may qualify for the Medicare Diabetes Prevention Program that goes into effect April 1

**15** University of Michigan details recommendations for using fewer opioids for specific surgeries

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## Direct reimbursement, *continued from Page 1*

Specific qualification requirements will be identified within each agreement. We'll share more detailed enrollment instructions in an upcoming newsletter.

All applicants must pass a credentialing review prior to participation. We'll notify applicants in writing of their approval status.

LLPs and LMFTs who practice in a substance abuse/ outpatient psychiatric clinic setting may continue to do so and do not have to go through any additional application process. As a reminder, marriage counseling is not a covered benefit for BCN members, but LMFTs may provide other covered behavioral health services within the scope of their licensure. In addition, the clinical supervision requirements for LLPs aren't changing.

An updated version of the **Requirements for providing behavioral health services to BCN members** will be available on the web in the spring of 2018. This document provides guidelines for various types of BCN behavioral health providers. It's located in the BCN section at **ereferrals.bcbsm.com**. Click **BCN** and then click *Behavioral Health*. Scroll down and click to open the document under the "Other resources" heading.

Information will also be provided in the spring of 2018 about how to transition authorizations for services by these practitioners.



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## BCN products, continued from Page 1

Some of the key product changes for 2018 for individual products include:

- Limited BlueCard coverage to urgent and emergency only
- Adjusted specialty prescription coinsurance from 20/25 percent for preferred/non-preferred to 40/45 percent to achieve coverage parity with competitors
- Limited the Gold Metal tier to the Preferred Network.
- Modified Silver Extra to conform with the 2018 version of the Centers for Medicare & Medicaid Services Silver Standard Plan
- Closed the Bronze (basic) Health Savings Account option, leaving the only individual HSA option to be the Bronze Saver plans
- Opened a Bronze (basic) plan that isn't HSA-eligible in the local networks. It covers primary care physician visits, laboratory services and urgent care, before the deductible.
- All Preferred plans are now available statewide

For the Silver Extra plan (the CMS standard plan), a prescription drug deductible has been added that applies only to specialty prescription drugs. The specialty drug deductible is separate from the medical deductible. Generics, preferred brand and non-preferred brand medications are covered with a copayment and no deductible.

We're continuing to monitor changes being made to the Affordable Care Act.

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 when you see patients

Some member ID cards will be reissued for individual products in 2018. Ask to see the latest member ID card and make sure it matches the coverage listed on web-DENIS.

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## BCN Service Company will no longer administer self-funded plans

Effective Jan. 1, 2018, BCN Service Company will no longer administer self-funded employer benefit plans. They will be administered by Blue Care Network. BCN Service Company provides administrative services, including claims payment, in support of self-funded health care coverage for employer groups. BCN Service Company also distributes capitation to physician groups and pays claims to providers. Recent changes in the Michigan Insurance Code allow HMOs to self-fund; therefore, BCN Service Company is no longer required.

We mailed a letter explaining this change to self-funded and Health Reimbursement Arrangement employer groups. The letter included the new BCN bank ID they'll need to provide to their financial institutions for 2018 payments. Checks and electronic Remittance Advices will also reflect the name change. We're also adding the HRA designation and new bank account number to applicable checks.

There are no changes to members' coverage and benefits, only the entity that administers the plan. We'll issue new member ID cards throughout December and January. We'll replace existing BCN Service Company certificates and riders with BCN certificates and riders. Members will be able to see these updated documents by logging in to their [bcbsm.com](http://bcbsm.com) accounts.

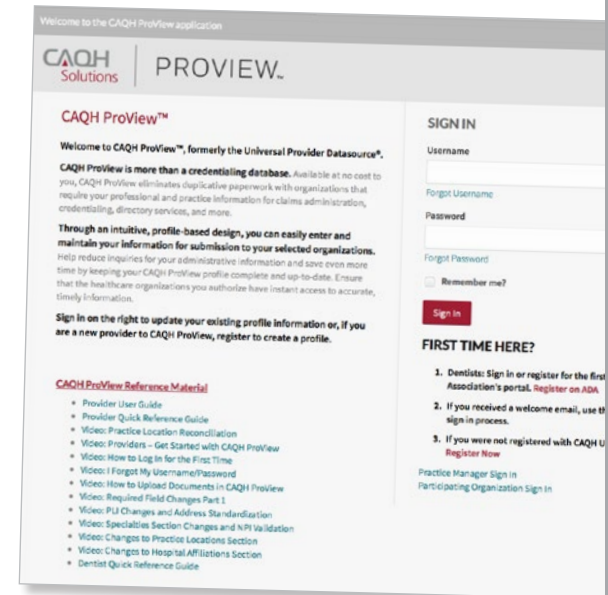
## Complete your attestation through CAQH

As communicated via web-DENIS in October, Blue Cross Blue Shield of Michigan and Blue Care Network have transitioned from the PRIME-Hub website to CAQH ProView for the quarterly attestation process.

Health care providers and practice managers should use CAQH to review and confirm their demographic data instead of going to the Atlas PRIME-Hub website.

New and existing users can access the **CAQH ProView Provider portal** to register, log in and validate existing information in their CAQH account. If you haven't done so already, please create a CAQH account, validate your existing provider information that's listed in CAQH and continue to submit changes through the Provider Self-Service tool.

The **CAQH website** has resources to help providers and practice managers use CAQH ProView. If you have questions or need support with completing your attestations, contact CAQH at 1-888-599-1771 or your provider consultant.



## Quality Rewards introduced

Blue Cross Blue Shield of Michigan and Blue Care Network are combining the 2018 Performance Recognition Program and Physician Group Incentive Program into one *2018 Quality Rewards* booklet. Primary care physicians can find it on BCN Health e-Blue<sup>SM</sup> in the *Resources* section.

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# What you need to know about the new Healthy *Blue* Living HMO options

In the November-December 2017 *BCN Provider News*, you learned about two new wellness options that Blue Care Network is offering starting Jan. 1, 2018: Healthy *Blue* Living HMO Basic<sup>SM</sup> and BCN Wellness Rewards Tracking<sup>SM</sup>. Here are some important tips on identifying these members and what to expect when they visit your office.

- Healthy *Blue* Living Basic members and those participating in the BCN Wellness Rewards Tracking program are required to visit their primary care physician within 90 days of their plan year for a BCN Qualification Form visit. After this exam, their doctor needs to electronically submit their qualification form through Health e-Blue<sup>SM</sup>.
- Once in Health e-Blue, you will see the member's name listed under the *Healthy Blue Living Qualification Form* panel. You can also identify them by checking their eligibility in web-DENIS. Here, BCN Healthy *Blue* Living HMO Basic will be listed at the top of their virtual ID card image. For Wellness Rewards Tracking participants, a qualification form message will appear on their Member Eligibility/Coverage page.
- A cotinine test to check for tobacco use is part of the qualification form. Neither Healthy *Blue* Living Basic subscribers nor Wellness Rewards Tracking participants are required to complete this. You will see a message in red in Health e-Blue indicating that results are not required for the tobacco question.

Instructions on filling out the qualification form will be available in January 2018 under the Supporting Documents section at the bottom of the Health e-Blue home page. If you don't have access to Health e-Blue, please contact your provider consultant. You can also find more information in the comparison chart on the *BCN Publications and Resources* web-DENIS page under *BCN Products*, then Healthy *Blue* Living.



## Blue Care Network is closed for holidays in December and January

Blue Care Network offices will be closed Dec. 22, 25 and 26 for the Christmas holidays, Jan. 1 for New Year's Day and Jan. 15 for Martin Luther King Day.

When BCN offices are closed, call the BCN After-hours Care Manager Hot Line at 1-800-851-3904 and listen to the prompts for help with:

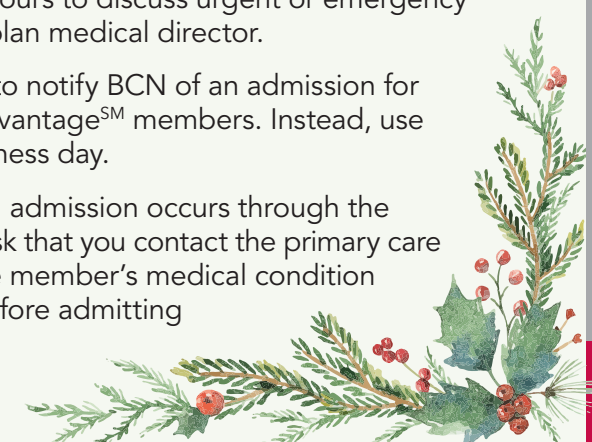
- Determining alternatives to inpatient admissions and triage to alternative care settings
- Arranging for emergency home health care, home infusion services and in-home pain control
- Arranging for durable medical equipment
- Emergency discharge planning coordination and authorization
- Expedited appeals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

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

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

Don't use this number to notify BCN of an admission for commercial or BCN Advantage<sup>SM</sup> members. Instead, use e-referral the next business day.

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



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## Blue Cross and Blue Care Network Medicare star ratings remain solid

Blue Cross Blue Shield of Michigan and Blue Care Network have received an overall 4-star rating from the Centers for Medicare & Medicaid Services. Blue Cross and BCN remain some of the most consistently higher-performing plans in our state.

The Medicare star program is nationally recognized, providing an overall rating of a health plan’s quality and performance for the types of services each plan offers. It ranges from 1 to 5 stars. The 2018 star ratings reflect health plan measurements from 2016.

The 2018 ratings provide us with a renewed opportunity to review factors that could be improved, and we have already determined some innovative steps to help with future ratings. We will continue our focus on member experience as it is critical to communicate effectively with members. It’s also important to stay focused on clinical measures as higher scores across the board in this area weigh heavily on the overall rating.

BCN Advantage will focus on making improvements in these areas:

- Getting appointments and care quickly
- Care coordination (“Doctors following up with test results” and “Doctors discussing taking medicines” were two questions showing the biggest decline.)
- Ease of getting prescription drugs

We’ve also identified two areas for improvement from the BCN Advantage Health Outcomes Survey.

- Monitoring physical activity
- Maintaining physical health



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# Your patients may qualify for the Medicare Diabetes Prevention Program that goes into effect April 1

Blue Care Network and Blue Cross Blue Shield of Michigan have partnered with an outside vendor, Solera, to provide a diabetes prevention program to our prediabetic members.

The Medicare Diabetes Prevention Program is a structured intervention with the goal of preventing progression to Type 2 diabetes in individuals with an indication of prediabetes. The program includes education and support, and is proven to help participants lose weight, adopt healthy habits and reduce their risk of Type 2 diabetes. The program begins April 1 and is part of all members' Part B coverage.

We're offering this program in response to a challenge to health plans from the Centers for Medicare and Medicaid Services to take on diabetes by providing Medicare Part B beneficiaries with access to evidence-based diabetes prevention services.

To qualify for the program, members must have a prediabetic diagnosis based on the following:

- BMI of at least 25 (23 if of Asian descent)
- One of three blood glucose test results:
  - Hemoglobin A1c between 5.7 and 6.4 percent
  - Fasting plasma glucose of 110-125 mg/dL
  - Two-hour post-glucose of 140-199 mg/dL (oral glucose tolerance test)

Additional qualification requirements:

- No previous or current diagnosis of Type 1 or Type 2 diabetes (nongestational)
- Doesn't have end-stage renal disease

## The Medicare Diabetes Prevention Program

There is no additional cost to Part B members who enroll in the program, but they do have to adhere to the following requirements:

- Attend 16 weekly program sessions over six months in a group-based, classroom-style setting from a CDC-recognized provider (Curriculum focuses on long-term dietary changes, increased physical activity and behavior change strategies for weight control.)
- A second year of maintenance sessions is available for those who meet a 5 percent weight-loss goal

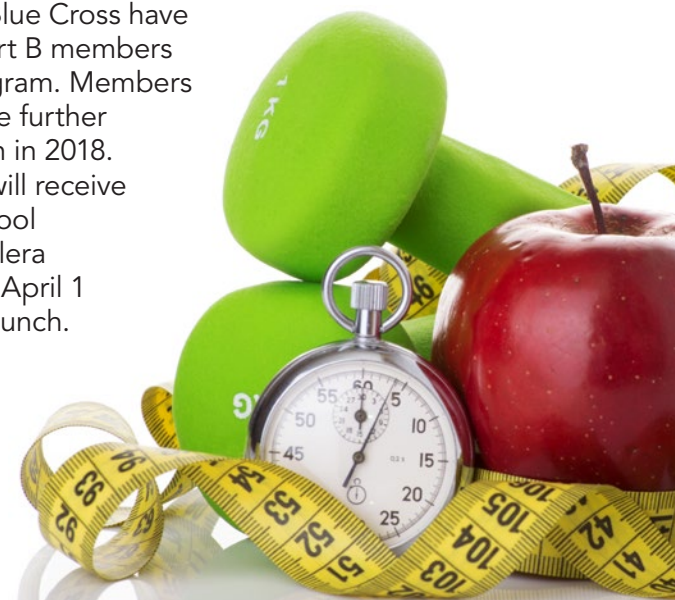
Additional participant support includes:

- A lifestyle health coach to help set goals and keep participants on track
- A small support group to encourage progress

## How to enroll

Members may self-enroll or providers may recommend their patients to the program.

BCN and Blue Cross have notified Part B members of the program. Members may receive further information in 2018. Providers will receive an MDPP tool kit from Solera before the April 1 program launch.







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## Reminder: Using place of service codes for skilled nursing facilities

Providers should use place of service code 31 for a skilled nursing facility. This is covered under Medicare Part A. A skilled nursing facility primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services. It doesn't provide the level of care or treatment available in a hospital and is short-term in nature.

Use place of service code 32 when billing for a nursing facility, non-skilled care or when the patient doesn't have Part A SNF benefits. A nursing facility primarily provides custodial or personal care and includes assistance with activities of daily living such as, bathing, dressing, eating, grooming, getting in and out of bed, and bathroom assistance. These services are considered non-skilled care and are typically long-term in nature.

## Providers must submit functional limitation G codes for BCN Advantage PT, OT and ST services

When billing outpatient physical, occupational and speech therapy services for BCN Advantage<sup>SM</sup> members, you must report the nonpayable functional limitation G codes and their applicable modifiers.

See full article on **Page 37**.

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## UAW Retiree Medical Benefits Trust coverage changing for Medicare members in 2018

Effective Jan. 1, 2018, the UAW Retiree Medical Benefits Trust will transition coverage for its Medicare primary members in Michigan from the Blue Cross Blue Shield Traditional Care Network plan to the Blue Cross Medicare Plus Blue<sup>SM</sup> PPO. This means that on Jan. 1, 2018, many of your patients who receive coverage through the Trust will be enrolling in a Blue Cross Blue Shield of Michigan Medicare Advantage PPO plan.

There are several advantages to enrolling in the Blue Cross Medicare Plus Blue PPO plan:

- No monthly contributions to the Trust required
- Free fitness club membership in the Silver Sneakers fitness program
- Lower deductibles than the TCN plan
- No referrals required to visit the doctor, specialist or hospital of your choice

You'll likely continue to see these same retirees, who will be Blue Cross Blue Shield Medicare Advantage members beginning Jan. 1, 2018. If you're part of the Blue Cross Medicare Advantage PPO network, these members will be able to find your practice or facility in our online provider directory.

While most of our health care providers are familiar with our Blue Cross Medicare Plus Blue PPO, there are some differences in benefits and care management. See our [website](#) for more information about the plan.

As always, it's important to ask your patients about recent changes in insurance carriers and benefits, and request a copy of their member ID card when they come for services. You can also check member benefits and eligibility on web-DENIS.

While referrals aren't required for the Blue Cross Medicare Plus Blue PPO, members may need authorization prior to receiving certain hospital services. You'll want to review the authorization guidelines and criteria on the [e-referral](#) site.

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# Adult pneumococcal vaccine guidelines

*Physicians can improve payment rates by choosing appropriate vaccine and using correct coding*

By Robert Goodman, D.O.



A national survey completed in 2012 revealed that providers reported concerns regarding payment as one barrier to offering adult vaccinations.<sup>1</sup> We examined Blue Care Network commercial claims data (from the first quarter of 2014 to the third quarter of 2015) for rates of vaccine dose non-payment (defined as a BCN allowed amount of \$0) and evaluated individual claims for vaccine type and reasons for non-payment.

One notable result: The rate of non-payment was substantial for the conjugate pneumococcal vaccine administered in the physician office setting. These denials were driven by clinical editing. These edits are included in initial automated claim processing that checks for diagnoses on the submitted claim that allow for payment; the absence of diagnoses results in a denial.

According to anecdotal reporting from the BCN pharmacy department, about 75 percent of these denials *that are subsequently appealed* don't have support in the actual medical record. Providers send physician charts as part of the appeal process, while the diagnosis code clinical edits are applied to administrative claims data only. Past BCN educational efforts may have been too general in nature and not sufficiently explicit.

The guidelines from the Centers for Disease Control and Prevention support Prevnar-13® in the 19 to 64 age group only for very specific reasons, which are reflected in BCN claim processing clinical edits. The CDC indications for coverage for Prevnar-13 in the 19-to-64 age group can't be extrapolated or otherwise viewed as broad categorical buckets subject to individual physician interpretation of what conditions can be included.

The current CDC guidelines for Prevnar-13 (conjugate pneumococcal vaccine) for adults 19 to 64 are: cerebrospinal fluid leaks; cochlear implants; sickle cell disease or other hemoglobinopathies; congenital or acquired asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; leukemia; lymphoma; Hodgkin disease; generalized malignancy; iatrogenic immunosuppression; solid organ transplant; multiple myeloma. Providers can improve the rate of initial payment for Prevnar-13 by including the ICD-10 code for the above indications in the claim, if indeed applicable to the member.

The 23-valent polysaccharide pneumococcal vaccine (Pneumovax®) is the vaccine supported for members 19 to 64 years of age with the common conditions typically seen on denied Prevnar-13 claims: chronic heart or lung disease, diabetes mellitus, alcoholism, chronic liver disease, and includes adults who smoke cigarettes. This likely is the disconnect and confusion that led to the high denial rate for Prevnar-13 in the under-65 population, when Pneumovax would be the appropriate choice.

**Dr. Goodman is a medical director at Blue Care Network.**

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Check the **CDC website** for guidelines for pneumococcal vaccine timing. We hope that sharing this specific link to the guidelines and pointing the specific nature of the Prevnar-13 indications in the 19 to 64 population will lead to more appropriate vaccine administration, as well as greater member and treating physician satisfaction due to fewer denials for administered vaccines.

An additional aspect of these two vaccines worth noting relates to the 65 and older age group. These individuals should have Prevnar-13 before their Pneumovax vaccination. Even though 12 of the 13 serotypes present in Prevnar-13 are also present in the Pneumovax product, the latest literature indicates that Prevnar-13 primes the immunologic pump and when followed by Pneumovax (as per guideline schedule) results in an enhanced level of patient immunity.<sup>2-5</sup>

Hopefully these additional details will assist BCN providers in successfully navigating the complicated guidelines regarding adult pneumococcal vaccination with the correct vaccine type for a member's age and any applicable medical conditions.

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# On the front line: Battling the opioid epidemic



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## CDC says doctors should talk to patients about opioid use

The Centers for Disease Control and Prevention advises doctors to **educate patients** about opioid use.

Doctors and patients should talk about:

- How opioids can reduce pain during short-term use, yet there is not enough evidence that opioids control chronic pain effectively long term
- Nonopioid treatments (such as exercise, nonopioid medications and cognitive behavioral therapy) that can be effective with less harm
- Importance of regular follow-up
- Precautions that can be taken to decrease risks, including:
  - Checking drug monitoring databases
  - Conducting urine drug testing
  - Prescribing naloxone if needed to prevent fatal overdose
  - Protecting your family and friends by storing opioids in a secure, locked location
  - Safely disposing unused opioids

Source: CDC factsheet



# What patients should know before taking opioids

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By Kristyn M. Gregory, D.O.

Dr. Gregory is a medical director at Blue Care Network.

Opioid abuse and overdose has become a nationwide epidemic. According to the Centers for Disease Control and Prevention, **91 Americans** die each day as a result of an opioid overdose. However, many patients may still be unaware that opioids carry serious risks of addiction and overdose, especially with prolonged use.

Because this epidemic is so far-reaching, open communication between doctors and their patients is important to help patients understand the risks and benefits of opioids and to promote safe use.

Share this key information with your patient when prescribing an opioid:

*First, know the level of your patient's health literacy to make sure he or she understands your directions.*

#### Set the stage

- Opioids can reduce pain during short-term use, yet there isn't enough evidence that opioids control chronic pain effectively long term.
- Nonopioid treatments such as exercise, nonopioid medications, including ibuprofen, acetaminophen, select antidepressants, as well as cognitive behavioral therapy can be effective with less harm.

#### Explain what patients can expect

- Opioids aren't meant to completely eliminate pain. Patients often have the misconception that opioids are used to stop pain altogether.
- Everyone experiences pain differently and it's not possible to predict how long someone will experience pain. Your patient likely will have some leftover medications that will need to be disposed of safely and appropriately.

#### Risks and side effects

- Combining opioids with alcohol or other prescription or over-the-counter medications can lead to serious consequences like overdose and death.
  - Medications of most concern: benzodiazepines, muscle relaxants, hypnotics
- Encourage your patient not to change the amount of medication he or she takes. Patients should always be encouraged to call you if they notice side effects or the pain medication doesn't seem to be as effective.
- Tolerance and physical dependence are normal responses to opioid therapy; this doesn't mean addiction. It can happen even when medication is taken as directed.
  - Tolerance is a need to take more of a medication for the same pain relief.
  - Dependence is when symptoms of withdrawal occur when the medication is stopped.

#### Protect family and friends

- Serious consequences can occur if opioids get into the wrong hands. It's important to keep them in a secure location to avoid access to children or teens in the household and prevent an accidental overdose.
- Properly dispose of leftover medication. The perfect opportunity to safely dispose of any prescription drugs is a community take-back facility. Patients can find a local drug disposal facility at the **U.S. Drug Enforcement Administration** website.



As part of our commitment to provide you with information to address opioid abuse, this section features the latest research and news on the opioid epidemic.

For information on Blue Cross Blue Shield of Michigan and Blue Care Network task force on opioid abuse, see the **Medical director column** in the Nov.-Dec. 2017 issue.

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## Guidelines to prescribe opioids safely

Prescribing opioids is a delicate and difficult balancing act but Howard Marcus, M.D., FACP, says the health care industry must prevent opioid misuse while protecting the wellbeing of patients affected by severe or long-lasting pain. In an article published in *The Doctor's Advocate*, Marcus lists not only the challenges involved in managing opioid use but also **guidelines** doctors should follow when prescribing them.

### Study: Patients with mental disorders get half of all opioid prescriptions

Adults with a mental illness receive more than 50 percent of the 115 million opioid prescriptions in the U.S. annually, according to a new study published in the *Journal of the American Board of Family Medicine*. It's a worrisome finding because people with mental illnesses are more likely to become addicted. Doctors recommend alternative treatment for many opioid patients but particularly for those with mental health issues. Read the **findings**.

### HEDIS measures updated to combat opioid addictions

In a recent change, the National Committee for Quality Assurance is updating its Healthcare Effectiveness Data and Information Set to combat opioid-related addictions. One new measure addresses high dosages for long-term treatment. Another one focuses on the rate of adult health plan members that are prescribed opioids from multiple providers and pharmacies. For details, see the article in **Healthcare Finance**.

# University of Michigan details recommendations for using fewer opioids for specific surgeries



In an effort to reduce opioid abuse, the University of Michigan developed a guide that details recommendations for 11 common surgeries based on pain control and surgical quality research as well as data from patient surveys.

The Michigan Opioid Prescribing Engagement Network, or Michigan-OPEN,, in collaboration with the Michigan Surgical Quality Collaborative, both based at the U-M Institute for Healthcare Policy and Innovation, created the guide.

Many of the patients factored into the recommendations had their operations at the 72 hospitals taking part in MSQC, which gathers and analyzes surgery-related data to help surgical teams find ways to improve and learn from others. Funded by Blue Cross Blue Shield of Michigan, MSQC provided a rich source of information about what patients were prescribed, what they used and how they fared after surgery.

Michigan-OPEN researchers have previously shown that when patients are prescribed fewer pills, they consume less with no changes in pain or satisfaction scores.

The first prescribing recommendations focus on a range of common operations, including hysterectomy, colon surgery, appendectomy and breast biopsy, and detail the amounts of hydrocodone, oxycodone, tramadol and codeine or acetaminophen to prescribe in an easy-to-print chart.

The amounts represent the maximum opioid use reported by three-quarters of surgery patients. Most patients took far less, from zero to five pills, even when their surgeon or another provider prescribed more.

The recommendations are meant specifically for patients who have never taken opioid painkillers before.



Read the full article at [uofmhealth blog](#).

Download the [opioid prescribing recommendations](#).

Read more about [M-OPEN](#).

Source: Michigan Medicine

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## Choosing Wisely — Avoid prescribing antibiotics for upper respiratory infections

*We first introduced you to Choosing Wisely® in 2015. Our partnership with Greater Detroit Area Health Council on Choosing Wisely continues. Choosing Wisely is an initiative of the American Board of Internal Medicine Foundation that aims to promote conversations between physicians and patients to discuss medical tests and procedures that may be unnecessary and, in some instances, harmful. In this issue, we discuss antibiotic use for upper respiratory infections.*

Most acute upper respiratory infections are viral and antibiotic treatment is ineffective, inappropriate and potentially harmful. Confirmed infection by Group A Streptococcal disease (Strep throat) and pertussis (whooping cough) should be treated with antibiotics. Treatment for URIs consists of treating the symptoms. It's important that health care providers educate patients about the consequences of misusing antibiotics for viral infections, which may lead to increased costs, antimicrobial resistance and adverse effects.

Choosing Wisely has **downloadable materials** available on the appropriate use of antibiotics. **More information** about appropriate use is also on their website.

Consumer Health Choices offers a **5 Questions to ask your doctor before you take antibiotics** flyer that you can print and give to your patients and posters that you can use in your office. These materials will help you have conversations with your patients about why antibiotics may not be needed.

For additional information on *Choosing Wisely*, visit **[choosingwisely.org](http://choosingwisely.org)**.



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## Criteria corner

*Blue Care Network uses McKesson’s InterQual Level of Care when conducting admission and concurrent review activities for acute care hospitals. To ensure that providers and health plans understand the application of the criteria and Local Rules, BCN provides clarification from McKesson on various topics.*

**Question:**

**A patient has abdominal pain of unknown etiology. Would it be appropriate to use General Medical Intermediate criteria: General, “IV medication administration” to meet for an inpatient admission?**

**Answer:**

There are criteria in the General Medical subset at the Observation Level of Care for Abdominal Pain of Unknown Etiology. If a higher level of care is needed for the patient with abdominal pain, the Intermediate criteria for the administration of IV medications may be applied if the following apply:

1. Medication is an analgesic or sedative and excludes patient controlled analgesia.
2. Administration, bolus every three to four hours and monitoring: This criteria point can only be applied if the analgesic is ordered and given at least every three to four hours for all or most of the day being reviewed. It may be applied as needed for medications that are given at the required frequency, but shouldn’t be applied when only a few doses are given (for example two doses). The doses must be given at the required frequency for all or most of the day being reviewed, as the need for the higher level of care is validated by the need for frequent dosing with IV analgesics; in the patient for whom a cause of the abdominal pain is unknown.
3. Another important point to remember is that the General Medical subset can’t be used if the abdominal pain is due to an issue addressed in another subset, or due to trauma or if the patient is to be taken to surgery.



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## February focus is on heart health

In support of American Heart Month in February, Blue Care Network is reminding providers to screen patients for conditions that can affect heart health. BCN supports Michigan Quality Improvement Consortium guidelines, including those for screening and management of high cholesterol, high blood pressure, overweight and obesity and tobacco control.

High blood pressure is a serious condition and, if left untreated, can lead to coronary heart disease, kidney disease and possibly stroke. About one in three adults in the United States has hypertension and it usually starts from the ages of 35 to 50, according to the Centers for Disease Control and Prevention. There are no symptoms or warning signs and it can affect anyone regardless of race, age or gender.

### Risk factors that can't be controlled

- Age (45 and older in men, 55 and older for women)
- Family history of early heart disease

### Risk factors that can be controlled by the member with guidance from the provider

- High cholesterol (high LDL or "bad" cholesterol)
- Low HDL ("good" cholesterol)
- Smoking
- High blood pressure
- Diabetes
- Obesity, overweight
- Physical inactivity

### Factors that determine LDL ("bad") cholesterol level

- Heredity
- Diet
- Weight
- Physical activity and exercise
- Age and gender
- Alcohol
- Stress

Please see [Heart health](#), continued on Page 19



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## Heart health, *continued from Page 18*

Some highlights from the MQIC guidelines are noted below. For the complete guidelines, visit [MQIC](#).

### Lipid screening and management

- Initial screening to include fasting lipid profile (total cholesterol, LDL-C, HDL-C, triglycerides). Repeat every four to six years if normal.
- Screening of LDL-C levels at least annually for member with a cardiac event (AMI, PTCA, CABG) or diagnosis of ischemic vascular disease.
- Treatment based upon presence of clinical atherosclerotic cardiovascular disease (ASCVD); 10-year ASCVD risk calculation for patients 40 to 75 without clinical ASCVD, diabetes mellitus (type 1 or 2) or LDL-C > 190 mg/dl. (See [ASCVD Risk Estimator Tool](#) from MQIC.)
- Statin dosing intensity based upon ASCVD presence and risk.
- Educate about therapeutic lifestyle changes such as losing weight if indicated, increasing exercise to moderate to vigorous activity for 40 minutes per day, three to four days of the week, and following a diet emphasizing vegetables, fruits, whole grains, low fat dairy, poultry, fish, legumes, nontropical vegetable oils and nuts, limited sweets and sugar sweetened beverages, and red meats.

## 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

- Cryoablation of peripheral nerves
- Spectral analysis of prostate tissue

### Covered service

- Radiofrequency ablation of primary or metastatic liver tumors
- Home cardiorespiratory monitoring – Pediatric



*Medical Policy Updates*

### Management of overweight and obesity in adults

- If BMI >30 or >27 with other risk factors or conditions, consider referral to a program that provides guidance on nutrition, physical activity and psychosocial concerns.
- Pharmacotherapy only for patients at increased risk because of their weight and coexisting risk factors or comorbidities.
- BMI >40 or >35 with uncontrolled comorbid conditions, consider weight loss surgery.

Providers can encourage healthy lifestyles by reminding patients to do the following:

- Develop a healthy eating pattern, which includes eating foods low in saturated fat and cholesterol.
- Reduce salt and sodium. (The CDC reports a potential of 11 million fewer cases of hypertension just by reducing sodium intake from the average 3,400 mg daily to 2,300.)
- Maintain a healthy weight.
- Get regular physical activity for at least 30 minutes most days of the week.
- Limit alcohol.
- Quit smoking.
- Take blood pressure medication as prescribed.

Providers can also refer members to the [National Heart Lung and Blood Institute](#) website for information about heart disease.

References:

MQIC.org

Lipid Screening and Management

Management of overweight and obesity in adults

National Health Lung and Blood Institute (<http://www.nhlbi.nih.gov/>)

<http://www.cdc.gov/bloodpressure/facts.htm>



## Five steps to avoid prescription medication abuse in teens

A nationwide survey among eighth-, 10<sup>th</sup>- and 12<sup>th</sup>-graders shows that teens perceive less risk in trying prescription drugs like Vicodin and OxyContin than in previous years. As the opioid crisis continues to affect communities across the country, it's important to note changing attitudes toward substance abuse often precedes changes in reported use.

Prescription medications are among the most commonly abused drugs in the United States. Unfortunately, many teenagers assume medications prescribed by the doctor are safe to take under any circumstances. Among those abused most often are Vicodin and OxyContin, two opioid drugs regularly used to control post-treatment dental pain.

In 2013, nearly 42,000 students from 389 public and private schools participated in a *Monitoring the Future* survey funded by the National Institute on Drug Abuse and conducted by the University of Michigan. The study measures drug, alcohol and cigarette use and related attitudes among eighth-, 10<sup>th</sup>- and 12<sup>th</sup>-graders nationwide.

When used as directed, narcotics like Vicodin and OxyContin are important and effective painkillers. However, when they're taken in ways other than prescribed, they can be deadly. The death rate from unintentional drug overdose has skyrocketed in the past decade, driven by deaths associated with prescription painkillers. Of those who die of an opioid overdose, almost two-thirds of the drugs used were originally prescribed for someone else.

While the **survey** showed non-medical use of prescription narcotics had dropped since 2009, there were still causes

for concern—including the finding that teens perceive less risk in trying prescription drugs like Vicodin and OxyContin than in previous years. Further research suggests that the abuse of prescription opioids like Vicodin and OxyContin is responsible for a recent spike in heroin use in suburbia.

Both Vicodin and OxyContin can also be most tempting for teens who may not have a personal interest in using them, but recognize the street market value. In 2014, a single hydrocodone or oxycodone tablet ranged from \$1 to \$80 in Michigan.

Adults play an important role in keeping prescription drugs from being abused by teens. Providers should remind adult patients receiving any treatment that requires the use of a prescription pain medication to take the following steps to prevent abuse of these medications:

- 1. Discuss the danger of legal prescription drugs misuse and how it compares closely to the use of illegal street drugs.**
- 2. Monitor dosage and quantities to ensure all pills are accounted for in the household.**
- 3. Keep prescription drugs in a secure location that isn't readily accessible to teens.**
- 4. Dispose of any unused prescriptions at a **safe collection site** near you.**
- 5. Talk with families, friends and neighbors about how teens are misusing prescription drugs and what can be done to prevent teens from becoming victims of drug abuse.**

Source: MI Blues Perspectives blog, Blue Cross Blue Shield of Michigan

### Know member rights and responsibilities

Blue Care Network members have certain rights and responsibilities. Providers should be aware of these rights. They are available at our **website**.

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## Patient Safety Awareness Week

The National Patient Safety Foundation has designated March 11-17, 2018, as National Patient Safety Week. This is designed to increase awareness about patient safety among health professionals and their patients.

Blue Care Network supports the efforts of the Patient Safety Foundation and encourages its provider community and members to get involved.

Studies show that patients who are more involved in their health care have better outcomes.

Communication between patients and their health care providers play an important role. Encourage your patients to become active participants in their health care.

- Provide an environment where patients feel comfortable talking openly.
- Provide information about your patients' care in a manner that is understandable to them.
- To learn more, visit the **National Patient Safety Foundation** website.

### Learn more about patient communication.

Listen to what patients say is important to them.

See how doctors balance busy schedules and spend time with patients.

Watch our video at [brainshark.com/bcbsm/patientcommunication](http://brainshark.com/bcbsm/patientcommunication).





## Help patients get annual health screenings

Here's a checklist to help patients start off the New Year by taking care of their health.

- Record a body mass index for every patient. All patients under 20 years old need a BMI percentage, including height and weight. For children 3 to 17, provide counseling for nutrition. Complete the checklist verifying the discussion. Don't forget to provide counseling for physical activity and complete the checklist verifying the discussion.
- For diabetics, check HbA1c, nephropathy monitoring (urine for protein **or** on ACE/ARB meds, **or** renal diagnosis), blood pressure and encourage patient to schedule a diabetic eye exam. Schedule follow-up visits as results indicate.



Record BMI  
 Check BP  
 Order Mammogram  
 GET FIT  
 JOIN GYM  
 DRINK LESS  
 LOSE WEIGHT  
 check values for diabetics  
 Follow-up on medications  
 Colon cancer screening  
 check immunization records  
 ENJOY LIFE

- For patients with hypertension, follow-up on medication regime, document lifestyle changes and do blood pressure checks to ensure appropriate management
  - 18 to 59 years old BP 139/89 or less
  - 60 to 85 years old with a diagnosis of diabetes BP 139/89 or less
  - 60 to 85 years old without a diagnosis of diabetes BP 149/89 or less
- Review history and order colon cancer screening test, if needed (age 50 to 75, colonoscopy every 10 years). For patients who refuse a colonoscopy, suggest they complete a FOBT.
- For all females from 50 and 74, order a mammogram (if haven't had one for 27 months). Order cervical cancer screening for females 21 to 64 (if they haven't had one in three years or five years). If last Pap and HPV test were done together on the same date of service, patients must be 30 years old on the date of service of the Pap/HPV to meet the five-year interval requirement.
- Discuss the need for physical exercise – 30 minutes a day
- Talk to seniors about their fall risks and offer tips for a safe home environment.
- Do a depression assessment.
- Check immunization records for children and adolescents on MCIR and schedule visits to complete immunizations.

Blue Care Network appreciates your efforts to keep our members healthy.

For information on preventive services, please call Quality and Population Health at HEDIS message-line at 1-855-228-8543.

# Behavioral Health



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## Blue Care Network and Blue Cross to cover online behavioral health visits

We’re adding mental health services to our Blue Cross® Online Visits<sup>SM</sup> to offer members an alternative to in-person behavioral health office visits, effective Jan. 1.

Blue Cross Online Visits will increase access to mental health services, especially in rural counties where there’s limited access. It’s also useful for patients who aren’t as comfortable with counseling in a face-to-face setting.

Health care practitioners in our networks can continue to conduct telemedicine visits with an authorization as they do now. Physicians who already provide or want to provide their own telemedicine services should review the Blue Cross **Telemedicine** policy and the BCN **eVisits** and **Telemedicine** policies.

Blue Cross Online Visits, formerly called 24/7 online visits (powered by AmericanWell®), will include scheduled appointments with therapy and psychiatry providers. Video-only sessions will last 45 minutes; phone options aren’t available. In most cases, members will have the same cost-share as their current outpatient behavioral health benefit. The one exception is Blue Cross Community Blue groups — the cost share for online mental health visits must be *equal to or less than* the office visit cost share.

A new online app — BCBSM Online Visits — will replace the Amwell app that we previously used for medical online visits.

Online visits offered through this service don’t include treatment for substance abuse disorders or urgent and emergency behavioral health issues.

Members talk with a practitioner through a secure web-based video application that’s compliant with the Health Insurance Portability and Accountability Act. Visits are confidential and compliant with the federal mental health parity rules.

### Who is eligible?

- Therapy: Children 10 and older by appointment from 7 a.m. to 11 p.m., seven days a week.
- Adults (therapy and psychiatry) 18 and older by appointment only. (Extended hours during evenings and on weekends may be available.)

Psychiatrists can conduct diagnostic interviews and prescribe and manage medications. American Well doctors, however, don’t write prescriptions for controlled substances or lifestyle medications.



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## Who doesn't have access to Blue Cross Online Visits:

- Medicaid; Medicare Advantage (group and individual); MiChild
- Non-exact fill Medicare Supplemental; Medigap
- PPO Federal Employee Program
- FlexLink groups
- Specialty products, such as dental, vision and hearing.

## Reminder: Behavioral health documentation guidelines now available

Contracted behavioral health providers must follow guidelines we recently published when documenting behavioral health services provided to members. These guidelines apply to services for BCN HMO<sup>SM</sup> (commercial), BCN Advantage<sup>SM</sup>, Blue Cross PPO (commercial) and Blue Cross Medicare Plus Blue<sup>SM</sup> members. They were developed for all products to make it easier for providers to locate and follow.

For details, see the **article** in the Nov.-Dec. 2017 issue.

## Check web-DENIS for coverage

Follow these steps to verify that your **Blue Care Network patient** has coverage for online behavioral health visits and find the office visit copay:

1. Go to web-DENIS.
2. Under *Subscriber Info.*, click *Eligibility/Coverage/COB*, type in the contract number, check the Blue Care Network Line of Business and click *Enter*.
3. Click on the member's name.
4. Click *Medical Benefits*.
5. Scroll down to *Mental Health Outpatient* to view the benefits.

To check coverage for **Blue Cross members**:

1. Log in to web-DENIS.
2. Type the member's ID for eligibility and click on the detailed benefits button that takes you to Benefit Explainer.
3. Enter the procedure code to verify that the procedure is payable.

Or you can check benefits through the Provider Automated Response System, or PARS, at 1-800-344-8525.

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## Blue Care Network to continue Behavioral Health Incentive Program in 2018

Blue Care Network will continue the Behavioral Health Incentive Program in 2018. The measures are the same, but we are phasing out manual submissions. Manual submissions for both the therapeutic alliance measure and the PCP contact measure will be accepted through June 30, 2018. After that date, only electronic submissions will be accepted.

As part of the phase-out process, incentive amounts for manual submissions will decrease slightly.

We encourage providers who are not yet submitting self-reported forms electronically to review instructions for electronic submission on web-DENIS. You may also reach out to your provider consultant with any detailed questions. We are committed to helping providers with this transition.

Quality Incentive Measures	Payment	Intake period	Provider Action
Follow-up after hospitalization	\$100	1/1 – 10/31/18	None – claims data
Anti-depressant medication management — acute	\$75	1/1 – 4/30/18	None – claims data
Anti-depressant medication management — continuation	\$100	1/1 – 4/30/18	None – claims data
Pharmacotherapy adherence for bipolar disorder	\$100	1/1 – 12/31/18	None – claims data
Appropriate glucose monitoring	\$100	1/1 – 12/31/18	None – claims data
Use of first-line psychosocial care for children and adolescents on antipsychotics	\$100	1/1 – 12/31/18	None – claims data
Therapeutic alliance — MANUAL submission	\$15	1/1 – 6/30/18	Submit forms
-OR-			
Therapeutic alliance — ELECTRONIC submission	\$35	1/1 – 12/31/18	Submit data via Excel
Primary care physician contact — MANUAL submission	\$30	1/1 – 6/30/18	Submit forms
-OR-			
Primary care physician contact — ELECTRONIC submission	\$50	1/1 – 12/31/18	Submit data via Excel

The 2018 booklet, forms, and instruction guides will be available on web-DENIS starting in January. To find the documents:

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



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## Best Practices

### Team approach keeps breast cancer screening rates high

A unique approach to caring for patients has resulted in a near-perfect breast cancer screening rate at Briarwood Medical Group in Ann Arbor. Using a team-based approach to care means specific staff members work in dedicated care teams with the physicians to provide care for patients' screening needs and chronic conditions.

"One of the most important things we did a few years ago was to transition to a team-based approach to care," says Dr. Linda Terrell, medical director at Briarwood Medical Group, an outpatient general medicine clinic that is part of Michigan Medicine.

"My medical assistant, nurse, the LPN and case manager work together to manage a panel of patients. It's not possible for one person to be responsible for ensuring the quality of care for more than a thousand patients."

As part of the team approach, the medical assistant reviews the schedule with the doctor at the beginning of each day to see which health screenings or tests the patients need. "The assistant queues up those orders and reminds me to discuss it with the patient," says Dr. Terrell.

The practice has 12,000 patients and 10 physicians. Transitioning to team-based care first meant getting the buy-in of all the physicians, nurses and staff in the practice. "It was a big leap of faith," says Dr. Terrell. Moving to a new approach to care also necessitated physical moves within the practices so doctors' offices could be near their care teams, rather than the doctors being peripherally located.

"There's a lot to gain by having consistency of communication and staffing," she says. "My patients know



**Dr. Linda Terrell and patient Lesa Huget.**

my nurse and medical assistant are speaking for me. Prior to this team-based approach, we had a nurse call center and patients might talk to a different nurse each time they called.

"The team approach is also a significant patient satisfier," continues Dr. Terrell. "My patients know my medical assistant by name and she greets them at each of their visits with me. They know who to connect with and that she represents me. Therefore, it's very important that team members are strong and committed to excellent patient care."

The team approach is also valuable in this particular practice because the office serves an older population. Many of Dr. Terrell's patients are of Medicare age. Therefore, a lot of time is spent managing acute medical issues as well as on chronic disease management, she explains.

Screenings are still a priority at the practice, though. Dr. Terrell uses the Epic-based electronic medical records to track when patients are due for screenings. "We also pick a focus quality measure of the month that we're working on at the clinic level to help keep the staff motivated toward pursuing a specific goal," she says.

One challenge to screening is the recent controversy about the appropriate interval for breast cancer screening, says Dr. Terrell. This can become confusing for patients and often takes some time to explain in detail.

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## Best Practices, *continued from Page 26*

“Regular breast cancer screening may not be right for everyone,” she says. “There are some who don’t care to do the screening, and part of being a PCP is understanding each patient’s values. We review family history, current health status, patient priorities and other risk factors to help determine the intervals that are appropriate for that particular patient.”

Dr. Terrell is a proponent of yearly visits and she believes it’s critical to a rich, long-term doctor-patient relationship. “Those visits provide a time and format to explore patients’ beliefs and values, discuss the importance of lifestyle interventions in health and disease, deliver patient education and establish a dialogue surrounding management of their chronic health issues,” she says.



*From left, Carly Ross, RN; Meghan Moore, administrative manager; Dr. Linda Terrell; and Mandi Urbanski, medical assistant.*

## MQIC releases new guidelines for opioid use in adults

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

MQIC’s vision remains as a collaborative approach to develop and implement evidence-based clinical practice guidelines. Its mission is to provide a core set of guidelines, achieve consistent delivery of evidence-based services and, most importantly, better health outcomes. The guideline provides concise recommendations to encourage appropriate prescribing, or discontinuation of opioids.

You can review it at the **MQIC** website.

## January is Cervical Cancer Awareness Month

Please remind your female patients 21 to 64 years old about the benefits of routine cervical cancer screenings.

Recommendation	When
Cervical cancer screening	<ul style="list-style-type: none"> <li>• Ages 21 to 64: Perform cervical cytology every three years</li> <li>• Ages 30 to 64: Perform cervical cytology and human papillomavirus co-testing every five years.</li> <li>• Hysterectomy with no residual cervix, cervical agenesis or acquired absences of cervix any time during the patient’s history will exclude them from the cervical cancer screening recommendations.</li> </ul> <p>*Reflex HPV tests are not considered co-testing.</p>
Chlamydia screening	<ul style="list-style-type: none"> <li>• Ages 16 to 24: Perform chlamydia testing on sexually active females annually</li> </ul>

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## Quality Improvement program information available upon request

We provide you with ongoing information about our quality improvement programs and clinical practice guidelines through this newsletter. Approved clinical practice guidelines are available to all Blue Care Network primary care physicians, primary care groups and specialists. Copies of the complete guidelines are available on our secure provider portal. To access the guidelines:

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

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

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

In 2017, BCN (commercial HMO) ranked in the top 10 percent of all health plans nationally on the following HEDIS measures that address important health improvement goals:

- Adult BMI assessment
- Weight assessment and counseling for nutrition and physical activity for children/adolescents
- Comprehensive diabetes care – nephropathy and BP control

- Non-recommended cervical cancer screening in adolescent females
- Pharmacotherapy management of COPD – systemic corticosteroids
- Persistence of beta blocker treatment after a heart attack
- Follow-up care for children prescribed ADHD medications
- Postpartum care
- Use of spirometry testing in the assessment and diagnosis of COPD

Some measures that scored as needing improvement included:

- Pharmacotherapy management of COPD – bronchodilator
- Initiation and engagement of alcohol and other drug dependence treatment

In 2017, BCN Advantage received 4 or 5 stars in the CMS Star rating or the NCOA 90th percentile on the following HEDIS measures that address important health improvement goals:

- Adult BMI assessment
- Breast cancer screening
- Colorectal cancer screening
- Use of spirometry testing in the assessment and diagnosis of COPD
- Comprehensive diabetes care – blood sugar controlled, eye exams and nephropathy
- Osteoporosis management in women who had a fracture
- Medication reconciliation post discharge
- Plan all-cause readmissions

Please see [Quality Improvement](#), continued on Page 29

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## Quality Improvement, *continued from Page 28*

Some measures that scored as needing improvement included:

- Potentially harmful drug-disease interactions in the elderly
- Pharmacotherapy management of COPD – bronchodilator
- Comprehensive diabetic care – HbA1c testing
- Persistence of beta blocker treatment after a heart attack

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

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

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

## Prepare for HEDIS record reviews

Annual HEDIS® 2018 data collection will start the first week in February and continue through the last week in April. Blue Care Network nurses and medical coders will contact some of our affiliated practitioner locations, either by telephone or fax, to request copies of medical records or schedule a visit to review medical records.

Thank you for your contribution toward providing quality care to our members and for allowing the BCN staff to conduct medical record reviews.

If you have any questions related to HEDIS, call the Blue Care Network HEDIS message line at 1-855-228-8543.

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

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## Controlling high blood pressure and A1c testing

Hypertension and diabetes are two of many HEDIS® accreditation measures for health plans.

The Controlling High Blood Pressure measure looks at members 18 to 85 years of age with a diagnosis of hypertension and a blood pressure reading of:

Reading	Age
138/89 mm Hg or less	18-59
138/89 mm Hg or less	60-85 with diabetes
149/89 mm Hg or less	60-85 without diabetes

### Blood pressure readings

- A representative blood pressure is the most recent BP reading taken during the measurement year (by Dec 31) and it occurs after the date of service in which the diagnosis of hypertension occurred. If multiple readings occur in a single visit, the lowest systolic and lowest diastolic is the representative blood pressure and determines BP control.
- Reported blood pressure readings taken by your patient are not considered accurate in diagnosing hypertension.
- Record all blood pressures taken during a visit and if initial BP is high (140/90 or 150/90 or higher for age/condition range), make sure to record second BP reading, if taken.
- Do not round up blood pressure readings.
- Do document lifestyle modifications and treatment changes in member's medical record, for example changes in medication dosage, diet, exercise and smoking cessation.

- Initiate pharmacologic anti-hypertensive treatment that includes angiotensin-converting enzyme inhibitor (ACEI), or angiotensin receptor blocker (ARB) if lifestyle changes are not effective.
- Make sure the correct cuff size is used:

Indications	Arm circumference (inches)	Arm circumference (cm)
Small adult	9-10	22-26
Standard adult	11-13	27-34
Large adult	14-17	35-44
Adult thigh	18-21	45-52

- Calibrate blood pressure device regularly according to manufacturer's recommendations.

### Diabetic HbA1c testing

- For the Comprehensive Diabetes Care measure, members age 18 to 75 identified as having diabetes should have a HbA1c test every six months with a goal of at least 7.9 or below.
- Follow-up visits and testing should be done every three months until the goal is reached.

If you would like more information about HEDIS, call the BCBSM Quality & Population Health department HEDIS message line at 1-855-228-8543.

References:

[http://millionhearts.hhs.gov/Docs/NYC\\_HHC\\_Hypertension\\_Protocol.pdf](http://millionhearts.hhs.gov/Docs/NYC_HHC_Hypertension_Protocol.pdf)

HEDIS® 2018 Technical Specifications for Health Plans

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## Blue Cross, BCN won't cover some drugs effective Jan. 1

To address the high cost of drugs and provide the best value for our members, while maintaining quality care, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans are removing select drugs from our Custom Select drug list that have more cost-effective therapeutic alternatives available.

To the right we've listed the drugs that we're removing from our Custom Select drug list effective Jan. 1, 2018, along with some covered alternatives.

This change:

- Affects high-cost drugs for which more cost-effective therapeutic alternatives are available
- Provides the best value for our members

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

Common drug use/ drug class	Drug not covered beginning Jan. 1, 2018	Alternatives
Vaginal antifungal	<b>AVC<sup>®</sup> vaginal cream</b>	<ul style="list-style-type: none"> <li>• Fluconazole (Diflucan<sup>®</sup>) oral</li> <li>• Terconazole (Terazol<sup>®</sup>) vaginal cream and suppository</li> </ul>
Urinary antispasmodic	<b>Enblex<sup>®</sup></b>	<ul style="list-style-type: none"> <li>• Oxybutynin (Ditropan<sup>®</sup>, Ditropan<sup>®</sup> XL)</li> <li>• Tolterodine (Detrol<sup>®</sup>, Detrol<sup>®</sup> LA)</li> <li>• Trospium (Sanctura<sup>®</sup>, Sanctura<sup>®</sup> XR)</li> </ul>
Migraine treatment	<b>Ergomar<sup>®</sup></b>	<ul style="list-style-type: none"> <li>• Dihydroergotamine (D.H.E. 45<sup>®</sup>, Migranal<sup>®</sup>)</li> <li>• Ergotamine/caffeine (Cafergot<sup>®</sup>, Migergot<sup>®</sup>)</li> </ul>
Pain management	<b>Fenortho<sup>®</sup> 200mg, 400mg</b>	Generic oral nonsteroidal anti-inflammatories (NSAIDs) Examples include: <ul style="list-style-type: none"> <li>• Diclofenac (Voltaren<sup>®</sup>)</li> <li>• Etodolac (Lodine<sup>®</sup>, Lodine<sup>®</sup> XL)</li> <li>• Fenoprofen 600mg (Nalfon<sup>®</sup>)</li> <li>• Ibuprofen (Motrin<sup>®</sup> – Rx only)</li> <li>• Meloxicam (Mobic<sup>®</sup>)</li> <li>• Naproxen (Naprosyn<sup>®</sup>)</li> <li>• Piroxicam (Feldene<sup>®</sup>)</li> </ul>
Gastrointestinal	<b>Kristalose<sup>®</sup></b>	Lactulose
Respiratory treatment	<b>Nebusal<sup>®</sup></b>	Generic sodium chloride inhalation 3%, 7% and 10%
Bowel preparation and cleansing	<b>Osmoprep<sup>®</sup> Prepopik<sup>®</sup></b>	Generic polyethylene glycol-electrolyte solution (Colytev <sup>®</sup> , Golytely <sup>®</sup> , Halflytely <sup>®</sup> -bisacodyl, Nulytely <sup>®</sup> )
Digestive enzymes	<b>Pancreaze<sup>®</sup> Pertyze<sup>®</sup> Viokace<sup>®</sup></b>	Pancrelipase (Creon <sup>®*</sup> , Zenpep <sup>®*</sup> )
Vitamin	<b>Phytonadione syringe</b>	Phytonadione ampule
Insomnia	<b>Seconal<sup>®</sup></b>	<ul style="list-style-type: none"> <li>• Eszopiclone (Lunesta<sup>®</sup>)</li> <li>• Temazepam (Restoril<sup>®</sup>)</li> <li>• Zaleplon (Sonata<sup>®</sup>)</li> <li>• Zolpidem (Ambien<sup>®</sup>, Ambien<sup>®</sup> CR)</li> </ul>
Topical antiviral	<b>Zovirax<sup>®</sup> cream</b>	<ul style="list-style-type: none"> <li>• Penciclovir cream (Denavir<sup>®*</sup>)</li> <li>• Famciclovir tablets (Famvir<sup>®</sup>)</li> <li>• Valacyclovir tablets (Valtrex<sup>®</sup>)</li> </ul>

\*Indicates that there is no generic version of the alternative drug currently available

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## Blue Cross and Blue Care Network will no longer cover hyaluronic acids, starting April 1

To provide the best value for our members, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans will not cover hyaluronic acids, beginning April 1, 2018.

Hyaluronic acids, also known as viscosupplements, are used to treat osteoarthritis of the knee.

A large body of evidence from randomized controlled trials and national guidelines have examined the effect of hyaluronic acids on pain and function. The combined data shows:

- A lack of defined meaningful clinical improvements over placebo
- Well-characterized biases among trials
- Publication bias
- Missing study results

These contributing factors conclusively determine there is insufficient evidence that hyaluronic acid therapy improves the net health outcome in patients with knee osteoarthritis.

J code	Drug description
J7320	Hyaluronan or derivative, GenVisc® 850 for intra-articular injection, 1 mg
J7321	Hyaluronan or derivative, Hyalgan® for Supartz™ for intra-articular injection, per dose
J7322	Hyaluronan or derivative, Hymovis® for intra-articular injection, 1 mg
J7323	Hyaluronan or derivative, Euflexxa® for intra-articular injection, per dose
J7324	Hyaluronan or derivative, Orthovisc® for intra-articular injection, per dose
J7325	Hyaluronan or derivative, Synvisc® or Synvisc-One® for intra-articular injection, 1 mg
J7326	Hyaluronan or derivative, Gel-One® for intra-articular injection, per dose
J7327	Hyaluronan or derivative, Monovisc® for intra-articular Injection, per dose
J7328	Hyaluronan or derivative, Gel-Syn™ for intra-articular injection, 0.1mg

Blue Cross and BCN will continue to provide coverage for first-line alternative therapies based on guideline recommendations for treatment of pain in knee osteoarthritis.

To get information on the types of covered drug therapy for pain management, refer to our approved **drug list**.

**Note:**

- These changes do not apply to Medicare and Medicaid members.
- If you've been prescribing hyaluronic acid therapies, be sure to complete all regimens prior to April 1, 2018. After April 1, 2018, no further coverage will be provided for these injections.

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## Blue Cross and BCN not covering select high-cost insulins that have comparable alternatives

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

- Apidra<sup>®</sup>, Apidra<sup>®</sup> Solostar<sup>®</sup>
- Humalog<sup>®</sup> (except Junior KwikPen), Humalog<sup>®</sup> Mix
- Humulin<sup>®</sup> (except U-500), Humulin<sup>®</sup> Kwikpen<sup>®</sup>

Members currently using these insulin products can continue to fill prescriptions for them through Feb. 28, 2018 so they have time to talk to their providers about treatment options.

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

Insulin products not covered beginning Jan. 1, 2018	Cost to Blue Cross (PPO) member	Cost to BCN (HMO) member
Apidra <sup>®</sup> , Apidra <sup>®</sup> Solostar	Full cost (not covered)	Full cost (not covered)
Humalog <sup>®</sup> (except Junior KwikPen), Humalog <sup>®</sup> Mix		
Humulin <sup>®</sup> (except U-500), Humulin <sup>®</sup> Mix		
Covered alternatives	Cost to Blue Cross member	Cost to BCN member
Novolin <sup>®</sup> (all forms)	Preferred brand copayment	Generic copayment
Novolog <sup>®</sup> , Novolog <sup>®</sup> Mix		

## BCN limits first fills of short-acting opioids to five days

In response to the opioid crisis, Blue Care Network continues to look for ways to combat the overuse and over-prescribing of opioid painkillers. Last year BCN limited opioid pain relievers to a 30-day supply and first fills of short-acting opioids to 15 days for commercial members.

Effective Feb., 1, 2018, BCN will lower the first fill limit of 15 days down to five days for short-acting agents such as Vicodin<sup>®</sup> and Tylenol #3<sup>®</sup>. Subsequent fills can be up to a 30-day supply.

Studies have shown that taking opioids for only a matter of days can lead to long-term use. Each additional day of therapy increases the risk for chronic opioid use. Initial opioid prescriptions of at least one day, eight days or 10 days can lead to long-term use in 6 percent, 13.5 percent

and 20 percent of patients respectively. To simplify, one in five patients receiving an initial 10-day supply opioid prescription will continue to use long-term.<sup>1</sup> Opioids should be limited to the shortest duration possible, and for acute pain less than seven days (ideally ≤ three) according to Centers for Disease Control and Prevention guidelines.

BCN recommends providers continue to use the Michigan Automated Prescription System when prescribing opioid prescriptions. Registration for **MAPS** online takes only a few minutes and reports can be requested at any time.

These changes don't apply to BCN Advantage<sup>SM</sup> members.

1. Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: <http://dx.doi.org/10.15585/mmwr.mm6610a1>.

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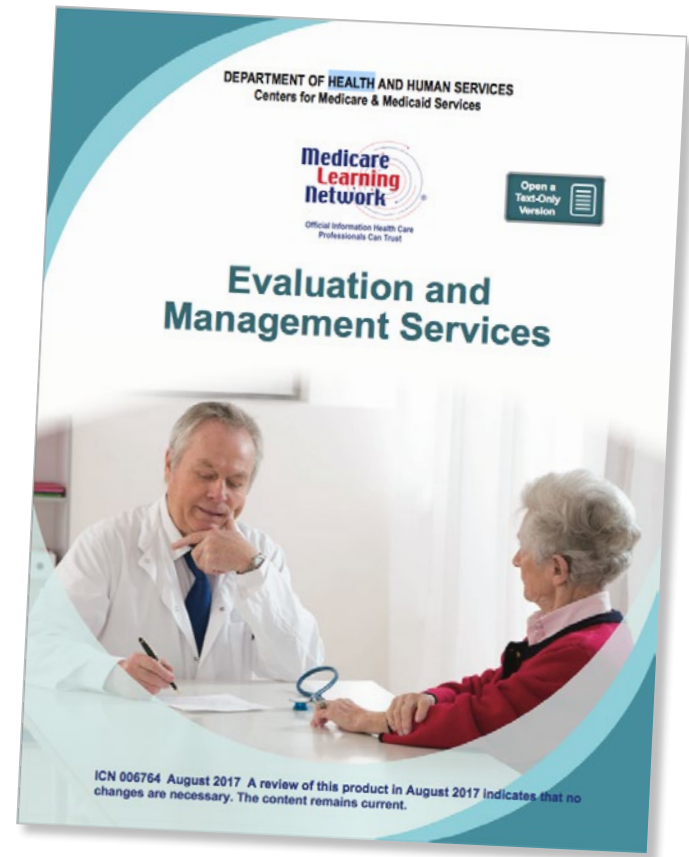
## Blue Care Network mails letters to physicians to address over-coding

In December 2015, Blue Care Network instituted a clinical editing program to address the high incidence of over-coding for certain evaluation and management services. The program is evaluated periodically and includes only those physicians that are identified as outliers.

The program was updated Feb. 15, 2017, and will again be updated Jan. 3, 2018. Updates will occur every six months. BCN has mailed letters to newly selected physicians explaining the clinical editing process. We're not making any changes for physicians currently in the program.

BCN recommends that physicians carefully code each service provided according to national guidelines and that the office documentation supports the code reported. Learn more about the coding guidelines, including the evaluation and management documentation, in the Center for Medicare & Medicaid Services ***Evaluation and Management Services Guide***.

If you disagree with a clinical edit on an evaluation and management service, you have a right to file an appeal. Follow the clinical editing appeal process as described in the *BCN Provider Manual Claims* chapter. BCN will review the medical records submitted and assess the intensity of service and complexity of decision-making for the evaluation and management services documented. BCN will make a determination based on the documents and the medical necessity of the evaluation and management service.





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## Question:

Some of the codes I bill have time units. It's not always clear in the record how much time was spent providing the service. For example, our office will do nutrition counseling. How do I know which code to report or how much time to document?

## Answer:

First, the service being provided must be clearly documented in the patient's record. Second, the time spent providing that service must also be documented. While the record does not need to record a start and end time, it does need to state the amount of time devoted to that service. For a time-based code to be reported, the time spent providing the service must exceed half of the time described in the code. For example, a code that describes 30 minutes, the provider must spend and document at least 16 minutes providing the service.

In the example you provided, two of the codes for nutrition counseling, the individual initial assessment and the individual reassessment, are both timed codes at 15 minutes. In identifying which code to report, you would need to identify if this was the first nutritional review with the patient and how much time was spent with the patient. It needs to be documented in the medical record.

## See the following examples.

**Example 1:** "Reviewed patient's dietary sheet and made recommendations for changes to meal plans." This documentation does not provide enough information to allow for separate coding of nutrition counseling. Information lacks detail and does not provide time components.

**Example 2:** "Spent 24 minutes reviewing patient's dietary sheet, subsequent to last visit when education was provided regarding diabetic education. Noted better compliance, but still needs improvement with coordinating meals due to work schedule. Recommendations provided. Will follow-up at next visit and review next diet sheet."

Example 2 indicates that the provider was doing a reassessment and would need to report two units of the nutrition counseling code. The reason for the two units: Each unit is 15 minutes and while the provider did not go the full 15 minutes for the second unit, the time spent exceeded half the time.

## Question:

I am a behavioral health provider, but sometimes my claims seem to get held up. Most seem to be when the diagnosis falls out of the behavioral health ICD-10 range, but is still related. One example that seems to cause an issue is the diagnosis of suicidal ideation. That is one we report, but it will not pay without an inquiry. What do we need to do?

## Answer:

Suicidal ideation is not a diagnosis code that falls within the "Mental, Behavioral and Neurodevelopmental Disorders" Chapter of the ICD-10-CM Manual. This chapter outlines the diagnosis codes which have been defined by our plan as the ones that should be reported as the primary diagnoses for behavioral health and substance abuse conditions.

While suicidal ideation, which is represented by ICD-10 code R45.851, is experienced by patients seeking behavioral health services, it is considered to be a symptom of an emotional state. As such, the appropriate primary diagnosis needs to be reported.

To facilitate timely and accurate claims processing of behavioral health and substance abuse claims, the primary diagnosis reported should be from the "Mental, Behavioral and Neurodevelopmental Disorders" Chapter of the ICD-10-CM Manual and fall between F01 and F99. Other supporting codes, indicating signs and symptoms the patient may be experiencing, should be reported as secondary diagnoses.

Please see [Billing Q&A](#), continued on Page 36

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## Billing Q&A, *continued from Page 35*

### Question:

**I do billing for a specialist. If he sees a patient in a nursing home, sometimes I need to get an authorization, but sometimes I don't. Is there an easy way for me to know when I need to call in or have the primary care physician get an authorization, so I can do the billing for the care my specialist is providing to the patient?**

### Answer:

To help know what type of authorization is required you need to determine if the patient is in a skilled nursing placement or a basic or custodial care setting and if the patient has commercial or BCN Advantage coverage.

When a patient with commercial or BCN Advantage coverage is in a skilled nursing care facility and an authorization has been provided for the patient's inpatient stay, a separate authorization isn't required for most professional services. If we have authorized the inpatient care, medically necessity for the patient's care falls under that authorization. The place of service for skilled nursing care is reported as location 31.

If a patient with commercial coverage is in a basic or custodial nursing home placement, this is reported as location 32. In many instances, this is considered the patient's home. It's not an authorized or covered admission by the health plan, and will require that a referral be issued by the patient's PCP.

When a patient with BCN Advantage coverage is in a basic or custodial nursing home placement, no referral is required.

It's important to note that the above information is related to standard visits provided in a nursing facility. Any services or procedures that are subject to pre-authorization (for example, potentially cosmetic services) would still require clinical review by the health plan.

### Question:

**Is there a new BCN medical policy for Lemtrada® (alemtuzumab)?**

### Answer:

For BCN commercial members, Lemtrada® requires prior authorization. The authorization for these members is handled within the Novologix tool.

In general, the guidelines for administration provide diagnosis and age restrictions, ordering physician qualifications, as well as a need for lab results and treatment history. For specific and current information regarding criteria, please refer to the "Drugs Covered Under the Medical Benefit" page on [e-referral](#).

Currently, Lemtrada requires pre-authorization for BCN commercial members, but not for BCN Advantage members.

## 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'll answer your question in an upcoming column, or have the appropriate person contact you directly. Direct urgent questions to your provider consultant. Don't include any personal health information, such as patient names or contract numbers.



# Providers must submit functional limitation G codes for BCN Advantage PT, OT and ST services

When billing outpatient physical, occupational and speech therapy services for BCN Advantage<sup>SM</sup> members, you must report the nonpayable functional limitation G codes and their applicable modifiers.

It's important to report the modifiers for the nonpayable G codes as secondary to the modifiers for the primary codes. If you report these modifiers as primary, it will cause an error in our payment system and the claim will be denied.

Here's an example of the how to report these codes and modifiers correctly:

- 1 Report as primary:** In the line item, report the BCN Advantage modifier for the type of therapy (physical, occupational or speech) along with the G code.
- 2 Report as secondary:** In the "Additional Modifiers" box, report the required Centers for Medicare & Medicaid Services modifier.

1	04/12/2017	04/12/2017	0420	TPM	G8991	GP	1	\$0.00	E11622
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**2 Additional Modifiers**

Line	From	To	Rev	Tos	Dx	Proc	Charges	Units
7	04/12/2017	04/12/2017	0420	TPM	E11622	G8991GP	\$0.00	1

Modifier

2nd  CK 3rd  PO 4th

OK Cancel Previous Next Help

Functional G codes and their modifiers tell us about the member's status throughout the episode of care as compared to his or her goals. They give us a fuller picture of the member's conditions, expected and actual outcomes, and expenditures.

At one time, reporting functional limitation G codes and their modifiers were optional for BCN Advantage. However, we've made payment system updates that make it necessary to report these codes. We'll revise the *BCN Provider Manual* and related documents to show this change.

If you have questions, call your provider consultant.

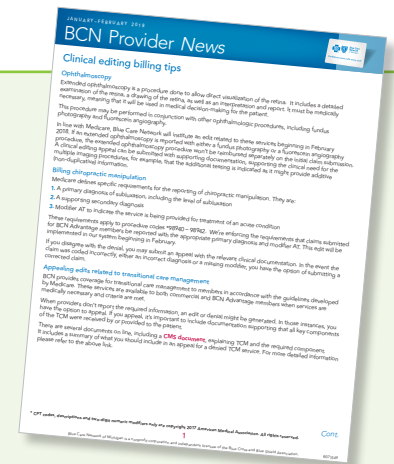
## Clinical editing billing tips

In most issues we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that the performed procedure is correctly reported to us.

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

This issue's billing tips include the following:

- Ophthalmoscopy
- Billing chiropractic manipulation
- Appealing edits related to transitional care management



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The Centers for Disease Control and Prevention reports that approximately 15.7 million Americans have been diagnosed with chronic obstructive pulmonary disease. The prevalence of COPD, coupled with the increased specificity required by ICD-10-CM, makes documenting the disease and any respiratory conditions currently associated with it imperative to ensure the appropriate diagnosis code is applied.

The two common forms of COPD are emphysema and chronic bronchitis. However, many patients diagnosed with COPD have both emphysema and chronic bronchitis.

### Important tips to remember

- Always document and code to the highest level of specificity and report diagnosis codes at their highest number of characters available. For example, if the provider documents “acute bronchitis” or “chronic bronchitis” (both unspecified), then report ICD-10-CM codes J20.9 and J42, respectively. However, if the provider doesn’t indicate whether the bronchitis is acute or chronic, the appropriate ICD-10-CM code would be J40 (bronchitis not specified as acute or chronic). It’s important to indicate, through coding, whether the condition is acute, chronic or in acute exacerbation.
- Since COPD-related conditions can be coded in a variety of ways, the final code selection must take into account the specific details of the patient’s condition as documented by the health care provider.
- ICD-10-CM code J44.9 (chronic obstructive pulmonary disease, unspecified) should only be used if the information in the medical record is insufficient to assign a more specific code.
- When COPD with an acute exacerbation is documented **without** acute bronchitis, then report ICD-10-CM code J44.1 (chronic obstructive pulmonary disease with acute exacerbation).
- Code J44.0 (chronic obstructive pulmonary disease with acute bronchitis) is assigned when the medical record supports acute bronchitis and COPD. (An additional code is used to identify the infection.)

Please see [Coding Corner](#), continued on Page 39

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ICD-10-CM code	ICD-10-CM Nomenclature
J41.0	Simple chronic bronchitis
J41.1	Mucopurulent chronic bronchitis
J41.8	Mixed simple and mucopurulent chronic bronchitis
J42	Unspecified chronic bronchitis
J43.9	Emphysema, unspecified
J44.-	Other chronic obstructive pulmonary disease J44.0 COPD with acute lower respiratory infection J44.1 COPD with (acute) exacerbation J44.9 COPD, unspecified
J45.-	Asthma (additional fifth and/or sixth characters required) J45.2- Mild intermittent asthma J45.3- Mild persistent asthma J45.4- Moderate persistent asthma J45.5- Severe persistent asthma J45.9- Other and unspecified asthma
R09.02	Hypoxemia
Z43.0	Encounter for attention to tracheostomy
Z93.0	Tracheostomy status
Z99.81	Dependence on supplemental oxygen

It's important to review the *ICD-10-CM Chapter Specific Coding Guidelines* (Chapter 10: Diseases of Respiratory System J00-J99) and any instructional notes under the various COPD subcategories and codes in the tabular list of the ICD-10-CM manual to select the correct code. In addition to the codes listed above, you may need to use additional codes to identify current or previous tobacco usage and dependence or other environmental exposure.

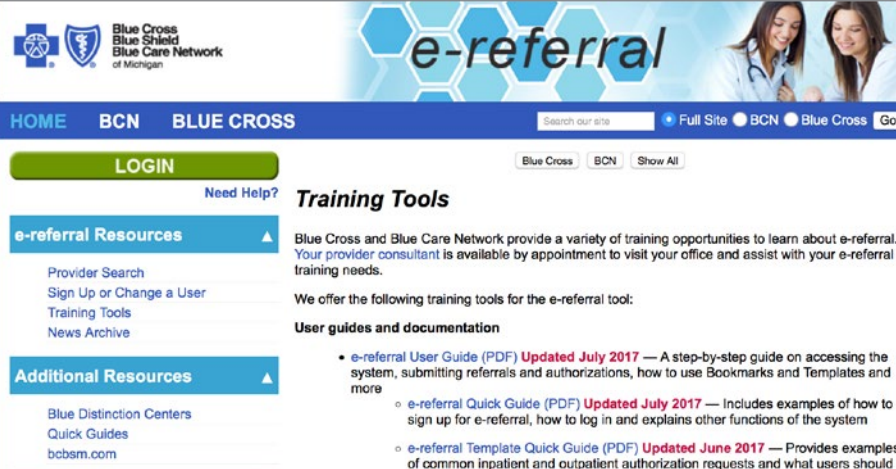
**Note:** ICD-10-CM coding for all conditions should follow the ICD-10-CM Official Guidelines for Coding and Reporting.

*ICD-10-CM diagnosis codes and ICD-10-CM Official Guidelines for Coding and Reporting are subject to change. It's the responsibility of the provider to ensure that current ICD-10-CM diagnosis codes and the current ICD-10-CM Official Coding Guidelines for Coding and Reporting are reviewed prior to the submission of claims.*

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

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## Have questions about our e-referral tool? Check out our training tools

Recently, we’ve received some questions from health care providers seeking assistance with the e-referral tool used to submit referrals and authorizations. Here’s a list of the many training opportunities available on the **e-referral** site.

On the **Training Tools** page, you’ll find the:

- **e-referral User Guide** (PDF), a step-by-step guide on accessing the system, submitting and more
- **e-referral Quick Guide** (PDF), a simple how-to guide on getting started
- **Behavioral Health User Guide** (PDF), a step-by-step guide for behavioral health providers
- **Blue Cross® Physician Choice PPO User Guide** (PDF), specifically for Physician Choice PPO authorizations
- **FAQs for using the e-referral system** (PDF), a useful guide for Blue Cross providers
- Online **self-paced learning** modules
- Physician Choice PPO **online training** presentation

If you still have questions after reviewing these resources, reach out to your **provider consultant**.

## We’re changing the way we describe care management

We’re changing the way we use care management terms to make it easier for you to find the information you need.

Here are some examples of the changes we’re making in the *BCN Provider Manual*:

- “Clinical review requirements” are now called “authorization requirements.”
- “Utilization Management” is the new name of BCN’s Care Management department.

During the first months of 2018, you’ll see these wording changes in all chapters of the *BCN Provider Manual* and in related BCN documents.

Here are other examples of changes we’re making:

- *BCN Referral and Authorization Requirements* is the new name for the *BCN Clinical Review & Criteria Charts* document.
- *Woman’s Choice Referral and Authorization Guidelines* is the new name for the *Woman’s Choice Referral and Clinical Review Guidelines* document.

You can find both these documents at **ereferrals.bcbsm.com**. Click *BCN* and then click *Authorization Requirements & Criteria*, which is the new name for the Clinical Review & Criteria Charts page.

These changes are just the first in a series being released throughout 2018 designed to bring greater consistency across lines of business to the language in our provider manuals and in the other documents we use to communicate with you about how to do business with Blue Cross and BCN.

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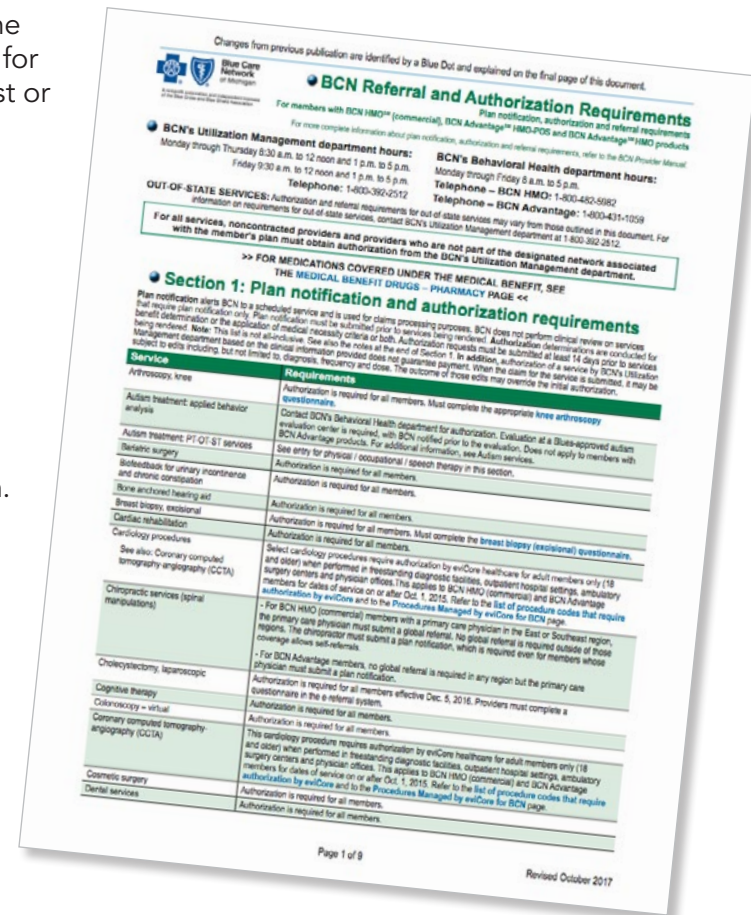
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## How regional authorization and referral requirements apply

As a rule, physicians must follow the authorization and referral requirements that apply to the region in which their medical care group headquarters is located. This means, for example, that a physician office located in the Mid or West region must follow the authorization and referral requirements for the East or Southeast region if the headquarters for their medical care group is located in the East or Southeast region.

Because the authorization and referral requirements differ from region to region, it's important that physicians are aware of which requirements they must follow. These requirements are summarized in the **BCN Referral and Authorization Requirements** document. This document is available online at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Click *BCN* and then click *Authorization Requirements & Criteria* in the left navigation. Finally, click *BCN Referral and Authorization Requirements* to open the document.



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# How to upload clinical information when re-entering the eviCore healthcare online provider portal

You can now upload and submit clinical documentation for a pending authorization request through the eviCore online portal even after you've left the case. The eviCore provider portal has always allowed clinical information to be attached when you're first submitting the authorization request, after the case is pended. But now you can attach it after you've left the case and returned to it.

This applies to authorization requests submitted for both Blue Cross and BCN members.

Here's how to upload clinical information online when you've left the portal and returned to a case that's been pended.

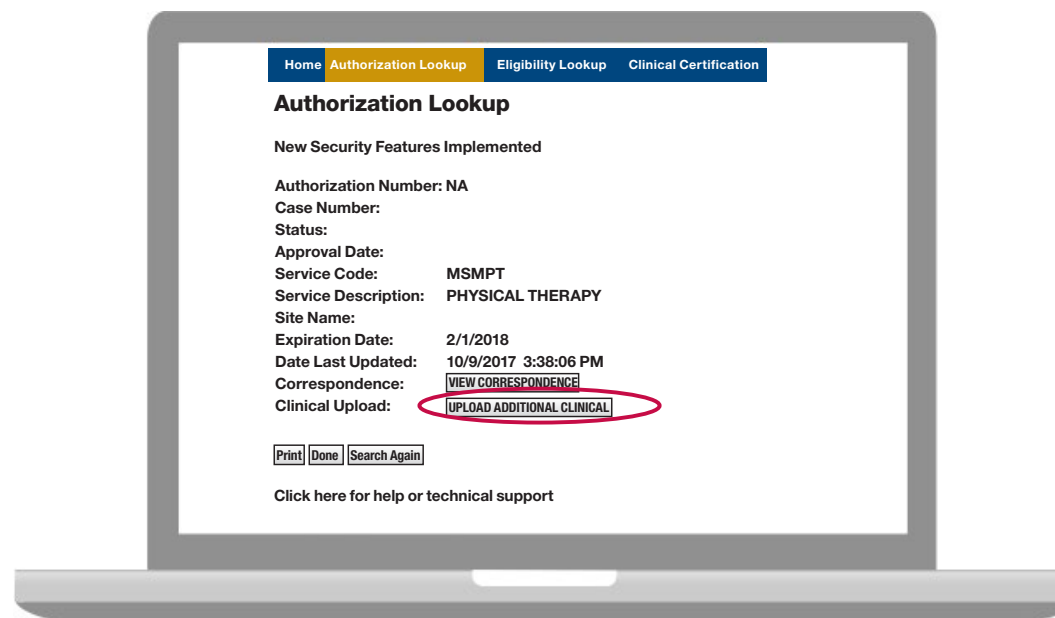
1. Log in to the eviCore portal as you normally would.
2. Click on the *Authorization Lookup* tab to search for the existing authorization request.
3. Select the request.
4. Verify that the status of the request is "pending."
5. Select *Upload Additional Clinical Information* in the Clinical Upload field.

You can upload clinical information only for pending requests. Once the request is in a final status (approved, denied, partially approved, withdrawn or expired), you'll have the option to upload additional clinical information.

Also, this information is specific to the eviCore health portal. It does not apply to requests to authorize physical, occupational and speech therapy by therapists (for BCN HMO and BCN Advantage) and physical medicine services by chiropractors (for BCN HMO only), which are handled through the provider portal at [www.LMhealthcare.com](http://www.LMhealthcare.com).

As a reminder, eviCore healthcare is an independent company that provides clinical review services for Blue Cross and Blue Care Network. For additional information related to requesting authorization from eviCore, visit [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Then –

- For BCN HMO and BCN Advantage, click *BCN*. Then click **eviCore-Managed Procedures**.
- For Blue Cross PPO (commercial) and Medicare Plus Blue PPO, click *Blue Cross*. Then click **eviCore-Managed Procedures**.



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### Blue Cross and BCN changing professional provider consultant model

Blue Cross Blue Shield of Michigan and Blue Care Network will be changing the way we assign our professional provider consultants in the next few months. Our new professional consultant model will have fewer office visits. However, it will maintain our commitment to serving the provider community with continued education, provider forums, online tools and telephone support. Watch for more information in upcoming issues of *BCN Provider News* and *The Record*.

As a reminder, we told you back in July **you can obtain claims information 24 hours per day** through our automated telephone system. In our November-December issue we gave you **tips for navigating PARS**.

Please see [Consultant model](#), continued on Page 3

### Physician organizations receiving additional information to help providers address opioid epidemic

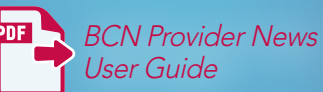
As part of Blue Cross Blue Shield of Michigan's continuing efforts to address the opioid epidemic, Value Partnerships, in cooperation with Pharmacy Services, is accelerating efforts on multiple fronts to further reduce fraud and the abuse of controlled substances.



Our current Fraud, Waste and Abuse Program already identifies the following:

- Health care providers who are writing opioid prescriptions for patients who may be doctor-shopping, which is the practice of visiting multiple physicians to obtain multiple prescriptions
- Patients who have been prescribed part of or all of a dangerous drug combination known as the triple threat — concurrent use of opioids, benzodiazepines and muscle relaxants. Triple threat combinations are often linked to recreational patient use and frequently lead to overdose and even death.

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



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## Physician organizations, *continued from Page 1*

Blue Cross has a long-standing practice of alerting prescribing physicians when one of these situations occurs. Since April of 2016, Blue Cross Pharmacy Services has seen a 33 percent drop in members identified in the doctor-shopping analysis, and a 54 percent drop in members receiving the dangerous triple threat drug combination.

Since December, our Physician Group Incentive Program’s participating physician organizations have been receiving monthly reports about physicians who could unknowingly be involved in these potentially dangerous scenarios.

This process change provides us with an additional venue for educating providers about the importance of using the Michigan Automated Prescription System, or MAPS. The tool helps prescribers identify patients who may be improperly seeking Schedule 2 to 5 drugs. It’s used to identify and prevent drug abuse and diversion at the prescriber, pharmacy and patient level.

For more information, go to [michigan.gov/mimapsinfo](http://michigan.gov/mimapsinfo) or reach out to your physician organization.

### New flyer on opioid epidemic

To learn more about what Blue Cross and Blue Care Network are doing to battle the opioid epidemic, see our recent **flyer**. It provides statistics about the opioid epidemic, outlines our comprehensive strategy and shows results from our various initiatives.



*Blue Cross opioid flyer*



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Consultant model, continued from Page 1

Here are the key phone numbers to call:

For patients with this coverage:

Call this number:

- Blue Cross Medicare Plus Blue PPO (Medicare Advantage PPO).....1-866-309-1719
- Federal Employee Program .....1-800-840-4505
- All other coverage (commercial Blue Cross, BCN and BCN AdvantageSM) for professional providers.....1-800-344-8525
- All other coverage (commercial Blue Cross, BCN and BCN Advantage) for facility providers .....1-800-249-5103
- All coverage for vision and hearing providers.....1-800-482-4047

## Provider forums coming to a town near you

As you read this article, we’re planning and scheduling the next set of Blue Cross Blue Shield of Michigan and Blue Care Network provider forums. As we work through the details, be sure to check next month’s issue of *The Record* for dates, times, registration information and topics.

This year, the morning sessions will have content specifically geared toward physician office staff who are responsible for closing quality measures and coding gaps. These sessions will also look at the overall patient experience.

Topics will include:

- Patient experience
- Coding and documentation
- HEDIS® measures

Afternoon sessions will be suited toward all office personnel and will cover topics like:

- New provider service model
- eviCore and prior authorizations
- eReferral
- The opioid epidemic
- Behavioral Health
- Updates for Provider Enrollment and Data Management and PARS (provider automated response system)

These forums are well received and provide valuable information to keep your staff up to date on the latest information. If you haven’t been to one yet... be sure to check your April issue of *The Record* and future issues of *BCN Provider News*. We look forward to seeing you.

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



# Michigan opioid legislation takes effect in March

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In December, Lt. Governor Brian Calley signed into law a bill package that will tighten requirements around opioid prescriptions in the state of Michigan. The bills become Public Acts 246-255 of 2017.

The new law states the following:

- Prescribers cannot prescribe a Schedule 2-5 drug unless the prescriber has a bona-fide prescriber-patient relationship with the patient (beginning March 31, 2018).
- Prescribers cannot prescribe or dispense a controlled substance that exceeds a three-day supply without obtaining and reviewing a report from the Michigan Automated Prescription System (MAPS). All prescribers also would have to register with MAPS by June 1, 2018.
- Opioid prescriptions for acute pain would be limited to a seven-day supply, effective July 1, 2018.
- Providers will be required to discuss with a minor and their parent the risks of addiction and overdose, before prescribing an opioid to a minor. Information on the dangers of opioid addiction would also have to be provided to adult patients. Both minors, their parents, and adult patients would have to sign a form provided by the state to confirm they received the information (effective June 1, 2018).

- A prescriber must obtain and review a patient’s data from MAPS before dispensing or prescribing buprenorphine, or a drug containing buprenorphine and methadone, to a patient in a substance use disorder program.
- A health professional who has treated a patient for an opioid-related overdose, is required to provide information to the patient on substance use disorder services.
- An eligible individual may receive medically necessary acute medical detoxification for opioid use disorder, medically necessary inpatient care at an approved facility, or care in an appropriately licensed substance use disorder residential treatment facility through Medicaid.
- By the 2019-2020 school year, the state model for health education is required to include instruction on prescription opioid drug abuse. By July 1, 2019, the state department of education is to provide to school districts a grade and age-appropriate model program of instruction on prescription opioid drug abuse based on the recommendations of the state’s Prescription Drug and Opioid Abuse Commission.

## Blue Cross Blue Shield of Michigan releases statement on opioid bill package

Blue Cross Blue Shield of Michigan is committed to reducing addiction and the toll it is taking on families across the state. We’re actively engaging with physicians, public health advocates and officials on initiatives to combat the opioid epidemic by enhancing awareness. The following is a statement about the new legislation from Blue Cross Blue Shield of Michigan CEO Dan Loepp:

*“We are pleased with this bipartisan approach to address the opioid epidemic. It is a strong step forward that strengthens Michigan’s efforts to reduce addiction and abuse. We applaud leaders across government for their work to protect families from this crisis.*

*As Michigan’s largest health insurer with a strong social mission, Blue Cross Blue Shield of Michigan shares the concern over the crisis and we are also expanding our efforts to prevent addiction and overdose deaths in Michigan. We have significant efforts underway to combat the opioid epidemic by enhancing awareness, and through partnerships with physicians and public health advocates and officials.”*



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## Blue Cross, Partners announce \$570,000 to communities across state

Nine community coalitions throughout Michigan will receive a total of \$570,400 in funding through the *Taking Action on Opioid and Prescription Drug Abuse in Michigan by Supporting Community Responses* initiative, courtesy of Blue Cross Blue Shield of Michigan, **The Blue Cross Blue Shield of Michigan Foundation, The Michigan Health Endowment Fund, The Community Foundation for Southeast Michigan** and **The Superior Health Foundation**. The partnership provides one-time grants to begin new projects, or to enhance or expand existing projects aimed at reducing opioid and prescription drug abuse and harm.

"This joint effort is a major initiative designed to help community coalitions address the growing opioid epidemic impacting Michigan residents in every corner of our state," said Daniel J. Loepp, president and chief executive officer of Blue Cross Blue Shield of Michigan. "It's imperative we turn our attention to the needs of the individuals and families being affected by this crisis. This funding will promote a larger network of resources throughout the state with an emphasis on prevention, treatment and support services."



### Opioid bill, *continued from Page 4*

We are working on several strategic initiatives to prevent overdose deaths, including:

- Limiting the quantity and day supply of addictive substances. An initial fill of a prescription for one of these medications will be limited to a five-day supply. Additional fills will be limited to no more than a 30-day supply, but will not apply to members with a cancer diagnosis or who are terminally ill.
- Working directly with doctors to coordinate care to reduce opioid abuse and overdose from prescriptions for controlled substances from multiple doctors without their shared knowledge of prescriptions from others.
- Creation of the Opioids Provider Toolkit, which provides physician organizations links to best practices and resources, tips to safely manage pain and information on available data and resources on opioid use.
- Development of awareness programs about deadly drug interactions from certain regimens with no legitimate medical rationale.
- Coordination of drug usage reviews and research to alert physicians before patients take a combination of opioids and other medications that can lead to fatal overdose. After six months of working with doctors, we've seen a nearly 51 percent reduction in Blue Cross members taking both opioid and benzodiazepine drugs.

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## New work group addresses health and health care disparities

Blue Cross Blue Shield of Michigan has formed a Health Disparities Action Team led by Diversity and Inclusion to support its social mission to increase access to affordable health care, enhance the quality of care patients receive and improve the health of Michigan’s citizens and communities.

“Helping to address health and health care disparities is a key objective of the Diversity and Inclusion Corporate Strategic Plan,” said Bridget Hurd, senior director, Diversity and Inclusion. “Promoting health equity and cultural competency in the delivery of health care is essential to achieving positive health outcomes for our members. The Health Disparities Action Team evaluates how we can impact health outcomes through our policy and programs.”

The cross-functional action team focuses on:

- Detecting and monitoring known health and health care disparities, and distinguishing what can be effectively addressed

- Implementing policies and programs that address the health and health care disparities among African-American members, other minority ethnicities and members of the LGBTQ community
- Influencing members to make healthy lifestyle choices and engage in regular preventive screenings
- Partnering with stakeholders to provide education and information to members

“Understanding the health and health care disparities of our diverse members is very important. Not only is it the right thing to do but it is also important from a business point of view,” said Dr. Marc Keshishian, senior vice president, chief medical officer, Blue Care Network and Blue Cross Blue Shield of Michigan vice president, Health and Clinical Affairs. “Understanding and responding to the health and health care needs of diverse cultures and communities makes people feel welcomed in the health care system and opens the door for obtaining care at the right time, in the right place and in the right way. As a result, we are able to improve everyone’s health and health outcomes, which leads to lower costs for all of us.”

The work team has a shared vision that includes building upon and leveraging existing Blue Cross and BCN policies and programs to effectively address health disparities.

Measures of success for the work of the Health Disparities Action Team include annual data collection; identification of disparities and focus areas; implementation, measurement, review, and evaluation of existing programs to ensure clear goals and measures; coalition-building of internal and external stakeholders and internal awareness of programs; and a comprehensive approach to addressing health and health care disparities.

Data collection and analysis conducted during the past year show disparities in preventive screenings, emergency department visits and hospital readmission within 30 days. Throughout 2018, the action team will initiate action items to address these disparities.



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## Direct reimbursement available to limited licensed psychologists and licensed marriage and family therapists beginning June 1, 2018

Starting June 1, 2018, limited licensed psychologists and licensed marriage and family therapists will have the opportunity to participate as Blue Care Network providers. Participating LLPs and LMFTs can receive direct reimbursement for covered behavioral health services within the scope of their licensure.

BCN is allowing LLPs and LMFTs to enroll as part of a group starting in March 2018.

In March, the enrollment forms and contract documents will be available at [bcbsm.com/providers](http://bcbsm.com/providers). Complete these steps:

1. Click *Join our network*.
2. Click **Provider Enrollment Forms**.

Specific qualification requirements will be identified within each agreement. We'll share more detailed enrollment instructions in an upcoming newsletter.

All applicants must pass a credentialing review prior to participation. We'll notify applicants in writing of their approval status.

LLPs and LMFTs who practice in a substance abuse/outpatient psychiatric clinic setting may continue to do so and do not have to go through any additional application process. As a reminder, marriage counseling is not a covered benefit for BCN members, but LMFTs may provide other covered behavioral health services within the scope of their licensure. In addition, the clinical supervision requirements for LLPs aren't changing.

An updated version of the **Requirements for providing behavioral health services to BCN members** will be available on the web in the spring of 2018. This document provides guidelines for various types of BCN behavioral health providers. It's located in the BCN section at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Click *BCN* and then click *Behavioral Health*. Scroll down and click to open the document under the "Other resources" heading.

Information will also be provided in the spring of 2018 about how to transition authorizations for services by these practitioners.

### Network guidelines for member access

All Blue Care Network members should have appropriate and timely access to their practitioners. The following established guidelines for member access to care serve as BCN quality indicators:

<b>Access to primary care</b>	<ul style="list-style-type: none"> <li>• Regular and routine care – 30 days</li> <li>• Urgent care – 48 hours</li> <li>• After-hours care – 24 hours a day, 7 days a week</li> </ul>
<b>Access to behavioral health care</b>	<ul style="list-style-type: none"> <li>• Non-life-threatening emergency – 6 hours</li> <li>• Urgent care – 48 hours</li> <li>• Initial visit for routine care – 10 business days</li> <li>• Follow-up routine care – within 30 days of request</li> </ul>
<b>Access to specialty care</b>	<ul style="list-style-type: none"> <li>• High-volume specialist:                             <ul style="list-style-type: none"> <li>Ob-GYN - Regular and routine care – 30 business days</li> <li>- Urgent care – 48 hours</li> </ul> </li> <li>• High-impact specialist:                             <ul style="list-style-type: none"> <li>Oncology - Regular and routine care – 30 business days</li> <li>- Urgent care – 48 hours</li> </ul> </li> </ul>

For more detailed information, see the Access to Care chapter in the *BCN Provider Manual*, located on web-DENIS.

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## Clinical review decisions are based solely on appropriateness of care

Utilization decisions regarding care and service are based solely on the appropriateness of care prescribed in relation to each member's medical or behavioral health condition.

Blue Care Network's clinical review staff doesn't have financial arrangements that encourage denial of coverage or service that would result in underutilization. BCN-employed clinical staff and physicians don't receive bonuses or incentives based on their review decisions. Review decisions are based strictly on medical necessity within the limits of a member's plan coverage.



## Staff available to our members for UM issues

Did you know that we're available for our members (your patients) to discuss utilization management issues during and after normal business hours? Our staff members identify themselves by name, title and organization when receiving or returning calls. We also provide language assistance free of charge to discuss utilization management issues to our members. We offer TTY/TDD assistance for the hearing impaired. Please instruct your patients to call the number on the back of their member ID card for information about our communication services.

See also "Behavioral health providers may discuss decisions with BCN physician reviewers," **Page 28.**

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## Your patients may be surveyed about their experiences and satisfaction

We recognize that providing quality care is a collaborative effort between our plan and our health care providers — and we're committed to partnering with our providers to create a seamless care experience.

One measure of our members' care experience is the Consumer Assessment of Healthcare Providers and Systems, or CAHPS®, survey. This standardized survey of the patient experience of care, will be sent to a random sampling of our members — your patients — soon.

This survey is administered by the Centers for Medicare & Medicaid Services and used to help assess quality of care from a health plan member's perspective. The survey measures patient experiences over the past six months in areas including:

- Getting needed care
- Getting care quickly
- How well doctors communicate
- Health plan customer service
- How people rate their health plan

Research has shown that practices with a high level of patient satisfaction benefit in many ways:

- Patients who are highly satisfied are more loyal.
- Patients who are highly satisfied are more likely to adhere to treatment plans.
- Practices with high patient satisfaction have higher levels of employee satisfaction and less employee turnover.

We'll provide more details in future web-DENIS messages and newsletter articles.

## Clarification: We've made changes to the Ambulance Provider Participation Agreement

As noted in the June 2017 *Record*, Blue Cross Blue Shield of Michigan has a new ground and air Ambulance Provider Participation Agreement, which includes Blue Care Network. At this time, Blue Cross ambulance providers that did not sign the new agreement will not be affected by this change. These providers may continue to participate under the Blue Cross-only agreement. However, eventually, Blue Cross may phase out the Blue Cross-only agreement and solely have the joint Blue Cross and BCN agreement for those providers that wish to participate.



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## Complete your attestation through CAQH

As communicated in the last issue, Blue Cross Blue Shield of Michigan and Blue Care Network have transitioned from the PRIME Hub website to CAQH ProView for the quarterly attestation process.

Health care providers and practice managers should use CAQH to review and confirm their demographic data instead of going to the Atlas PRIME Hub website.

New and existing users can access the **CAQH ProView Provider portal** to register, log in and validate existing information in their CAQH account. If you haven't done so already, please create a CAQH account, validate your existing provider information that's listed in CAQH and continue to submit changes through the Provider Self Service tool.

The **CAQH website** has resources to help providers and practice managers use CAQH ProView. If you have questions or need support with completing your attestations, contact CAQH at 1-888-599-1771 or your provider consultant.

A video is now available explaining the new CAQH ProView Practice Location Reconciliation tool. Go to the **CAQH page** and look for the video on "Updating your practice locations in CAQH ProView."



The tool will be available on March 16.

Welcome to the CAQH ProView application



PROVIEW™

### CAQH ProView™

Welcome to CAQH ProView™, formerly the Universal Provider Datasource®.

**CAQH ProView is more than a credentialing database.** Available at no cost to you, CAQH ProView eliminates duplicative paperwork with organizations that require your professional and practice information for claims administration, credentialing, directory services, and more.

**Through an intuitive, profile-based design, you can easily enter and maintain your information for submission to your selected organizations.** Help reduce inquiries for your administrative information and save even more time by keeping your CAQH ProView profile complete and up-to-date. Ensure that the healthcare organizations you authorize have instant access to accurate, timely information.

**Sign in on the right to update your existing profile information or, if you are a new provider to CAQH ProView, register to create a profile.**

#### CAQH ProView Reference Material

- [Provider Quick Reference Guide](#)
- [Dentist Quick Reference Guide](#)
- [Provider User Guide](#)
- [Video: Single Sign-on for Dentists](#)
- [Video: Practice Location Reconciliation](#)
- [Video: Providers – Get Started with CAQH ProView](#)
- [Video: How to Log In for the First Time](#)
- [Video: I forgot my username/password](#)
- [Video: How to Upload Documents in CAQH ProView](#)
- [Video: Required Field Changes Part 1](#)
- [Video: PLI Changes and Address Standardization](#)
- [Video: Specialties Section Changes and NPI Validation](#)
- [Video: Changes to Practice Locations Section](#)
- [Video: Changes to Hospital Affiliations Section](#)

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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 on Friday, March 30 for Good Friday.

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

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

### Acute initial inpatient admissions

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

### Post-acute initial and concurrent admission reviews

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

### Other authorization requests

The types of requests listed below must be submitted by fax:

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

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

### Additional information

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

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

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

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

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

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## BCN medical directors are a resource for physicians

Plan medical directors work with affiliated practitioners and providers to ensure appropriate care and service for BCN members. Plan medical directors are available throughout the state. Our medical directors:

- Provide clinical support for utilization management activities, including investigation and adjudication of individual cases
- Assist in the design, development, implementation and assessment of clinical protocols, practice guidelines and criteria that support the appropriate use of clinical resources
- Adjudicate provider appeals
- Work with physicians and other health care providers to improve clinical outcomes, appropriate use of clinical resources, access to services, effectiveness of care and costs
- Serve as a liaison with the physician community

### Clinical review decisions are based solely on appropriateness of care

Utilization decisions regarding care and service are based solely on the appropriateness of care prescribed in relation to each member's medical or behavioral health condition. BCN's clinical review staff doesn't have financial arrangements that encourage denial of coverage or service that would result in underutilization. BCN-employed clinical staff and physicians don't receive bonuses or incentives based on their review decisions. Review decisions are based strictly on medical necessity within the limits of a member's plan coverage.

### Providers may discuss decisions with BCN physician reviewers

Blue Care Network demonstrates its commitment to a fair and thorough process of determining utilization by working collaboratively with its participating physicians.

BCN's plan medical directors may attempt to contact the treating health care practitioner for additional information about any review deemed necessary. When BCN

doesn't approve a request, we send written notification to the appropriate practitioners and providers, and the member. The notification includes the reason the service wasn't approved as well as the phone number to contact BCN's plan medical directors to discuss the decision.

If you're a practitioner and would like to discuss your patient's condition or treatment with one of our plan medical directors, call 248-799-6312 from 8:30 a.m. to 5 p.m. Monday through Friday. To discuss an urgent case with one of our plan medical directors after normal business hours, call 1-800-851-3904.

### How to obtain a copy of utilization management criteria

Upon request, Blue Care Network provides the criteria used in the decision-making process. Call Care Management at 248-799-6312, from 8:30 a.m. to 5 p.m. Monday through Friday.

Due to licensing restrictions, BCN can't distribute complete copies of the InterQual® criteria to all practitioners and providers. However, all contracted hospitals have the electronic version of the criteria as part of BCN's licensing agreement.

### Staff available to our members for utilization management issues

Did you know that we're available for our members (your patients) to discuss utilization management issues during normal business hours and after hours? Our staff identifies themselves by name, title and organization when receiving or returning calls. We also provide language assistance free of charge to discuss utilization management issues to our members. We offer TTY/TDD assistance for the hearing impaired. Please instruct your patients to call the number on the back of their ID card for information about our communication services.



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## Tell us what you think about our provider manuals – you could win a prize!

Blue Cross Blue Shield of Michigan and Blue Care Network have several provider manuals. Here's how to find them:

1. Go to **bcbsm.com** and log in to Provider Secured Services.
2. Click on *Provider Manuals* (lower right side of page).

You can also click on *Provider Manuals* within web-DENIS.

We want our provider manuals to be easy for you to use, so you can find the information you need quickly. As part of our continuing effort to improve service to you, we would like your opinion on our provider manuals. Can you spare five minutes to take an online survey? Your input will give us insight into which manuals you use and how we can improve them.

Please complete the **online survey** by **April 30**. You could win a **\$25 gift certificate**.

Participation in the survey is not necessary to win. The drawing is open to all active Blue Cross or BCN providers. Enter by completing the survey no later than April 30, 2018, or by sending an e-mail with your name, phone number and "Survey drawing" in the subject line to [ProviderOutreach@bcbsm.com](mailto:ProviderOutreach@bcbsm.com) by April 30, 2018.

All entries must be received by April 30, 2018. One winner will be selected in a random drawing from among all eligible entries. The winner will receive a \$25 gift card. The drawing will take place by May 4, 2018. The winner will be notified by telephone or email following the drawing.



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## Get ready for annual visits for your Medicare Advantage patients

Now that we're embarking on a new year, you'll start seeing new and existing BCN Advantage patients for their "Welcome to Medicare" visits, annual wellness visits or routine physical exams. To help you prepare, we want to share this important information about these different visits:

- New BCN Advantage members should be scheduling their "Welcome to Medicare" preventive visit, also known as the initial preventive examination, and their routine physical exams.
- Existing BCN Advantage members should begin scheduling their annual wellness visit and their routine physical exams.

### Welcome to Medicare visit

The "Welcome to Medicare" preventive visit is sometimes referred to as the initial preventive examination. This is a one-time appointment for new Medicare patients to be scheduled within their first 12 months of enrollment. Medicare pays for one visit per member, per lifetime.

This visit is a great way to get up-to-date information on health screenings, shot records, family medical history and other preventive care services for your patients. These visits can be scheduled at the same time or coordinated with the patient's routine physical exam to get the best picture of your patient's health.

The "Welcome to Medicare" visit will include a health risk assessment and self-reported information from your patient to be completed before or during the visit. For more information about health risk assessments, visit [Framework for Patient-Centered Health Risk Assessments](#) on the Centers for Disease Control and Prevention website.

During the "Welcome to Medicare" visit, you should:

- Perform a health risk assessment
- Record your patient's medical and social history (like alcohol or tobacco use, diet and activity level)
- Check height, weight and blood pressure
- Calculate body mass index
- Perform a simple vision test

- Review potential risk for depression and patient level of safety
- Offer to talk about creating advance directives
- Educate the patient on preventive services needed and prescribe appropriate services
- Create a screening schedule (checklist) for appropriate preventive services

**Billing code for "Welcome to Medicare" visit, also called initial preventive physical examination**

G0402

### Annual wellness visit

The annual wellness visit is a chance for you to develop or update your patient's personalized prevention plan based on his or her current health situation and risk factors. Health risk assessments are also part of the annual wellness visit. The assessment includes self-reported information from your patient to be completed before or during the visit.

Medicare will cover an annual wellness visit every 12 months for patients who've been enrolled in Medicare for longer than 12 months. Patients can schedule their annual wellness visit on the same day or coordinate it with their routine physical exam (next page) to help give you a complete view of their health.

Services at the annual wellness visit include:

- Health risk assessment
- Review of medical and family history
- Develop or update a list of current providers and prescriptions
- Height, weight, blood pressure and other routine measurements
- Detection of any cognitive impairment
- Personalized health advice
- A list of risk factors and treatment options
- Education on preventive services needed and prescribe appropriate services

Please see [MA annual visits](#), continued on Page 15



**MA annual visits**, *continued from Page 14*

- A review and update of the screening schedule (checklist) for appropriate preventive services

**Billing codes for annual wellness visits, which include a personalized prevention plan of service**

G0438 — First visit AWW, can only be billed one time, 12 months after a G0402 (IPPE)

G0439 — Annual wellness visit (subsequent)

Note: G0438 or G0439 must not be billed within 12 months or previous billing of a G0402 (IPPE)

**Routine physical exam**

The routine physical exam is typically covered annually by the patient’s Medicare Advantage health care plan. These exams are part of preventive services that aren’t part of the “Welcome to Medicare” visit or annual wellness visit.

Routine physical exams are used to get information about the patient’s medical history, family history and perform a head-to-toe assessment with a hands-on examination to assess your patient’s health, address any abnormalities or signs of disease. Routine physical exams should include the following:

- A visual inspection
- Palpitation
- Auscultation
- Manual examination

**Billing codes for annual exams or physicals**

**New patient**

\*99386 (40-64 years old)

\*99387 (65 years and older)

**Established patient**

\*99396 (40-64 years old)

\*99397 (65 years and older)

**Care plans**

These preventive visits are an excellent opportunity for you and your patients to plan their care for the year. Care plans should include a schedule for preventive services and health screenings, many of which are required annual services to meet Healthcare Effectiveness Data and Information Set, commonly known as HEDIS® specifications.

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

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

You’ll need to recommend and prescribe — or refer your patient — needed preventive services that apply to his or her care plan. Some examples of preventive services include:

- Colon cancer screening
  - FOBT yearly
  - Sigmoidoscopy every five years
  - Colonoscopy every 10 years
  - Cologuard® every three years
- Breast cancer screening
  - Mammography every two years
- Osteoporosis testing in older women
  - Bone mineral density testing in women ages 65-85 every two years
- Comprehensive diabetes care
  - A1c blood sugar screening — two to four times per year
  - Urine microalbumin screening — yearly
  - Retinal eye exam — every other year if negative or every year if positive

These visits also provide a great opportunity to review or create a risk assessment for your patients, including a full list of their long-term chronic conditions. This will help your patients take advantage of disease and care management programs, as well as prevention initiatives.

This visit benefits both you and your patient by:

- Uncovering care management opportunities
- Identifying practice patterns
- Managing patient medications better
- Reducing avoidable hospital admissions

For more information on risk adjustment and HEDIS best practices, refer to our online provider manuals.

Note: BCN Advantage only reimburses one evaluation and management code on a date of service.

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## Reminder: CMS transitioning to new fraud-protected Medicare card

As you read in the **September Record** and the September-October **BCN Provider News**, the Centers for Medicare & Medicaid Services is taking steps to remove Social Security numbers from Medicare cards. This initiative will help prevent fraud, fight identity theft and protect essential program funding, as well as the private health care and financial information of Medicare beneficiaries.

CMS will issue new Medicare cards with a new unique, randomly-assigned number called a Medicare Beneficiary Identifier to replace the existing Social Security-based Health Insurance Claim Number — both on the cards and in various CMS systems. **Keep in mind that your systems must be able to accept the new MBI format by April 2018.**

CMS will start mailing cards to Medicare recipients in April 2018. All Medicare cards will be replaced by April 2019.

### Provider ombudsman announced

CMS recently named Dr. Eugene Freund as the provider ombudsman for the new Medicare card. He will:

- Serve as a CMS resource for the provider community
- Ensure that CMS hears and understands any implementation problems experienced by clinicians, hospitals, suppliers and other providers
- Communicate about the new Medicare card to providers
- Help develop solutions to any implementation problems that may arise

To reach the ombudsman, contact: [NMCPProviderQuestions@cms.hhs.gov](mailto:NMCPProviderQuestions@cms.hhs.gov).

For more information, visit the **CMS** website.

## Amerigroup is not affiliated with Blue Cross Blue Shield of Michigan or Blue Care Network

If you recently received an invitation from Amerigroup Michigan, Inc., an Anthem, Inc. company, to participate in Amerigroup's Medicare Advantage provider network, please note the following:

- While Amerigroup is a subsidiary of Anthem, Inc., it does not offer Blue Cross or Blue Shield branded products or services.
- Amerigroup's Medicare Advantage offering and provider network is not affiliated in any way with Blue Cross Blue Shield of Michigan or Blue Care Network and is not part of the Blue Cross and Blue Shield Association's BlueCard Program.
- Claims, provider inquiries, and member servicing for Amerigroup will not be handled by Blue Cross or BCN.

If you have additional questions, the invitation document contains Amerigroup's contact information.

# Patient Care

## Making the case for medication-assisted treatment

By Dr. Kristyn Gregory



Addiction is a chronic disease, one characterized by compulsive use despite harmful consequences and relapse. However, relapse doesn't mean that the treatment did not work. As with other chronic health conditions, treatment generally isn't a cure. Those in recovery will be at relapse risk for years, possibly for life. Successful treatment and management may include medications, much like other chronic health conditions, such

as diabetes or hypertension, in addition to lifestyle changes and improved health habits.

In the battle against opioid abuse and addiction, there are evidence-based prevention and treatment strategies designed to help people recover and regain control of their lives. Tragically, these are highly underutilized throughout the United States, which prompted an initiative by the Secretary of Health and Human Services in 2015 to address the problem of opioid use.

This initiative emphasizes **preventive measures** like health care provider education in appropriate opioid-prescribing, increasing availability and access to naloxone, and wider implementation of evidence-based treatment strategies. Combined, these strategies all have a role in combatting the **opioid epidemic** affecting Michigan and the rest of the country.

### A unique approach

**Medication-assisted treatment**, or MAT, combines behavioral therapy and medications to treat substance use disorders. Methadone, buprenorphine and naltrexone are effective medications used to treat opioid use disorders. While these medications could assist many in recovery and have been shown to reduce mortality, they remain underutilized. Overcoming barriers, such as limited number of trained prescribers, and common misperceptions regarding these medications, is an essential part of fighting the opioid epidemic.

While relapse is a normal part of the recovery process, it can also be a time of increased risk for fatal overdose. The period following detoxification is one of elevated risk if the person returns to drug use. Maintaining abstinence using medications that reduce withdrawal and cravings, without producing the euphoria, can reduce the risk of a potentially fatal relapse in this period.

Because methadone and buprenorphine are themselves opioids, many assume that utilizing them in recovery is just replacing one addiction for another. Unfortunately, this belief has contributed to low access and utilization of medication-assisted treatment. However, when prescribed and monitored properly, these treatments have proven effective in helping patients recover. They have been shown to be safe and cost effective and reduce the risk of overdose. Aside from their clinical effectiveness, medication-assisted treatments also allow for patients to regain a sense of normalcy and functionality in their lives, often by decreasing criminal activity associated with substance abuse disorders, increasing patients' ability to secure and maintain employment and even improving birth outcomes for pregnant women who have substance use disorders.

Please see [From the medical director](#), continued on Page 18

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From the medical director, continued from Page 17

## Buprenorphine and methadone

Methadone is a synthetic full mu-opioid agonist that can reduce or eliminate cravings, control physiological withdrawal and prevent the euphoria from the use of other mu agonists. It has a long half-life and is dosed daily when used for opiate maintenance treatment. It is *dispensed*, not prescribed, from an opioid treatment program, or OTP. OTPs are subject to both federal and state regulations and initially require patients to have daily observed dosing. When certain criteria are met, the patient may have gradual increase in abilities to have “take-home doses” and self-administer them at home. When used for opioid maintenance, methadone must be dispensed from an OT; program physicians are required to be either board-certified in addiction medicine or a psychiatrist.

Buprenorphine is an opioid partial agonist that is effective for the treatment of opioid use disorder. Like methadone, it can reduce or eliminate cravings and control withdrawal. Unlike methadone, it can be prescribed outside of an opioid treatment program. Under the **Drug Addiction Treatment Act of 2000**, or DATA, any physician can apply for a waiver to treat 30 to 100 patients in the office. Physicians are required to complete an eight-hour course, which is free through multiple avenues and can be completed on line. There’s a shortage of providers, and increasing the number of providers is a key element in increasing access to medication-assisted treatment.

Buprenorphine comes in an oral tablet or sublingual formulation; buprenorphine/naloxone preparations reduce the risk of misuse by injection. Generally, the oral formulations are taken one to two times a day for maintenance. In addition, there have been recent U.S. Food and Drug Administration approvals of longer acting formulations — a six-month subdermal implant (Probuphine®) which was FDA-approved in 2016 and a monthly subcutaneous formulation, Sublocade™, approved in November 2017. Any of these formulations may be prescribed by a DATA- waived physician. The longer acting formulations have the potential to reduce the risk of diversion and provide lengthier periods of recovery.

## Naltrexone

Naltrexone is an opioid antagonist that works by blocking the activation of opioid receptors. Instead of controlling withdrawal and cravings, it treats addiction by preventing any opioid drug from producing rewarding effects. It can be prescribed without a DATA waiver, and does not require dispensing in an OTP. Naltrexone is also used to reduce cravings for alcohol. Naltrexone comes in an oral tablet formulation, as well as an injectable monthly long acting formulation, Vivitrol. Because it is not an opiate agonist, it does not carry the risk of diversion associated with the agonist medication-assisted treatment. However, it requires a more extensive period off any opiate medication, generally seven to 10 days, to avoid a precipitated withdrawal. Like the agonist medications, it has been shown to reduce the risk of relapse and increase time in recovery.

## A holistic approach

The success of medication-assisted treatment is partly due to its integrated approach to recovery. It is a single component of a more complex treatment plan that involves regular counseling, behavioral therapies and collaboration of patient and provider. We can join the fight in this epidemic by increasing access, reducing barriers and challenging negative stigma of addiction.

### References

Drug Overdose Data Deaths <https://www.cdc.gov/drugoverdose/data/statedeaths.html>

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths. ASPE. <https://aspe.hhs.gov/basic-report/opioid-abuse-us-and-hhs-actions-address-opioid-drug-related-overdoses-and-deaths> Published November 23, 2015

The American Society of Addiction Medicine. *Advancing Access to Addiction Medications*. [http://www.asam.org/docs/default-source/advocacy/aaam\\_implications-for-opioid-addiction-treatment\\_final](http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final)



# Checklists for opioid prescribing

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By Manveen Saluja, M.D.FACP

*Dr. Manveen Saluja is a clinical associate professor at Wayne State University, assistant professor of medicine at Oakland University William Beaumont School of Medicine and a board-certified rheumatologist.*

Initial evaluations and follow-up are important when prescribing an opioid to a patient. Following specific office protocols and using a checklist can help avoid overdose and prevent drug diversion.

### Initial evaluation before starting opioids

- Consider opioid therapy only if the expected benefits for both pain and function are anticipated to outweigh risks to the patient. Confirm non-drug therapy and non-opioid medications have been tried and optimized.
- Assess risk of dependence and potential harm. Consider the following:
  - Screen for risk of dependence using an instrument such as SOAPP-R or ORT.
  - Obtain a Prescription Drug Monitoring Program report, for example, MAPS.
  - Obtain a urine drug screen to determine concurrent substance use.
  - Conduct a mental status examination as these medications can cause drowsiness and impair cognitive function.
- Conduct standard elements of pain assessment on all new and established patients including the PEG scale. Tracking the PEG scale throughout therapy can help avoid inappropriate dose escalation and lead to conversations about dose tapering.
- Avoid prescribing opioids with benzodiazepines, muscle relaxants or hypnotics due to high risk of death. Counsel patients on current alcohol use.
- Prescribe the lowest effective dose of immediate-release opioids and no greater quantity than needed for the

expected duration; if acute pain, three days or fewer is sufficient for most cases.

- There is no safe lower limit of dose or duration for opioid use. After seven days of use, the risk of chronic use rises three to four-fold.

- Consider using a controlled substance agreement with the patient to outline concurrent drug use, periodic monitoring (MAPS, urine screens) including the office refill policy.

### When considering long-term opioid therapy (Adults with chronic pain $\geq$ three months, excludes cancer and palliative care)

- Set realistic goals for pain and function based on diagnosis (for example, ability to perform daily functions).
  - Assess pain and function (for example, **PEG scale**) at baseline and throughout therapy.
- Use opioids as part of a pain management plan that includes non-drug and non-opioid therapies, as appropriate.
- Discuss benefits, risk factors and potential harm (addiction, overdose) with your patient.
- Evaluate misuse; consider re-checking MAPS and a urine drug screen.
- Set criteria for stopping or continuing opioids.
- Schedule initial reassessment within one to four weeks.

Please see [Opioid checklist](#), continued on Page 20

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## Opioid checklist, continued from Page 19

## Assessment at return visit

- Continue to re-assess pain and function (for example, PEG scale) and compare results to baseline.
  - Improvement in pain and function of at least 30 percent as compared with the start of treatment or in response to a dose change. *(A decrease in pain intensity in the absence of improved function is not considered meaningful improvement except in very limited circumstances such as catastrophic injuries, including multiple trauma or spinal cord injury.)*
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk. Taper as necessary.
  - Check MAPS.
  - Check for opioid use disorder if indicated (difficulty controlling use). Refer for treatment if needed.
- Determine whether to continue, adjust, taper or stop opioids.
  - Calculate opioid dosage morphine milligram equivalent (MME).
  - If  $\geq 50$  morphine milligram equivalents /day total, increase frequency of follow-up; consider offering naloxone with overdose prevention education to your patient and caregivers. Consider specialist referral when factors that increase risk for harm are present, such as:
    - History of overdose
    - History of substance use disorder
    - Higher dosages of opioids ( $\geq 50$  MME/day)
    - Concurrent use of benzodiazepines with opioids
    - Avoid  $\geq 90$  MME /day total, or carefully justify; consider specialist referral.
  - Schedule reassessment at regular intervals ( $\leq$  three months).
    - If renewing without a patient visit, make sure you schedule a return visit less than or equal to three months from the last visit.

50 MME/day = Total daily dose:

- 50 mg/day of hydrocodone
- 33 mg/day of oxycodone

90 MME/day = Total daily dose:

- 90 mg/day hydrocodone
- 60 mg/day oxycodone

## Additional tips to consider:

- Avoid providing early refills for lost or stolen prescriptions.
- Require face-to-face visits based on the patient's level of risk.
- Prescribe opioids electronically, if possible.

Sources:

Parchman ML, Von Korff M, Baldwin LM, et al. Primary care clinic re-design for prescription opioid management. J Am Board Fam Med 2017;30:44-51

<https://www.cdc.gov/drugoverdose/prescribing/guideline.html><http://www.mqic.org/guidelines.htm>



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## Choosing Wisely – Imaging tests often unnecessary for low back pain

Low back pain is a common problem for many adults. In fact, as many as 80 percent of all adults will have low back pain at some point in their lifetime, according to the National Institute of Neurological Disorders and Stroke. It is the most common cause of job-related disability and a leading contributor to missed work days.

### Causes of low back pain

The most common causes of low back pain are muscle strains and sprains. These injuries often happen from improper lifting, twisting or overstretching.

In many cases, low back pain will get better on its own after a few days or weeks without the need for any imaging tests, such as an X-ray, MRI or CT scan, unless they've had:

- Back pain for longer than six weeks
- Weight loss
- Fever
- Loss of bladder or bowel control
- Loss of feeling or strength in your legs
- Problems with reflexes
- History of cancer

### Treatments for low back pain

In most cases, self-care and medicines are all that's required to treat low back pain. If these treatments don't relieve your patient's pain, he or she may need another type of treatment.

- **Heat or ice.** Hot or cold packs can help reduce swelling and relieve pain.
- **Rest.** A day or two of rest may be good for back pain, but more than this may cause more harm than good. Instruct your patients to try lying on their back with pillows propped up under their knees to relieve pressure on the back.



- **Exercises, physical therapy or massages.** Prescribing specific exercises to help stretch and strengthen the back muscles may also be helpful as well as a physical therapy program or massages.
- **Pain relievers.** You may want to suggest starting with over-the-counter medicines to help relieve the pain and inflammation of low back pain. These include nonsteroidal anti-inflammatory drugs like ibuprofen, naproxen sodium and ketoprofen. If NSAIDs don't help, stronger pain relievers may be necessary.
- **Surgery.** This may be an option if other treatments don't work. In most cases, surgery is only used to repair serious injuries or relieve a compressed nerve.

As we've discussed in previous issues of the *BCN Provider News*, *Choosing Wisely* is a great place to look for information on health topics. The organization has valuable information on treating low back pain and imaging tests for low back pain. Please visit [choosingwisely.org](http://choosingwisely.org) for more information.

*Choosing Wisely is an initiative of the American Board of Internal Medicine Foundation that aims to promote conversations between physicians and patients to discuss medical tests and procedures that may be unnecessary and, in some instances, can cause harm.*

*To assist in these conversations, several specialty societies have created lists of "Things Physicians and Patients Should Question" — evidence-based recommendations that should be discussed to help make wise decisions about the most appropriate care based on your individual situation.*

References:  
National Institute of Neurological Disorders and Stroke  
[Choosing Wisely](http://choosingwisely.org)

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## Online health assessment helps your patients identify their health risks

Looking for a tool that can help your patients pinpoint their health risks? Then the Blue Cross Blue Shield of Michigan and Blue Care Network online health assessment on the Blue Cross® Health & Wellness website can help. It gives our members an easy way to see how their lifestyle choices affect their health and helps them learn about their modifiable health risks.

When your patients with BCN coverage take the health assessment, they receive immediate feedback. A report explains their risk levels and makes recommendations so they can take action. The assessment also gives them a health risk score to encourage positive changes. Members can print this information to share with you so you can work with them to lower those risks.

The health risk score your patients receive is derived from an analysis of their modifiable health risks. These include:

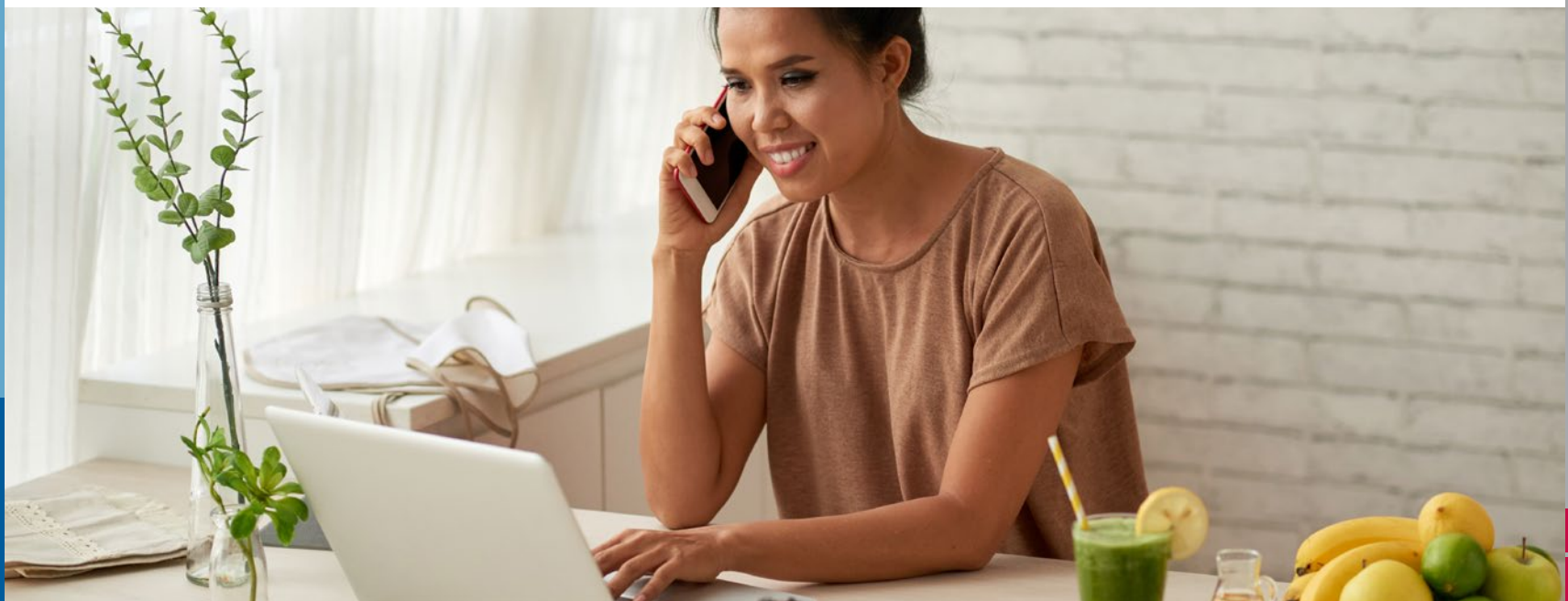
- Alcohol use
- Blood pressure
- Blood sugar
- Cholesterol
- Emotional health
- Exercise
- Nutrition
- Sleep
- Stress
- Tobacco use
- Weight

The Blue Cross health assessment uses engaging graphics and easy-to-read questions that guide members through a series of modules that assess various aspects of their lifestyle, health conditions and well-being. It also asks questions that assess a member’s readiness to make changes. Members are asked to input various biometric screening results; For BCN members who use the qualification form, their test results automatically upload into the health assessment.

### Fast and easy to use

The health assessment only takes a few minutes to complete, and it’s intuitive and user-friendly. Your patients with BCN coverage can take the health assessment on their computers or mobile devices through their member account at [bcbsm.com](http://bcbsm.com) or they can take it using the Blue Cross mobile app. The Blue Cross health assessment is powered by WebMD® and NCQA-accredited.

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



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## March is Kidney Month

To raise awareness and promote kidney health, the National Kidney Foundation has designated March as National Kidney Month.

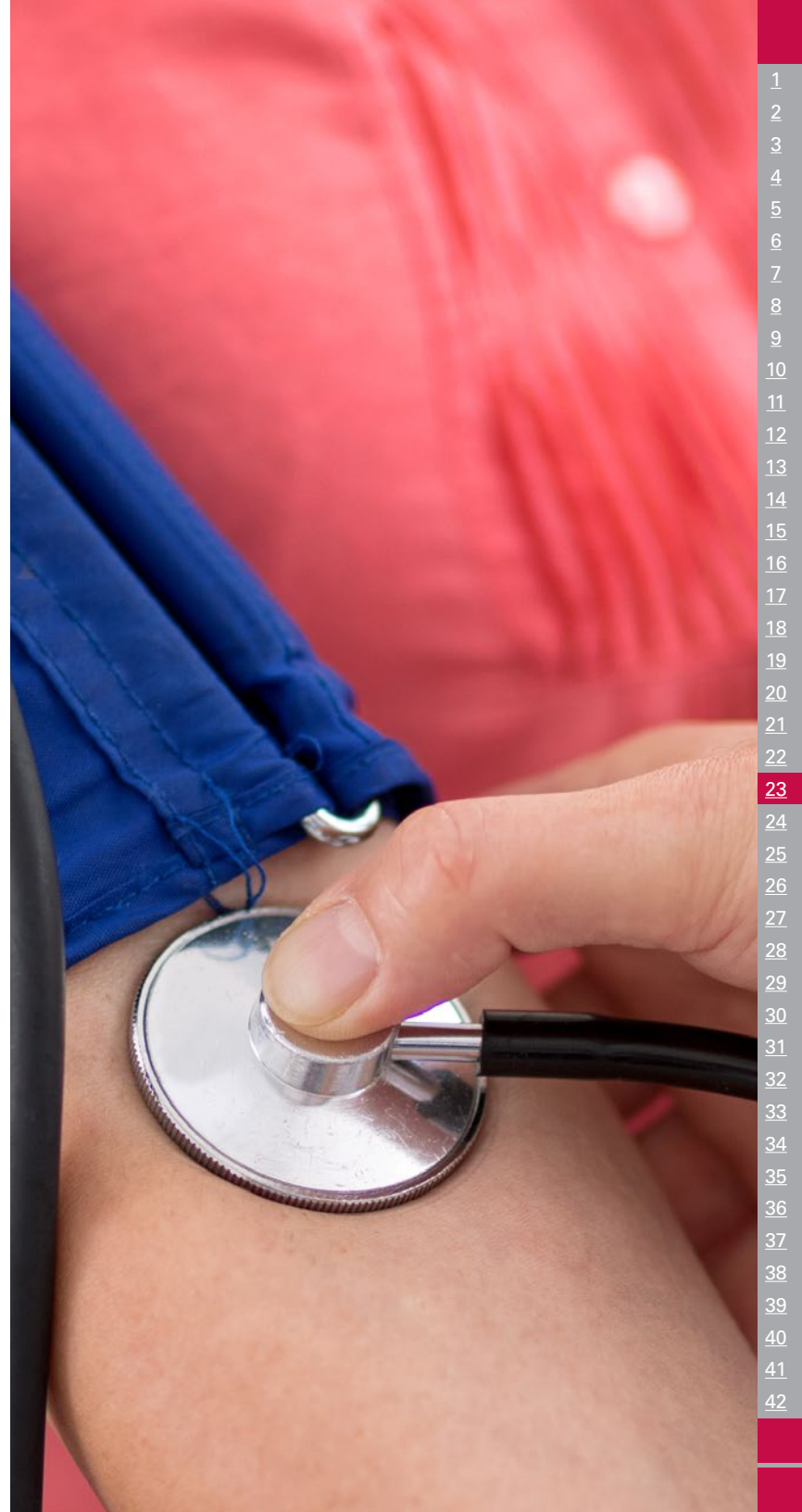
People with diabetes, high blood pressure and family history of kidney disease are at risk of developing chronic kidney disease. African Americans, Hispanics and senior citizens have a much higher risk of developing CKD.

You can do your part by monitoring the blood pressure of diabetic and hypertensive members and evaluating their kidney function annually by performing tests such as urine albumin and glomerular filtration rate. You can also encourage healthy lifestyle changes pertaining to diet, exercise and symptom management, such as a stable hemoglobin A1C and cholesterol level.

For more information regarding kidney disease, check the [National Kidney Foundation](#) website.

We want to stress the importance of educating your at-risk patients about CKD. Through early detection and member education, you can help slow progression of the disease as well as minimize the severity of other associated medical conditions, such as heart disease and stroke.

For additional information regarding [CKD guidelines](#) refer to the Michigan Quality Improvement Consortium guidelines.



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## Criteria corner

Blue Care Network uses McKesson's InterQual Level of Care criteria when conducting admission and concurrent review activities for inpatient care. To ensure that providers and health plans understand the application of the criteria and Local Rules, BCN provides clarification from McKesson on various topics

### Interpreting symbols: Greater than or equal to

*In all subsets, when a greater than or equal to sign is associated with the frequency of an intervention, what is the correct interpretation or application of the criteria?*

This frequency indicator covers services provided greater than or equal to every x hours, depending upon the time specified. For example, greater than or equal to 6x/24h should be interpreted as the service is provided at least six times in 24 hours or more than six times in 24 hours. This would be inclusive of more frequent services, such as those occurring every five hours or more frequently, every four hours or more frequently. Confusion sometimes arises when a physician orders a treatment frequency of q.i.d. (four times a day). In this instance, it is acceptable for the reviewer to convert the frequency to every six hours.

### Interpreting symbols: Slash marks (/)

*How are slash marks (/) interpreted in the InterQual® Level of Care Criteria?*

When interpreting InterQual criteria, the slash mark is read as either "or" or "per" depending on how it appears in the criteria. The slash mark means "per" when there are no spaces before or after the slash mark. For example, "3x/24h" should be interpreted as "3x per 24h". The slash mark means "or" when there is a space before and after the slash mark. For example, "Antireflux surgery / Hiatal Hernia Repair" should be interpreted as "Antireflux surgery" or "Hiatal Hernia Repair."

When criteria points are more complex, the case type (upper- vs. lower-case letters) assists the reviewer in interpreting the criteria, as indicated in the following example:

Example: "Craniotomy: Biopsy of brain tumor / metastases." Because the first letters after the slash are in lower case, the correct interpretation of this criterion is "Craniotomy: Biopsy of brain tumor" or "Craniotomy: Biopsy of brain metastases."

### Interpreting symbols: Asterisk (\*) in the Guidelines for Surgery and Procedures in the Inpatient Setting

BCN has a local rule that states:

BCN criteria classify procedures on the InterQual Inpatient surgery list that are followed by a single asterisk (\*) as outpatient procedures except when the procedure is on the CMS inpatient only list and the member is a BCN Advantage member.

- BCN criteria classify all other procedures on the InterQual inpatient list as inpatient procedures.
- BCN criteria classify procedures deemed by CMS as inpatient procedures to be inpatient procedures for BCN Advantage members only.

#### Example — Appendectomy\*:

- Appendiceal abscess
- Appendiceal phlegmon
- Perforated appendix

### Procedures known by other names in the Guidelines for Surgery and Procedures in the Inpatient Setting

When a procedure is also known by another name, or if a different procedure will produce the same result, the additional procedure name is italicized and indented beneath the original. For example: "Total Joint Replacement (TJR), Hip" is also known as "*Arthroplasty, Total, Hip.*"

#### Another example — Antireflux Surgery / Hiatal Hernia Repair:

- *Belsey's Wrap*
- *Collis Gastroplasty*
- *Dor Fundoplication*
- *Hill's Gastropexy*
- *Laparoscopic Fundoplication*
- *Nissen Fundoplication*
- *Open Fundoplication*
- *Rossetti Fundoplication*
- *Thal-Nissen Repair*
- *Toupet Fundoplication*

## Twice-yearly Drug Take Back Day events help battle opioid crisis



Americans nationwide did their part to reduce the opioid crisis as part of the 14th Prescription Drug Take Back Day on Oct. 28. The Drug Enforcement Administration announced that a record-setting 912,305 pounds — 456 tons — of potentially dangerous expired, unused, and unwanted prescription drugs were

turned in for disposal at more than 5,300 collection sites.

That's almost six tons more than was collected at last spring's event. This brings the total amount of prescription drugs collected by the DEA since the fall of 2010 to 9,015,668 pounds, or 4,508 tons.

As the state's largest health insurers, Blue Cross Blue Shield of Michigan and Blue Care Network have supported the DEA's Drug Take Back Day since 2011.



National Prescription Drug Take Back Day events continue to remove ever-higher amounts of opioids and other medicines from the country's homes, where they could be stolen and abused by family members and visitors, including children and teens.

"More people start down the path of addiction through the misuse of opioid prescription drugs than any other substance," said DEA Acting Administrator Robert W. Patterson. "The abuse of these prescription drugs has fueled the nation's opioid epidemic, which has led to the highest rate of overdose deaths this country has ever seen."

The DEA's next Drug Take Back Day is April 28, 2018, so mark your calendar.

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## 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

- Intensive cardiac rehabilitation
- Intravenous anesthesia for chronic pain, depression and other mood disorders
- Patient-specific cutting guides and custom knee implants
- Transmyocardial (periventricular) closure of ventricular septal defects

### Covered services

- Genetic testing-chromosomal microarray testing for the evaluation of early pregnancy loss and intrauterine fetal demise
- Magnetic resonance imaging for detection and diagnosis of breast cancer
- Prostatic urethral lift procedure for the treatment of BPH



*Medical Policy Updates*

# CDC offers opioid training for providers



The Centers for Disease Control and Prevention offers web-based **training** to help providers gain a deeper understanding of the CDC’s opioid prescribing guideline. Continuing education credits are available.

The web-based training features self-paced learning and case-based content.

The CDC also offers a webinar series that applies the CDC Guideline in a primary care practice setting from CDC and University of Washington experts. Archived webinars include slides, real case examples and question-and-answer sessions.

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# University of Michigan offers online course about the opioid crisis

The University of Michigan is offering an online course, “Solving the Opioid Crisis,” through its Teach-Out program. Registration starts March 5 and will be available for three weeks.

Teach-Outs are short learning experiences, each focused on a specific current issue. In this Teach-Out, experts from the fields of Medicine, Pharmacy, Public Health, and Dentistry will examine the impacts of this national epidemic and answer key questions: What are opioids? How did we get to the current crisis? How can we recognize opioid abuse and what can we do about it? What makes the crisis so complex?

Providers and office staff can **enroll**.

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## Blue Care Network offers adult intensive services for members with acute behavioral health needs

Blue Care Network has contracted with select mental health providers to offer intensive services for adult members with more complex behavioral health treatment needs. We've developed referral and payment arrangements with these providers to offer this comprehensive service to our members.

Adult intensive services providers offer comprehensive services to members who may be having difficulty succeeding in routine outpatient care in the community or when stepping down from an inpatient or residential level of care with ongoing intensive needs.

Services may include psychiatric evaluation, psychological testing, partial hospitalization services, respite care (in home or crisis residential), patient support coordinator interventions, psychotherapy treatment, medical evaluation, possible hospitalization, medication administration and other specific interventions based on member needs. Providers may also offer injectable medications when appropriate. Research studies have shown improved clinical outcomes and increased quality of life scores as a result of using injectable medications<sup>1</sup>.

Members who might benefit from these services could include those who are diagnosed with chronic-complex depression, bipolar illness, schizoaffective/schizophrenic disorders or other psychotic disorders which have led to repetitive emergency room use or inpatient hospitalizations. The use of intensive outpatient services is an alternative to those repetitive inpatient hospitalizations. Outpatient services and short-term respite care may help even those with severe illness function better.

When a member is identified for these services, Blue Care Network arranges a clinical evaluation, coordinated with the family and caregiver and with the knowledge of the current treating provider. Depending on the outcome of the evaluation, the provider would develop an initial treatment plan and request BCN to authorize services.

Members can be referred to BCN behavioral health for these services from emergency rooms, therapists, facilities, clinics and primary care physicians. Please contact us at 1-800-482-5982. Our behavioral health clinicians are on call 24 hours a day, every day of the year.

### References:

1. The Use of Long-Acting Injectable Antipsychotics in Schizophrenia: Evaluating the Evidence  
Christoph U. Correll, MD (Chair); Leslie Citrome, MD, MPH; Peter M. Haddad, MD; John Lauriello, MD; Mark Olfson, MD, MPH; Stephen M. Calloway; and John M. Kane, MD  
<http://www.psychiatrist.com/JCP/article/Pages/2016/v77s03/v77s0301.aspx>

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## Blue Care Network 2018 Behavioral Health Incentive Program

Blue Care Network is phasing out manual submissions for the Behavioral Health Incentive Program. Manual submissions for both the therapeutic alliance measure and the primary care physician contact measure will be accepted through June 30, 2018. After that date, only electronic submissions will be accepted.

As part of the phase-out process, incentive amounts for manual submissions will decrease slightly.

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

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

- Log into Provider Secured Services and click on *BCN Provider Publications and Resources*.
- Click on *Behavioral Health* under Other Resources.
- Scroll down to Behavioral Health Incentive Program.

## Behavioral health providers may discuss decisions with BCN physician reviewers

Blue Care Network is committed to a fair and thorough process of determining utilization by working collaboratively with its participating behavioral health practitioners.

BCN's behavioral health physician reviewers may contact practitioners for additional information about their patients during their review of all levels of care, patient admissions, additional hospital days and requests for services that require medical policy and benefit interpretations.

When BCN doesn't approve a service request, we send written notification to the requesting practitioner. The notification includes the reason the service wasn't approved as well as the phone number to call BCN's behavioral health physician reviewers to discuss the decision.

Practitioners may discuss any decision with a BCN behavioral health physician reviewer. Call Behavioral Health at 1-877-293-2788 Monday through Friday, 8 a.m. to 5 p.m. To discuss an urgent case after normal business hours with one of our behavioral health physician reviewers, call 1-800-482-5982.

### How to obtain a copy of Behavioral Health criteria

Upon practitioner request, Blue Care Network will provide you with the behavioral health criteria used in our decision-making process. Call 1-877-293-2788 to request a copy of the criteria.



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## Best Practices

### Controlling high blood pressure

An interview with Dr. Tackabury

*Blue Care Network conducted an interview with Dr. Daniel Tackabury, in North Branch, about how he helps patients with high blood pressure stay healthy.*

#### What do you do to help your patients control their blood pressure?

I provide patient education and have patients come for blood pressure checks. Patients like the idea that they can come in and get a blood pressure check without a copay. It lets them know we do care.

#### How frequently do you schedule follow-up appointments for patients with high blood pressure?

It depends on how high a patient's blood pressure is. Sometimes, we check it every couple of days until we get it down. For others, it may be one to two weeks. If it's borderline high and we're starting a patient on medication, we might check monthly.

#### How have you responded to the new blood pressure guidelines from the American Heart Association?

We are following the older guidelines from the American Academy of Family Physicians until we have a consensus. With the American Heart Association guidelines, a lot more people have borderline high or high blood pressure. I do discuss it with patients if they're in that range and we start working on dietary and lifestyle mediations – increasing exercise and quitting smoking for example.



Dr. Daniel Tackabury

#### How do you make sure patients are compliant with taking medications or other treatments you recommend for high blood pressure?

I always educate the patient about medications and significant side effects. I advise them that if anything feels different (if they're lightheaded or dizzy or blood pressure is too low) definitely call us. We always want to know how the patient is feeling. If a patient has to discontinue a certain medication, there are other options. It doesn't necessarily mean another office visit.

#### What do you encourage patients to do in between follow-up visits?

We try to get patients to get a home blood pressure cuff and do self-monitoring. If they're getting a discrepancy, we have them bring in their blood pressure cuff and compare their blood pressure with one we take. If there's anything questionable or high when staff takes a patient's blood pressure, I repeat it myself in the office.

#### How else do you help patients stay on track?

I'm honest with patients about consequences. If blood pressure stays out of control, whether taking medications or not, these are the long-term consequences: kidney disease, heart attack, stroke. I think people respond to that.

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## Appropriate treatment for upper respiratory infections in children and adults

At least two million people a year in the United States are infected with bacteria where antibiotic treatment is ineffective, according to the Centers for Disease Control and Prevention. At least 23,000 of them die each year as a result of these antibiotic-resistant infections.

Healthcare Effectiveness Data and Information Set® has three measures which focus on reducing antibiotic use.

- Appropriate testing for children with pharyngitis
  - The percentage of children ages 3 to 18 who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode
- Appropriate treatment for children with upper respiratory infection
  - The percentage of children ages 3 months to 18 years who were given a diagnosis of upper respiratory infection and weren't dispensed an antibiotic prescription
- Avoidance of antibiotic treatment in adults with acute bronchitis
  - The percentage of adults 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription

Blue Care Network participates in HEDIS annually. To support success in these three measures, we have two clinical practice guidelines for antibiotic utilization that are available at [Michigan Quality Improvement Consortium](#) website.

The guidelines address the following:

- Acute pharyngitis in children 2 to 18 years old
- Management of uncomplicated acute bronchitis in adults

These guidelines are printed on one-page templates for convenient reference.

It's challenging to work with a patient who is requesting an antibiotic when it isn't appropriate for them or their child. Both the [CDC](#) and [Michigan Antibiotic Resistance Reduction](#) websites offer resources to help providers with this discussion.

Go to the CDC website for a list of the top 18 [drug-resistant threats](#) to the United States as well as activities to combat antimicrobial resistance.



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## It's important for pharmacies to report patients' vaccinations to MCIR

Pharmacies play an important role in immunizations because they're easily accessible and offer convenient locations and hours. Vaccines protect children, adolescents and adults from potentially serious vaccine-preventable diseases, including measles, pertussis, meningitis, pneumonia and influenza.

Michigan's statewide immunization registry, the Michigan Care Improvement Registry, tracks all vaccines administered in Michigan. By law, providers are required to report all immunizations administered to every person younger than age 20 within 72 hours of administration. MCIR was expanded to a lifespan registry in 2006; reporting adult vaccinations is strongly encouraged.

Reporting data to MCIR is a good public health practice because:

- It reduces over-immunization by maintaining the patient's immunization history.
- It helps decrease missed opportunities for vaccination.
- It allows for sharing immunization records between vaccine provider offices.

Under Schedule B of the *Blue Cross and BCN Restated & Amended Preferred Rx Participation Agreement*, we require providers who administer vaccine products to do all of the following:

- Complete the required immunization training.
- Use reasonable commercial efforts to maintain and make available the provider inventory of covered vaccine products at the location the provider anticipates the eligible members may schedule their vaccine administration.
- Provide a secured area for physical storage of drugs. This doesn't mean that the provider will have inventory or security measures outside of the normal business setting.
- Register all administered vaccines with the Michigan Care Improvement Registry or another organization as identified by Blue Cross Blue Shield of Michigan and Blue Care Network.
- Require a written prescription from a licensed prescriber for all vaccine products.\*\*

Help your pharmacy, your patients and your patients' other providers know which vaccines the patients have received by documenting them in the Michigan Care Improvement Registry.

For more information on participating in MCIR, visit [mcir.org/providers/pharmacies](http://mcir.org/providers/pharmacies).

\*\*Blue Cross and BCN will accept standing orders from physicians.



## Chorionic gonadotropin and Novarel undergo tier changes, starting March 1

Blue Care Network and Blue Cross Blue Shield of Michigan have moved chorionic gonadotropin and Novarel® from Tier 2 to Tier 3 (nonformulary) for all HMO and PPO formularies, effective March 1, 2018.

Patients who are prescribed these drugs will have to pay a higher copayment if they don't switch to a lower-cost alternative drug. Tier 3 drugs may not be covered for members with a closed benefit.

On March 1, the following will become nonpreferred (Tier 3) drugs:

- Chorionic gonadotropin
- Novarel

Instead of the products listed, members can save money by switching to the lower cost alternative:

Higher cost drug	Tier	Copayment level
Chorionic gonadotropin	3	Nonpreferred brand
Novarel	3	Nonpreferred brand
Lower cost alternative	Tier	Copayment level
Pregnyl®	2	Preferred brand

This change doesn't apply to BCN Advantage<sup>SM</sup> members.

We've sent letters to affected members notifying them of these changes. Members are encouraged to contact their physicians and discuss switching to the preferred option listed.

You can also view all drug lists online at [bcbsm.com](http://bcbsm.com).

## Blue Care Network will no longer cover Alvesco

To address the high cost of drugs and provide the best value for our members, Blue Care Network commercial will no longer cover Alvesco®, starting March 1, 2018. If members continue to use Alvesco on or after this date, they will be responsible for the full cost.

Alvesco is used to treat asthma. There are lower-cost prescription alternatives available. The covered alternatives are listed below.

Drug not covered beginning March 1, 2018
Alvesco® (member pays full cost)
Covered preferred alternatives
Arnuity® Ellipta®
Asmanex®, Asmanex® HFA
Flovent® HFA, Flovent® Diskus®
Pulmicort solution, Pulmicort® Flexhaler®
Qvar®

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## Effective March 1, 2018, prescriptions for all growth hormone products will have mandatory prior authorization requirements

At Blue Care Network and Blue Cross Blue Shield of Michigan, we regularly review drug therapies to ensure we cover the right medication for the right situation.

Beginning March 1, 2018, all growth hormone products will require approval from us before they'll be covered under the Blue Cross and BCN prescription drug plan. Drug approval requirements for coverage and all drug lists can be found online at [bcbsm.com/pharmacy](http://bcbsm.com/pharmacy).

- Pediatric members and adult members have different coverage requirements.
- We cover nonpreferred growth hormone products after the member tries all preferred products and finds them not effective.

Here's some information about growth hormone products and copayment levels.

Higher cost (nonpreferred) drugs	Copayment level		
	3-tier benefit	4-tier benefit	5-tier and 6-tier benefits
Humatrope®	Nonpreferred brand (tier 3)	Specialty (tier 4)	Nonpreferred specialty (tier 5)
Omnitrope®			
Saizen®, Saizenprep®			
Serostim®			
Zomacton™			
Lower cost (preferred) alternatives	3-tier benefit	4-tier benefit	5-tier and 6-tier benefits
Genotropin®	Preferred brand (tier 2)	Specialty (tier 4)	Preferred specialty (tier 4)
Norditropin® FlexPro® (will be preferred effective 3/1/18)			
Nutropin AQ® Nuspin™			

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## BCN and Blue Cross fight Hepatitis A outbreak with access to vaccines at Michigan pharmacies

Eligible Blue Care Network and Blue Cross Blue Shield of Michigan commercial members are now covered for both the Hepatitis A vaccine and the combination Hepatitis A and B vaccine (Twinrix®) under their pharmacy benefits plan.

“In light of the Hepatitis A outbreak in Michigan, we wanted to make it as easy as possible for members to receive the Hepatitis A vaccine if they need it,” said Timothy Antonelli, R.Ph., manager, Pharmacy Services. “The vaccine is the best way to prevent this disease and it can even prevent the disease in those individuals who have been exposed to the Hepatitis A virus recently, so long as they get it within two weeks of exposure.”

Some of the vaccines that are currently billed under the medical benefit can also be billed through the pharmacy claims processing system.

In addition to influenza, pneumonia, shingles, HPV, meningitis and Tdap vaccines, the new policy allows participating pharmacies to bill Hepatitis A vaccines.

Hepatitis A is a highly contagious liver infection caused by the Hepatitis A virus, which often spreads when an infected person doesn’t wash his or her hands after going to the bathroom, then touches objects or food. Symptoms can range in severity from a mild illness of a few weeks to a severe illness lasting several months.

More than 20 Southeast Michigan residents have died since the outbreak began in August 2016. Transmission appears to occur through direct person-to-person contact and illicit drug use. Most Blue Cross and BCN commercial (non-Medicare) members with prescription drug coverage are eligible. The vaccine has no cost share to members if their benefits meet the coverage criteria.

Members who are outside of Michigan can get vaccines through the Express Scripts Pharmacy network.

Share this **fact sheet** from the Centers for Disease Control and Prevention with your patients.

You can find out more about the Southeast Michigan outbreak from the **Michigan Department of Health & Human Services**.



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## Two medical benefit drugs require authorization, beginning April 1

Blue Care Network will require prior authorization for two medical benefit drugs for dates of service starting April 1, 2018.

Drug name	Procedure code	Additional information
Makena™	J1726	Applies only to BCN HMO (commercial) members who start this drug on or after April 1, 2018
Tysabri®	J2323	Applies to BCN HMO (commercial) members who start this drug on or after April 1, 2018, and those who currently take the drug

Providers must submit an authorization request through the NovoLogix electronic system to demonstrate medical necessity. Authorization requests for these drugs should be submitted prior to the start of services.

Medical necessity criteria for these drugs include but are not limited to diagnosis, lab results, dose and frequency of administration. Documentation may also be required that shows the medications previously used to treat the member's condition, including the dose, regimens, dates of therapy and response. Additional pertinent clinical information may also be required.

These new authorization requirements do not apply to BCN Advantage<sup>SM</sup> members.

For a full list of drugs that require authorization and for information on how to request authorization, visit [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Click *BCN* and then click **Medical Benefit Drugs – Pharmacy**.

## Blue Cross and BCN will no longer cover topical lidocaine and benzocaine, effective May 1, 2018

To address the high cost of drugs and provide the best value for our members, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans do not cover select high-cost drugs for which more cost-effective therapeutic alternatives are available.

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

The following table includes lower-cost prescription drugs and over-the-counter alternatives:

Prescription drug not covered beginning May 1, 2018
Benzocaine 10% ointment (Anacaine®)
Lidocaine jelly 2%
Lidocaine ointment 5%
Lidocaine/prilocaine cream (Emla®)
Over-the-counter alternatives
Benzocaine ointment 2%, 5%, 20%
Lidocaine gel 2%, 4%
Lidocaine ointment 2%, 4%, 5%

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

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## Prevent unnecessary delays: Include key information for oncology medications

Blue Care Network and Blue Cross Blue Shield of Michigan are working with the medical community to ensure appropriate oncology care through pharmacy utilization management. To help us deliver effective therapy to your patients, while ensuring safe and appropriate use, we're asking providers to include key information for oncology medications.

To prevent delays in processing claims for oncology medications, submit all oncology pharmacy requests with the following information:

- Recent chart notes
- Diagnosis
- Documentation of trial and failure of alternatives

Chart notes are useful to verify dosing regimens and patient usage. If a patient continues therapy that was initiated in a hospital setting, hospital chart notes are required. This is especially important for cancer patients on chemotherapy. Claims will be denied if chart notes aren't included.

Documentation of trial and failure of alternatives and diagnosis ensure that the most up-to-date oncology prescribing guidelines are followed.

For more information on the Blue Cross utilization management criteria for oncology medications, visit the **Prior Authorization and Step Therapy Guidelines** page at [bcbsm.com](http://bcbsm.com).

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Selecting the diagnosis code that best captures a patient's condition at the time of his or her visit can be a challenge, but keeping some basic guidelines in mind helps. And to ensure best coding practices, providers can always refer to ICD-10-CM guidelines.

## Here's what you need to know about coding for cancer.

The documentation should always clearly indicate **one** of the following:

- The cancer is active and still being treated.
- The cancer is no longer active or is in remission **and** there's no recurrence; i.e., no further treatment is necessary.

When coding for active malignancy versus coding for a person with a history of malignancy, ICD-10-CM coding guidelines are specific. Section I.C.2.m. states:

"When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

"When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85, personal history of malignant neoplasm, should be used to indicate the former site of the malignancy."

### Forms of active treatment include:

- Current hormonal therapy for the cancer or neoplasm (not for prophylactic purposes)
  - Watchful waiting or active surveillance, meaning the malignant neoplasm has not been treated but is being closely monitored for progression
  - A patient has a condition but isn't being treated because he or she refuses treatment or is too frail

An exception to these rules occurs when coding multiple myeloma and leukemia. For these diagnoses, there are "in remission" codes that providers should use once treatment is completed and the patient achieves remission.

Please see [Cancer coding](#), continued on Page 38

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The following scenarios help differentiate between situations where providers should use “history of malignancy” codes and those in which the malignancy should be coded as active.

**Scenario one:**

A patient with a history of breast cancer who had chemotherapy, radiation and a mastectomy — and who currently has no evidence of recurrence — comes in for an office visit. The provider documents that the patient isn’t receiving active therapy for breast cancer. The code for personal history of malignant neoplasm of the breast (Z85.3) should be used.

**Scenario two:**

A female patient who was diagnosed with cancer of the central portion of the right breast returns to the office for a visit after a mastectomy and is currently receiving radiation therapy. Doctors should document current active treatment (radiation), and use a code for active breast cancer; e.g., C50.111 malignant neoplasm of central portion of right female breast.

**Scenario three:**

A patient who was diagnosed with cancer of the axillary tail of the left breast three years ago — and who had a mastectomy followed by radiation and chemotherapy — comes in for an office visit. She is currently taking Arimidex® and undergoing adjuvant therapy, which is considered active treatment. Therefore, it’s inappropriate to use a “history of breast cancer” code. Providers should use active cancer codes for as long as the patient is still undergoing adjuvant therapy.

**Scenario four:**

A patient who was diagnosed with acute myeloblastic leukemia was treated with chemotherapy and successfully achieved remission. He returns to the office for a visit and has no evidence of recurrence. The code for acute myeloblastic leukemia in remission (C92.01) should be used.

**In summary**

- Clinical evidence needs to be documented to support an active cancer code. The documentation must clearly indicate that the cancer was either not treated or is being actively treated, including with adjuvant therapy.
- If the cancer has been eradicated and there’s no evidence of recurrence and no further treatment is needed, then it’s appropriate to use a “personal history of cancer” code.
- Multiple myeloma and leukemia have “in remission” codes that providers should use when a patient achieves remission following treatment.

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

*Also, keep in mind that ICD-10-CM diagnosis codes and ICD-10-CM Official Guidelines for Coding and Reporting are subject to change. It’s the responsibility of the provider to ensure that current ICD-10-CM diagnosis codes and the current ICD-10-CM Official Coding Guidelines for Coding and Reporting are reviewed prior to the submission of claims.*



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### Question:

Our physician is providing conscious sedation services in the outpatient setting. We are reporting codes \*99152 and \*99153, but only being paid for the \*99152. The procedures are longer than 15 minutes. What do I need to report to have our physician paid for the services beyond 15 minutes?

### Answer:

CPT code \*99153 is considered a technical-only code when reported in the inpatient or outpatient locations. This determination is based on Centers for Medicare & Medicaid Services policy.

The rationale for this determination is that the physician work is typically performed in the initial part of the procedure, which would be the first 15 minutes, and be covered by either CPT code \*99151 or \*99152. Additional work performed after this time in a facility location is usually handled by a nurse or other trained person employed by the hospital.

### Question:

I sent in a clinical editing appeal for a code that was denied. That code was paid on the appeal, but another code was then denied. I did not appeal or question anything on that code. Why was payment taken back on a code that was not appealed?

### Answer:

When a claim line is appealed, our analysts are asked to review the documentation you submit, as well as all codes submitted on the claim. The goal of our review is to ensure that documentation supports the services and procedures reported on the claim and to make sure they're reported in line with correct coding and billing guidelines.

In the rare event where coding and documentation are not in alignment, you may see an adjustment to the claim. This can occur, even on a code or service that was not appealed. When this occurs, as it is a new edit or denial, you have a right to appeal the new determination.

### Question:

I do billing for a specialist who performs tilt table testing. I understand there are diagnosis restrictions and you expect the patient to have a cardiac work-up prior to a tilt table test. Can you explain why we received a denial for the testing when the patient had the cardiac workup including the required EKG within five months of the tilt table testing?

### Answer:

As you note, there are diagnostic restrictions for tilt table testing, which is reported under CPT code \*93660. We review claims to confirm other conditions have been ruled out, including cardiac related ones, and that the testing has been done within a reasonable period of time.

Our guidelines are based on the American Heart Association and the National Institute for Health and Care Excellence. In accordance with these guidelines and our health plan policy, we expect that the cardiac work-up, for which we would accept a 12-lead EKG, be completed within 90 days prior to performance of the tilt table testing.

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

## 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.



# Air ambulance billing instructions are now available

Instructions for billing emergency and non-emergency air ambulance services for dates of service on or after Jan. 1, 2017, are now available. Click on the PDF below to see them.

These instructions apply to both Blue Cross PPO (commercial) and BCN HMO (commercial) air ambulance claims. The Blue Cross PPO (commercial) and BCN provider manuals are being updated with links to this document.

To obtain the instructions on our website, complete the following steps:

1. Visit [bcbsm.com/providers](http://bcbsm.com/providers).
2. Click *Login*.
3. Log in to Provider Secured Services.
4. Click *BCN Provider Publications and Resources*.
5. Click *Billing / Claims*.
6. Click *Air ambulance services*.



The instructions document is also available on the BCBSM Provider Publications and Resources page titled "Clinical criteria and other resources." Look under the "Clinical criteria" heading.

In line with standard Blue Cross and BCN claims auditing policies, all air ambulance claims are subject to post-payment audit to ensure the appropriateness of claims payment.



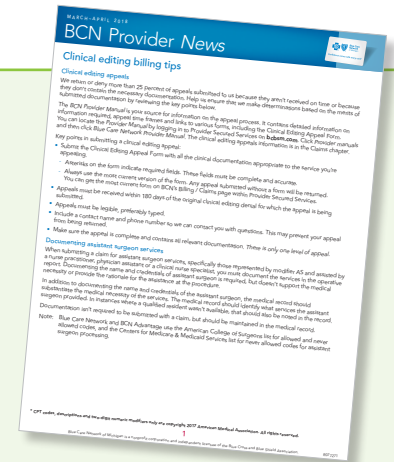
## Clinical editing billing tips

In most issues we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that the performed procedure is correctly reported to us.

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

This issue's billing tips include the following:

- Clinical editing appeals
- Documenting assistant surgeon services



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## Non-emergency air ambulance services require authorization starting April 2, 2018, for commercial members

Effective for dates of service on or after April 2, 2018, all non-emergency air ambulance transports for Blue Cross PPO (commercial) and Blue Care Network HMO<sup>SM</sup> (commercial) members require authorization. Requests for authorization must be submitted to and approved by Alacura Medical Transportation Management, LLC, prior to the flight. This requirement applies to both in-state and out-of-state air ambulance transports.

Alacura, an independent company working with Blue Cross and BCN, will use the Blue Cross and BCN medical policy titled **Air Ambulance Services** to determine the appropriateness of non-emergency flights.

There are no changes to member benefits related to air ambulance services. Non-emergency air ambulance services are eligible for reimbursement if the member has the benefit and if Alacura authorizes the flight.

### How to request an authorization

To contact Alacura about a non-emergency flight request, call 1-844-608-3676. If you're required to submit documentation, fax it to Alacura at 1-844-608-3572.

We're making this change because air ambulance transports that are not medically necessary or that are flown by noncontracted providers expose Blue Cross and BCN members to significantly greater out-of-pocket costs and are much costlier for the plan. The requirement for authorization prior to non-emergency flights is expected to lower costs for Blue Cross and BCN members and customers.

## Reminder: We're changing the way we describe care management

We're changing the way we use care management terms to make it easier for you to find the information you need. Here are some examples of the changes we're making in the *BCN Provider Manual*:

- "Clinical review requirements" are now called "authorization requirements."
- "Utilization Management" is the new name of BCN's Care Management department.

During the first months of 2018, you'll see these wording changes in all chapters of the *BCN Provider Manual* and in related BCN documents. Here are other examples of changes we're making:

- *BCN Referral and Authorization Requirements* is the new name for the *BCN Clinical Review & Criteria Charts* document.
- *Woman's Choice Referral and Authorization Guidelines* is the new name for the *Woman's Choice Referral and Clinical Review Guidelines* document.

You can find both these documents at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Click *BCN* and then click *Authorization Requirements & Criteria*, which is the new name for the *Clinical Review & Criteria Charts* page.

These changes are just the first in a series being released throughout 2018 designed to bring greater consistency across lines of business to the language in our provider manuals and in the other documents we use to communicate with you about how to do business with Blue Cross and BCN.

## Coming soon: One e-referral tool for BCN and Blue Cross

We're working to make our e-referral tool easier for you. We'll be combining the BCN and Blue Cross e-referral applications into one. This means you have one place to go to request authorizations and referrals for all your Blue Cross and BCN patients. Watch for announcements on [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com).

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## CONSULTANT MODEL

## LONG-TERM BENEFITS



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

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

#### What's changing

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

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

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

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

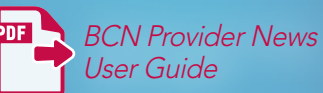
We strongly encourage you to submit your claims within the limits to avoid rejection. We've outlined the information you need to know about filing limits here, for your reference.

#### BCN claims filing limit policy

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

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

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



#### Inside this issue...

**03** BCN covers digital breast tomosynthesis

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Consultant model, continued from Page 1

### Why this will help you

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

### What you need to know

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

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

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

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

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

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## Provider forums coming to a town near you

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

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



## Blue Care Network now covers digital breast tomosynthesis

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

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

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



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## Blue Cross designates centers of distinction for expectant parents

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

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

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

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

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

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

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

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

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

Beaumont Hospital – Dearborn  
 Beaumont Hospital – Farmington Hills  
 Beaumont Hospital – Grosse Pointe  
 Beaumont Hospital – Royal Oak  
 Beaumont Hospital – Troy  
 Beaumont Hospital – Wayne  
 Bronson Battle Creek  
 Bronson Methodist Hospital  
 Covenant Medical Center  
 Garden City Hospital  
 Henry Ford Allegiance Health  
 Henry Ford Hospital  
 Henry Ford Macomb Hospital  
 Henry Ford West Bloomfield  
 Henry Ford Wyandotte Hospital

Hurley Medical Center  
 Huron Valley Sinai Hospital  
 McLaren Bay Regional Medical Center  
 McLaren Flint  
 McLaren Greater Lansing  
 McLaren Northern Michigan  
 Mercy Health Saint Mary’s  
 Metro Health Hospital  
 MidMichigan Medical Center – Alpena  
 Munson Healthcare Grayling Hospital  
 Munson Medical Center  
 Promedica Bixby Hospital  
 Promedica Monroe Regional Hospital  
 Sinai-Grace Hospital  
 Sparrow Carson City Hospital

Spectrum Health Butterworth Campus  
 Spectrum Health Gerber Memorial  
 Spectrum Health Ludington Hospital  
 Spectrum Health Pennock  
 Spectrum Health United Hospital  
 Spectrum Health Zeeland Community  
 Hospital  
 Spectrum Health Big Rapids Hospital  
 St. John Hospital & Medical Center  
 St. Joseph Mercy Hospital Ann Arbor  
 St. Joseph Mercy Oakland  
 St. Mary Mercy Hospital – Livonia  
 campus  
 University of Michigan Hospital – Main  
 Campus

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

Harper University Hospital & Hutzel  
 Women’s Hospital

Lakeland Community Hospital Niles  
 Lakeland Hospital at Niles & St. Joseph

Mercy Health Muskegon

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## Blue Cross designates top bariatric treatment centers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

North Ottawa Community Hospital  
Providence Hospital  
John Hospital & Medical Center

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## CAQH ProView application reminders

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

### Retired status

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

### Health plan authorization

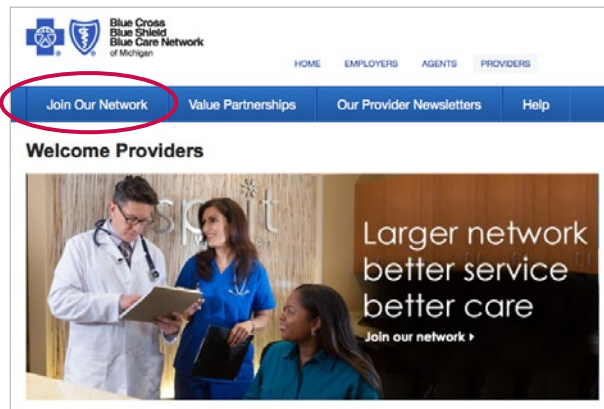
We use CAQH for physicians during recredentialing verification cycles. It's essential that you list Blue Cross, or BCBSM, as one of the health plans authorized to receive your information from CAQH. If we aren't listed as an authorized plan, your credentialing will be delayed until you grant authorization.

### Update your practice information

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

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

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



Resources to help you use the Blue Cross Provider Self-Service tool are available at [bcbsm.com/providers](http://bcbsm.com/providers).

To sign up for self-service:

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

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

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

Are you completing your medical residency training this summer?

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

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

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

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



## Blue Cross and BCN's newborn coverage policy changes

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

Here's how the new policy works:

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

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

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

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

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

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## Most BCN Advantage services do not require referrals

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

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

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

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

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

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

## BCN Advantage has special rules for local networks

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

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

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

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

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

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



## Medicare Advantage Diagnosis Closure Incentive program continues in 2018

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

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

- Blue Cross Medicare Plus Blue<sup>SM</sup> PPO
- Medicare Plus Blue<sup>SM</sup> Group PPO
- BCN Advantage<sup>SM</sup> HMO-POS
- BCN Advantage<sup>SM</sup> HMO

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

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

### *Diagnosis Evaluation Panel*

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

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

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

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

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

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

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

### Rewards for closing gaps

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

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

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## Diagnosis Closure Incentive, *continued from Page 9*

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

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

### web-DENIS member care alerts

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

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

### 2017 incentive payment

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

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

Providers should be prepared to discuss exercise and sound mental health with their BCN Advantage<sup>SM</sup> patients.

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

## Training available

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

Follow these steps to access online training resources:

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

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

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



The first postcard mailing in February dealt with exercise.

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

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





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



## By Dr. Marc Keshishian

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

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

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

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

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

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

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

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

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

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

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



**Star ratings**, *continued from Page 11*

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

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

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

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

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

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

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

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

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

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

Medicare criteria for eligibility are:

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

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

Patient  
CareCommunicating screening and treatment  
options for prostate cancer

By Denice Logan, D.O.



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

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

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

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

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

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

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

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

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

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

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

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From the medical director, *continued from Page 14*

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

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



## Diagnosis and treatment of cancer

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

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

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

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

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

\*Source: American Cancer Society

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

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

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## Blue Care Network promotes continuity of care in some situations

Continuity of care services are available for the following members:

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

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

BCN provides notification to members within 15 days after learning of the effective date of the practitioner's disaffiliation.

BCN permits the member to continue treatment in the situations described below provided that the practitioner:

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

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

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

An active course of treatment is defined as:

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

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

Providers may contact BCN's Care Management department at 1-800-392-2512 to arrange for continuity of care services.

Members should contact Customer Service by calling the number on the back of their member ID card.

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

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## Blue Care Network promotes coordination of care with specialists

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

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

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

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

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

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

## Medical record guidelines policies require providers to maintain member records

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

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

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

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

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

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

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

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

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

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

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## Hypertension is Michigan's top health problem

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

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

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

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

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

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

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

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



## Michigan's top 10 health concerns

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



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

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

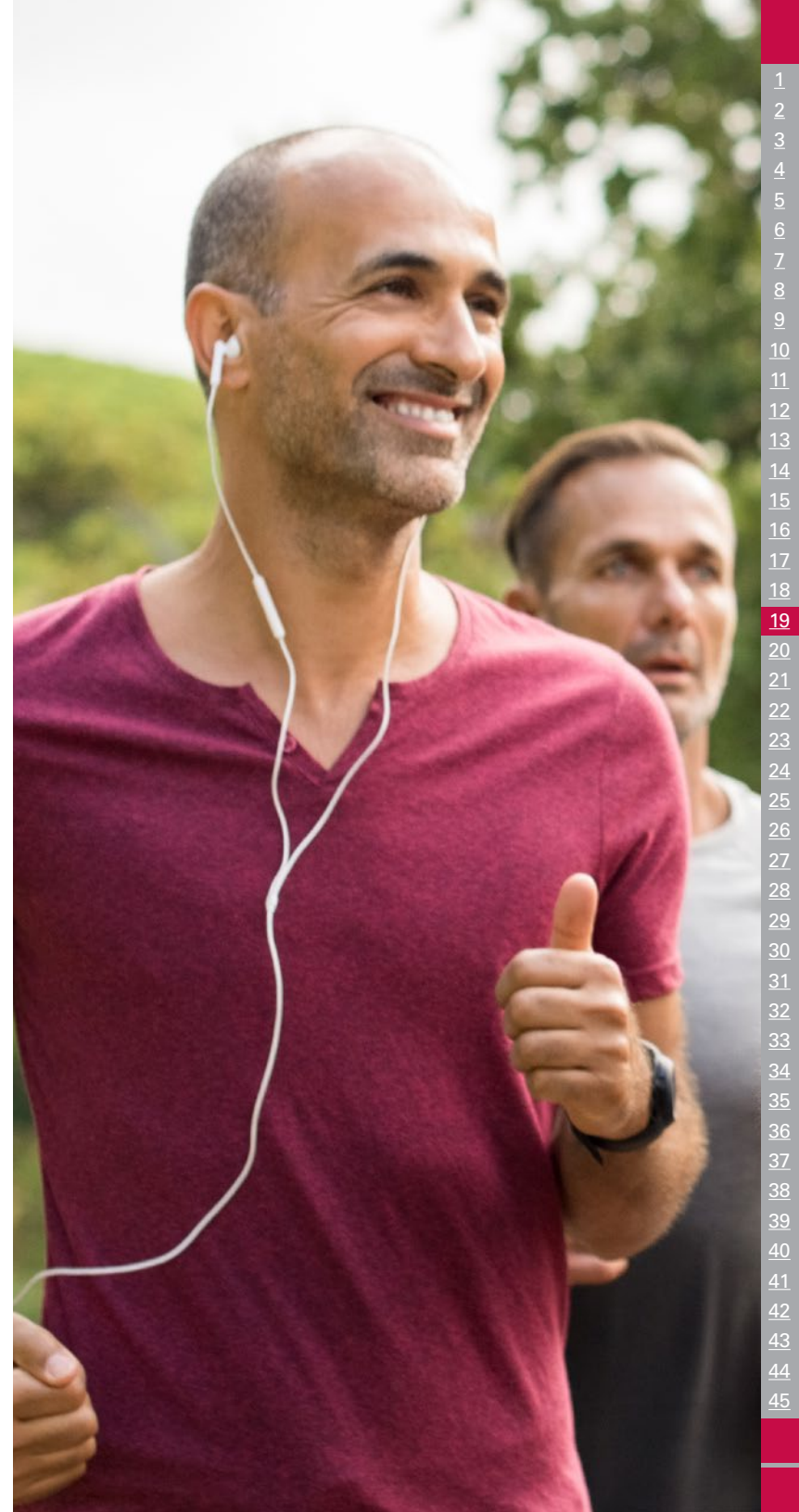
Blue Care Network encourages all men to get their recommended screenings to maintain good health.

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

Here are some tips you can give your male patients:

- **Eat healthy.** Say no to supersizing and yes to healthy breakfast. Eat many different types of foods to get all the vitamins and minerals needed. Add at least one fruit and vegetable to every meal.
- **Get moving.** Play with the kids or grandkids. Take the stairs instead of the elevator. Do yard work. Play a sport. Keep comfortable walking shoes handy at work and in the car. To stay motivated, choose activities that you enjoy.
- **Make prevention a priority.** Many health conditions can be prevented or detected early with regular checkups. Regular screenings may include blood pressure, cholesterol, glucose and prostate health.

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





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

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

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

### Medication take-back programs

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

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

## Help patients find a local opioid drop-off location

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



## How to dispose of medicines in the household trash

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



# Mi-CCSI offers basic and advanced pain management training



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

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

The advanced practical workshops include:

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

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

The dates and locations are on the table below.

To register, go to [Mi-CCSI website](#).

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



## Provider resources available for CDC opioid prescribing guideline

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

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





## Referral to BCN not needed for diabetic retinopathy exam

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

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

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

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

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

Procedure codes:

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

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

Another resource for ICD-10 is [CDC.gov](#).

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

## Medical policy updates

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

### Noncovered services

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

### Covered services

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



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

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

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

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

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

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

The treatment protocol consists of key phases:

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

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

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

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

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**substance abuse treatment protocol**, continued from Page 23

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

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

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

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

The goals of the pilot include the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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## Best Practices

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

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

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

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

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

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

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

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



**Dr. Salvatore Ventimiglia and patient Myles Shroyer**

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

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

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

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

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

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



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Best Practices, continued from Page 26

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

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

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

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

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

## Do you have any final thoughts?

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

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

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



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## Report focuses on health care disparities by race and socioeconomic status

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

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

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

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

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## Disparities, continued from Page 28

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

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

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

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

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

References:

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

Hadley J, Holahan J. The cost of care for the uninsured: what do we spend, who pays, and what would full coverage add to medical spending? Kaiser Issue Update. Washington, DC: The Henry J. Kaiser Family Foundation; May 10, 2004.

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

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

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

## What's an action plan?

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

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

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

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

## Sample Health e-Blue report

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

### References

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

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

"Fact Sheets." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 12 Mar. 2015, [www.cdc.gov/copd/maps/index.html](http://www.cdc.gov/copd/maps/index.html).

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

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

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## Discuss medication adherence with patients

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

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

For questions regarding this article please contact [RxQualityPrograms@bcbsm.com](mailto:RxQualityPrograms@bcbsm.com).



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## Saving lives through better maternal health

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

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

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

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

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

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

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

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

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

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

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





## Reminder: MQIC releases new guidelines for opioid use in adults

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

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

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

Key recommendations include:

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

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

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

## Pharmacy News

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

### Key features

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

\*SAHMSA: Substance Abuse and Mental Health Services Administration

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## Effective June 1, there are new state requirements for MAPS

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

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

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

Here's what changed:

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

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

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

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

## Blue Cross and BCN now cover Shingrix shingles vaccine

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

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

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

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

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

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

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

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





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

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

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

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

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

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

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

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

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

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

This requirement applies only to BCN HMO<sup>SM</sup> (commercial) members, for both first-time and current users of these medications. It does not apply to BCN Advantage<sup>SM</sup> members.

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

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

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

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

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

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

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

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

Members will receive letters with updated information.

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

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

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

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

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

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

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



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

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

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

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

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

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

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

### BCN HMO (commercial)

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

### Blue Cross

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

References:

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

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# BCN clinic code policy clarified

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

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

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

## Filing requirements

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

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

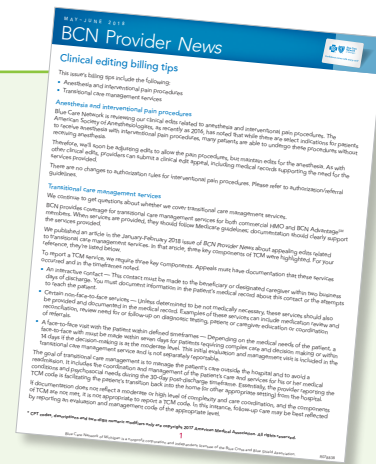
## Clinical editing billing tips

In most issues we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that the performed procedure is correctly reported to us.

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

This issue's billing tips include the following:

- Anesthesia and interventional pain procedures
- Transitional care management services



## Billing Q&amp;A

**Question:**

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

Can you clarify?

**Answer:**

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

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

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

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

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

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

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

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



*Modifier 25 usage*



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Billing Q&amp;A, continued from Page 40

**Question:**

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

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

- CPT 20552\*
- CPT 58661\*

**Answer:**

Blue Care Network has general guidelines for use of modifier 50. You can find these guidelines by visiting [bcbsm.com/providers](http://bcbsm.com/providers).

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

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

## Have a billing question?



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

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

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

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

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

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

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

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

# Referral Roundup

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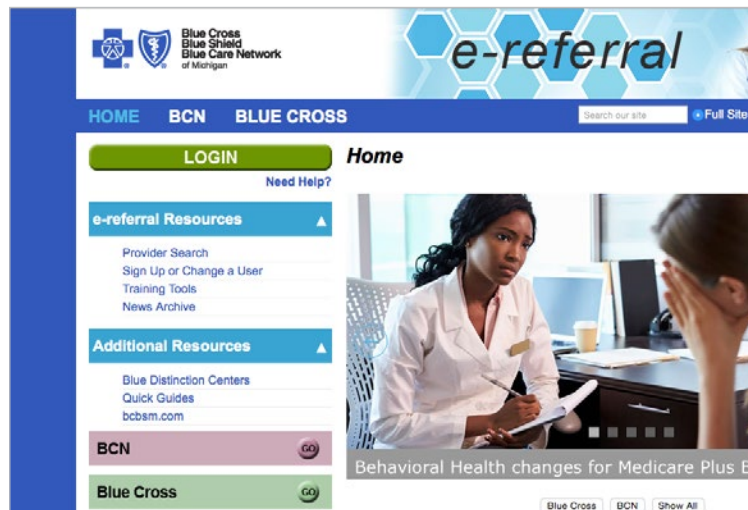
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## Blue Cross and BCN e-referral systems combined, upgraded

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

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

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



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

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

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

This change will apply to requests for BCN HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members and to the following providers:

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

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

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



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

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

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

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

### How to request an authorization for non-emergency flights

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

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

### Reason for authorization requirement

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

### Additional information

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

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

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# Respondents to physician satisfaction survey suggest referrals, appeals improvements

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

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

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

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

## About the survey

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

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

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

A five-point response scale allowed you to rate your satisfaction as very satisfied, satisfied, neutral, dissatisfied or very dissatisfied. We also allowed an "opt out" response of no opinion/don't know. We didn't include the no opinion/don't know responses in the totals.

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

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

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*Dr. Christine Jones and patient John Boyer*

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

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

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

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

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

## BCN is updating its clinical editing system

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

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

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

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

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

Inside this issue...

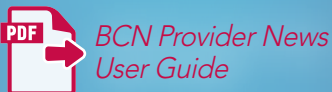
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**Best Practices**, continued from Page 1

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

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

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

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

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

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

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

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

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**Best Practices**, continued from Page 2

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

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

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

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



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## Healthy *Blue* Living reminders

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

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

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

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

## Blue Care Network updates professional fees July 1

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

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

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

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

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

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

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

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



## Helpful hints to expedite your Provider Secured Services application

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

### Section 1 — Applicant demographics

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

### Section 2 — Clone IDs

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

### Section 3 — e-Referral

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

### Section 4 — New access NPIs

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

### Section 5 — Health e-Blue access

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



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## Section 6 — User features

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

Access features include:

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

## Section 7 — Authorization

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

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





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

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

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

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

### Acute initial inpatient admissions

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

### Post-acute initial and concurrent admission reviews

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

### Other authorization requests

The requests listed below must be submitted by fax:

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

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

### Additional information

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

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

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

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

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



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

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

### Definition of fraud

Fraud is intentional deceit or misrepresentation of the truth that results in some extra cost to the health care system. Fraud schemes range from those committed by individuals acting alone to broad-based activities by institutions or groups of individuals. Seldom do these schemes target only one insurer or the public or private sector exclusively.

Most are simultaneously defrauding several private and public-sector victims, including Medicare and Medicaid. Medicare health care fraud is defined in Title 18, United States Code (U.S.C.) § 1347, as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

### Definition of abuse

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

### Differences between fraud and abuse

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

### Definition of waste

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

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

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



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

**Fraud, waste and abuse prevention**

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

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

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

In writing, contact:

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

**Fraud, waste and abuse compliance training**

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

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

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

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

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

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

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

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

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

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

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

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

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## NOMNC, continued from Page 9

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

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

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

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

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

## Some important facts about the NOMNC

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

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

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

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



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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

By Dr. Felecia Williams



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

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

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

### Vaccination rates are suboptimal

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

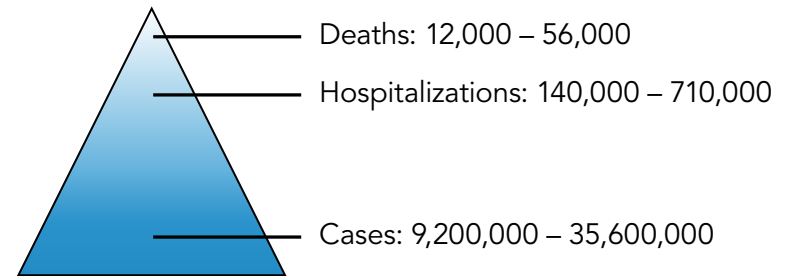
### Vaccine effectiveness

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

### Disease burden and economic costs

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

#### Disease Burden of Influenza



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





From the medical director, *continued from Page 13*

### Providers can improve vaccination rates

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

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

### Help dispel vaccination myths

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

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

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

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



## State opioid commission releases prescribing guidelines

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

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

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



*Acute Care Opioid Treatment and Prescribing Recommendations – Dental*



*Acute Care Opioid Treatment and Prescribing Recommendations – ED*



*Acute Care Opioid Treatment and Prescribing Recommendations – Surgical*

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



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

- Methadone
- Naltrexone
- Buprenorphine

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



## Blue Cross develops opioid resource guide for employers

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

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

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

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

## NIH doubles funding for scientific solutions to opioid crisis



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

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

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





# Emergency room data show increase in opioid overdoses

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

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

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

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

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

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



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

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

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## AHIP responds to senate Democrats on opioid issues

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

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

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

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



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

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

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

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## Case management program helps you care for patients

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

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

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

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

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

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

### Case management in 2018

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

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

BCN respects your right to:

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

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

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

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

### For children with asthma

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

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

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Tips, continued from Page 20

## For children with diabetes

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

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

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

## Medical policy updates

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

### Noncovered services

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

### Covered services

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



*Medical Policy Updates*

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# COPD diagnosis should include spirometry

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

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

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

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

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

## Spirometry

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

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

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

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

Source

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

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

# Behavioral Health



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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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



### Dr. Beecroft

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

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

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

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

### Dr. DiFranco

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

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



## About the honors

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

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

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

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

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

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

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

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

Authorization is required for these services if you are:

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

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

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

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

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

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



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

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

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

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

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## Quality improvement program information available upon request

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

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

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

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

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

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

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

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

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

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

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

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

From the homepage of web-DENIS:

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

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

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

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

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

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

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

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

## BCBSM and BCN drug lists updated, available online

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

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

### Other useful links

#### Drug lists

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

#### Quantity limits

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

#### Prior approval and step therapy

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

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

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

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

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

### When authorization is required

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

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

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

### Why authorization is required

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

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

### How to request authorization

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

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

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

### Authorization requirements for other products

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

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

### Additional information

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



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

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

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

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

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

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

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

Both medications are billed with HCPCS procedure code J3590.

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

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

### Additional information

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







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

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

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

## Documents pertaining to readmissions

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

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

## Additional information

Access these documents by completing the following steps:

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

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

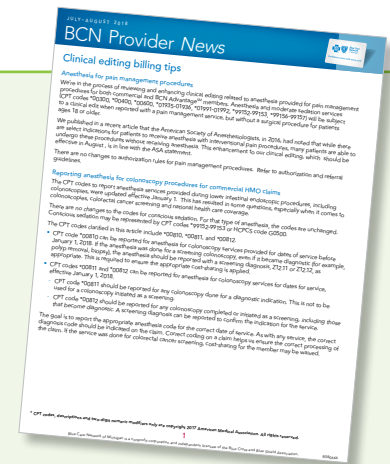
## Clinical editing billing tips

In most issues we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that the performed procedure is correctly reported to us.

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

This issue's billing tips include:

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





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

### Immunodeficiency

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

#### Congenital immunodeficiency

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

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

#### Acquired immunodeficiency

This can occur in one of two ways:

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

### Immunosuppression

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

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

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

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

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

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

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

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## Billing Q&A

### Question:

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

### Answer:

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

## Have a billing question?



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

### Question:

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

### Answer:

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

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

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

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

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

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

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

### How to sign up for a webinar

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

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

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

### Additional information

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

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

### Webinars offered in August, September and October

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

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

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

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

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

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

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

This change will apply to requests for BCN HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members and to the following providers:

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

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

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

[Provider Portal Login | eviCore](#)



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# Providers Delivering Medical Solutions That Benefit Everyone.

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

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

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

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

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

### How the questionnaires work

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

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

### Where to find authorization criteria and preview questionnaires

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

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



*Authorization criteria and questionnaires*

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

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

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

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

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

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

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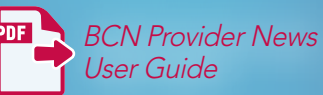
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## Check to see if you have a new professional provider consultant

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

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

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

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

## Blue Cross and BCN program reduces doctor shopping



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

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

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

Inside this issue...

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

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## Consultants, continued from Page 1

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

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

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

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

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

## Only minor changes to hospital and facility consultant assignments

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

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

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

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# Here's an update on Blue Distinction Specialty Care

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

## About the program

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

The goal of the program is to help members find quality specialty care on a consistent basis nationwide and encourage health care providers to improve the overall quality and delivery of specialty care. The program currently includes the following seven areas of specialty care:

- Bariatric surgery
- Cardiac care
- Knee and hip replacement
- Spine surgery
- Maternity care
- Cancer care
- Transplants

Blue Cross Blue Shield of Michigan awards health care facilities and providers with two levels of designation:

- **Blue Distinction Centers** are providers recognized for their expertise in delivering safe, effective, high-quality specialty care.
- **Blue Distinction Centers+** are providers recognized for their expertise and cost-efficiency in delivering specialty care. Only those providers that first meet Blue Distinction Centers' nationally established, objective quality criteria are considered for designation as a Blue Distinction Center+.

## About selection criteria

Blue Distinction Center and Blue Distinction Center+ designations are awarded to facilities and providers based on a thorough, objective evaluation of their performance in the areas that matter most, including quality care, treatment expertise and overall patient results. Selection criteria are

developed with the help of expert physicians and medical organizations. Blue Distinction Centers and Blue Distinction Centers+ have a proven history of delivering better quality and results, such as fewer complications and lower readmission rates, than those without these recognitions.

## Recent program changes

- The new complex and rare cancer care program launched Jan. 1, 2018, replacing the program that ended Dec. 31, 2017. Here are features of the new program:
  - There's no restriction on cancer type.
  - Hospitals, physician groups and individual physicians can be designated.
  - The provider must be engaged in a value-based payment arrangement with a Blue plan to be designated.
  - There's no BDC+ designation; only BDC.
- As of Jan. 1, 2018, the bariatric surgery program went from a type of service designation (stapling versus banding) to a place-of-service designation (comprehensive center versus ambulatory surgery center). This means that an entity can either be designated for bariatric surgery as a comprehensive center or an ASC.

## Program refreshes

- The Blue Cross and Blue Shield Association refreshes criteria for designation in each specialty area of the program about every two years to provide meaningful quality and cost differentiation to employers, employees and providers. To remain designated, facilities must reapply for Blue Distinction Center designations during each re-evaluation cycle.
- The spine surgery and knee and hip replacement programs are being refreshed this year. In the new cycle, ASCs can earn BDC designation in addition to hospitals. This August, Blue Cross Blue Shield of Michigan will be sending a letter to each facility and ASC that performs these procedures, inviting them to apply for designation by submitting a provider survey. The refreshed programs are tentatively scheduled to be effective July 1, 2019.

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### Coming next

- A new fertility care program will launch Jan. 1, 2019.
- A new gene therapy program is tentatively scheduled to launch Jan. 1, 2019.
- A new cellular immunotherapy program is tentatively scheduled to launch Jan. 1, 2019.
- A new substance use disorder program is tentatively scheduled to launch Jan. 1, 2020.

### Finding a center

The Blue Distinction Specialty Care program provides broad national access to facilities and providers by delivering better quality specialty care, making them easy to find wherever you work and live across the U.S. You can easily locate a Blue Distinction Center using the **Blue Distinction Center Finder** or by using our **Find a Doctor** feature at **bcbsm.com**.

### Did you know?

Today, more than 3,600 Blue Distinction Center and Blue Distinction Center+ designations have been awarded to more than 1,900 health care facilities in 48 states.

## Getting results

As you may have read in the **2017 Value Partnerships Annual Report**, Blue Distinction Specialty Care is helping members find high-quality, cost-efficient facilities nationwide. The program is a key tool in our efforts to manage health care costs. Analysis confirms that, overall, patients treated at Blue Distinction Centers and Blue Distinction Centers+ have better outcomes, such as fewer complications and lower readmission rates. Overall, Blue Distinction Centers+ are also more cost-efficient than non-Blue Distinction Centers+, with episode savings of nearly 20 percent on average.

Here’s an overview of national savings in six areas for providers receiving the Blue Distinction Center+ designation:

- Bariatric surgery — 29 percent savings
- Cardiac care — 23 percent savings
- Knee and hip replacement — 24 percent savings
- Maternity care — 23 percent savings
- Spine surgery — 22 percent savings
- Transplants — 31 percent savings

**Note:** Savings, calculated from Blue Cross and Blue Shield Association data, are based on total episode cost, and compare Blue Distinction Center+ facilities versus a relevant comparison group.

## Important information about the new audit process

Blue Cross Blue Shield of Michigan and Blue Care Network have partnered with Health Management System to assist with various post pay audits.

- For Blue Cross, HMS will conduct selective professional and non-hospital facility audits.
- For both Blue Cross and BCN, HMS will conduct the diagnosis-related group audits.
- Inpatient high dollar audits will remain as they are.

DRG audits are a retrospective review of paid claims. The review ensures that billed and paid services were ordered, medically necessary, documented, and reported correctly. For these audits, medical records will be requested for review. Once the review has been completed, HMS will send the findings letter and information on how to request an appeal, if necessary.

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## How to request peer-to-peer review of inpatient admissions

Blue Cross Blue Shield of Michigan and Blue Care Network allow onsite physician advisors at contracted facilities to discuss reviews of inpatient admissions with a Blue Cross or BCN medical director. According to our policy, facilities should start peer-to-peer conversations only through their employed physician advisors, and not through third-party advisors or organizations.

This applies to members with coverage with commercial Blue Cross PPO and BCN HMO<sup>SM</sup>, Blue Cross Medicare Plus Blue<sup>SM</sup> PPO and BCN Advantage<sup>SM</sup> products.

The purpose of the peer-to-peer discussion is to exchange information about the clinical nuances of the member’s medical condition and the medical necessity of the inpatient admission, not to discuss InterQual<sup>®</sup> criteria or Blue Cross and BCN local rules.

*Use the following guidelines to request a peer-to-peer review with a Blue Cross or BCN medical director.*

### Non-behavioral health inpatient admissions

For BCN HMO and BCN Advantage members:

1. Call 248-799-6312
2. Select prompt 3 for a *peer-to-peer discussion*
3. Leave a message that includes:
  - Reason for requesting a peer-to-peer review
  - Member’s name, date of birth and contract number
  - Physician advisor or physician’s name and phone number
  - Best date and time to reach the physician advisor or physician

For Blue Cross PPO and Medicare Plus Blue members:

1. Call 1-866-346-7299
2. Select prompt 2 for the *Facility Precertification department*
3. Select prompt 1 to request a *provider peer-to-peer review*
4. Wait for the prompt to leave a message, then provide:
  - Reason for requesting a peer-to-peer review
  - Member’s name, date of birth and contract number
  - Physician advisor or physician’s name and phone number
  - Best date and time to reach the physician advisor or physician

### Behavioral health inpatient admissions

For BCN HMO, BCN Advantage and Medicare Plus Blue members:

1. Call 1-877-293-2788
2. If a live operator doesn’t answer the call, leave a message that includes:
  - Name of the person calling and a call-back number
  - Member’s name, date of birth and contract or case number
  - Specific times the provider is available to discuss the case
  - Physician advisor or physician’s name and phone number

For Blue Cross PPO members, call the behavioral health number on the back of the member’s ID card.

The peer-to-peer phone lines are open Monday through Friday, from 8 a.m. to 5 p.m. Eastern time, except for holidays. We’ll return your call within 48 business hours.



# Talk with your patients about osteoporosis

Many people don't know they have osteoporosis until they suffer a fracture. That's why it's important to maintain ongoing conversations with your older patients about the risks of falls and the benefits of osteoporosis screening.

## Starting the conversation

- Proactively evaluate the risk of falls with older patients at each office visit:
  - Ask your patients if they've fallen or had issues with balance and walking.
  - As appropriate, suggest:
    - » A cane or walker
    - » An exercise program
    - » Vision testing
  - Assess the potential causes such as medications.
  - Consider the need for vitamin D supplementation.
- For women ages 65 and older, reinforce the importance of screening for osteoporosis with bone mineral density testing. This test is the only one that can diagnose osteoporosis.
- For women ages 67 and older who've already incurred a fracture, order a bone mineral density test and prescribe an osteoporosis medication within six months of the fracture. Do this unless BMD testing was done within two years of the fracture or osteoporosis treatment has occurred 12 months before the fracture.



## Checking on osteoporosis care

HEDIS® star measures, including the Health Outcomes Survey, evaluate osteoporosis care and the risk of falls.

- **HEDIS measures:**
  - The Osteoporosis Management in Women Who Had a Fracture measure assesses the percentage of women ages 67 and older who had a bone mineral density test or treatment for osteoporosis within six months of a fracture.
    - » Patients who had bone mineral density testing two years prior to a fracture or osteoporosis treatment 12 months before the fracture are excluded.
  - The Risk of Falls measure assesses the percentage of members 65 and older who:
    - » Were seen by a practitioner in the past 12 months
    - » Discussed falls or problems with balance or walking with their current provider
- The Health Outcomes Survey asks patients:
  - Have you ever had a bone mineral density test to check for osteoporosis?
  - Has your doctor discussed the risk of falls, how to prevent falls or treat problems with balance or walking?

## For more information

The U.S. Preventive Services Task Force [webpage on osteoporosis](#) indicates that doctors should screen all women age 65 and older for osteoporosis.

The American College of Physicians published evidence-based [osteoporosis treatment guidelines](#) in the *Annals of Internal Medicine* on May 9, 2017. The group recommends that doctors offer pharmacologic therapy to reduce the risk for hip and vertebral fractures in women with known osteoporosis.

You can also check out the Centers for Disease Control and Prevention's [Older Adult Falls](#) webpage.



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## Physicians should recommend physical activity to older patients

One in three older adults fall every year and these falls threaten the lives, independence and health of these adults. Twenty to 30 percent of those adults who suffer moderate to severe injuries after experiencing a fall will find it harder to get around, or live independently. Falls also increase the risk of an early death.

One out of every five falls causes a serious injury such as a broken bone or head injury. The most common cause of traumatic brain injury is a fall.

People who fall but don't experience an injury may develop a fear of falling which may cause many to limit their activities. This can lead to reduced mobility and loss of physical fitness, which increases their actual risk of falling.

One of the most important things providers can recommend to their older patients is physical activity.

There are four types of exercise that encompass all the benefits of physical activity: Endurance, strength, balance and flexibility. It's important to remind patients to start out slowly and build up to more activity and intensity of activity. Exercising shouldn't cause pain or tiredness. Many local fitness centers, hospitals, churches, religious groups, senior and civic centers, parks, recreation associations, YMCAs, YWCAs and shopping malls have exercise, wellness or walking programs.

Here are some groups you can recommend to older patients looking for information about physical activity:

- American College of Sports Medicine  
1-317-637-9200  
[www.acsm.org](http://www.acsm.org)
- Centers for Disease Control and Prevention  
1-800-232-4636 (toll-free)  
1-888-232-6348 (TTY/toll free)  
[www.cdc.gov](http://www.cdc.gov)
- National Library of Medicine  
Medline Plus  
*Exercise for Seniors*  
*Exercise and Physical Fitness*  
[www.medlineplus.gov](http://www.medlineplus.gov)
- President's Council on Fitness, Sports and Nutrition  
1-240-276-9567  
[www.fitness.gov](http://www.fitness.gov)

### For more information contact:

National Institute on Aging Information Center  
1-800-222-2225 (toll-free)  
1-800-222-4225 (TTY/toll-free)  
[www.nia.nih.gov](http://www.nia.nih.gov)  
[www.nia.nih.gov/Go4Life](http://www.nia.nih.gov/Go4Life)

### References:

- [http://www.cdc.gov/physicalactivity/basics/older\\_adults/index.htm](http://www.cdc.gov/physicalactivity/basics/older_adults/index.htm)
- <http://www.cdc.gov/HomeandRecreationalSafety/index.html>
- <https://www.nlm.nih.gov/medlineplus/falls.html>
- [http://www.niams.nih.gov/Health\\_Info/Bone/Osteoporosis/Fracture/prevent\\_falls\\_ff.asp](http://www.niams.nih.gov/Health_Info/Bone/Osteoporosis/Fracture/prevent_falls_ff.asp)
- <https://www.nia.nih.gov/health/publication/exercise-and-physical-activity>
- <http://www.cdc.gov/features/activity-older-adults/index.html>

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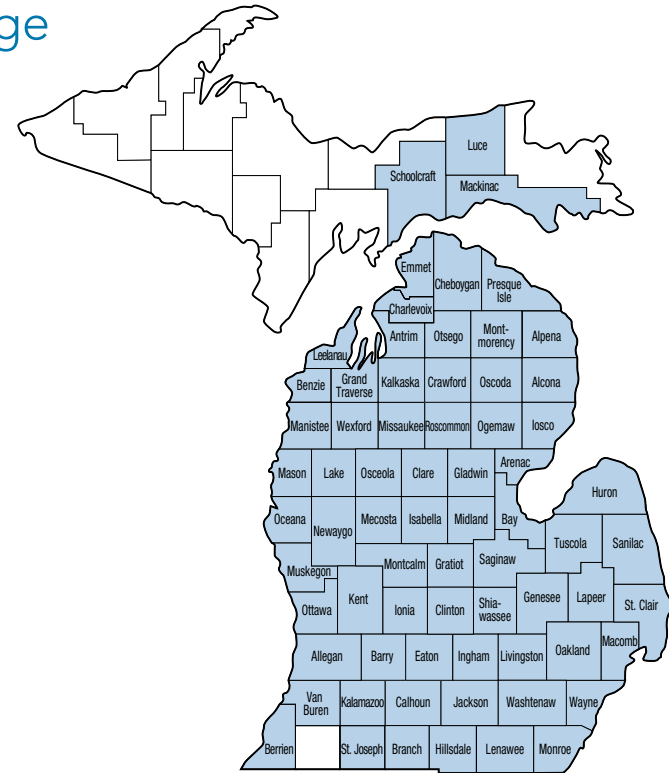
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## We've expanded BCN Advantage coverage area

We've expanded services for BCN Advantage<sup>SM</sup> HMO-POS products to Berrien County and added new ZIP codes that enable us to provide full access in St. Joseph county. This brings BCN Advantage coverage into 70 Michigan counties.

The expansion applies to the HMO-POS products – Elements, Basic, Classic and Prestige.



## Clarification: Vivaglobin does not require authorization

We published an article in the **July-August issue** announcing that additional specialty medications covered under Medicare Part B medical benefit require authorization for BCN Advantage members, starting Oct. 1.

Vivaglobin<sup>®</sup> (HCPCS code J1562) won't require authorization because it's being discontinued. This is a change from what we communicated in the newsletter article.

Authorization is required for these medications when they're billed on a professional HCFA 1500 claim form or when the claim is submitted electronically via an 837P transaction, for the following sites of care:

- Physician office (Place of Service code 11)
- Outpatient facility (Place of Service codes 19, 22 and 24)

**Note:** In the July-August 2018 newsletter article, we mentioned only Place of Service codes 19 and 22 for outpatient facilities, but authorization is also required for Place of Service code 24.

Authorization is not required for these medications when they are billed on a facility claim form (such as the UB 04) or electronically via an 837I transaction



# Substance use disorders: How primary care physicians can be part of the treatment team

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By Michael L. Fox, D.O., DFASAM

*Dr. Fox is board-certified in addiction medicine. He serves as medical director, chemical dependency unit, at St. Mary Mercy Hospital, Livonia and is an associate clinical professor at Michigan State University, Wayne State University and the University of Detroit.*

When it comes to treating substance use disorders, a primary care physician is an integral part of the treatment team.

Typically, a primary care physician can make a diagnosis, or a suspicion of a diagnosis, using some simple measures. Those measures include using the Michigan Automated Prescription System, a urine drug screen and a patient history.

Using MAPS is now required by the state of Michigan when prescribing opiates. It allows you to see if your patient is visiting other physicians to obtain prescriptions, sometimes known as doctor shopping.

Periodic drug screens are useful because they might be a clue that your patient may be using illicit substances or prescription medicines that aren't prescribed by you. This is a red flag, especially when a person is requesting a medication refill.

As we all know, a history is critical. When doing a history, one should always include three things:

- Alcohol use
- Street drug use (most patients will not classify cannabis as a street drug)
- Prescription drug use

When taking a history, it's also important to ask about present and past use. It's critical to ask the frequency of use and the typical amount. Ask patients if their use is past or present; is it regular or somewhat regular? What is the amount (the most) they can or have consumed? This applies to alcohol, illicit substances and prescription medicine.

Providers can easily assess whether a patient is participating in high-risk drinking. Using readily available information, you can determine:

- How much a female can drink in one sitting
- How much a 70-year-old can drink
- How much a male can drink before he passes the threshold of what is known as high-risk drinking

It's always important to ask when your patient first used a substance. Typically, their first use would have been in middle or high school and, typically it would have been alcohol or cannabis.

You should also discuss problems that may be related to the patient's substance use. Patients don't always realize the problems caused by their disorder.

The following are indications that the patient may be have problem related to substance use disorder:

- A physician is concerned about the patient.
- A psychiatrist has expressed concern about the patient.
- The patient has a history of driving under the influence or some other legal problem.
- The patient has an issue on his or her job or a problem with family relationships.

Sometimes there are other significant problems, or the patient may have an inkling that their substance use has a causal relationship or other issues in their lives.



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**Substance use**, *continued from Page 9*

**When you're treating a patient who has already been diagnosed**

If a primary care physician is on the other end of the care spectrum (after the disorder has been diagnosed) and a patient tells you he or she has been in treatment for substance use disorder, it's important to know a few things.

The first thing is what not to prescribe. Typically, benzodiazepines are a big problem in the country and, for the most part, should never be prescribed for more than two weeks.

This class of medication should also never be prescribed for a patient taking an opiate for pain.

Consequently, PCPs wouldn't want to use any prescription medications that are problematic. I stress stimulants, such as Adderall, benzodiazepines and opiates. There are alternative medications that can be prescribed for ADD. And there are many medications that can be prescribed as alternatives for benzodiazepines.

If the patient has a past use disorder with opiates, he or she will always have a tolerance, always be at risk and will be very difficult to treat for pain without high risk relapse.

You can consult with an addiction specialist if you're uneasy with a pain issue in a patient who has a history of opiate dependency. Typically, those patients do better when they're on medication-assisted treatment, which could be buprenorphine or vivitrol, the latter of which would block any use of opiates. (Some people don't think Tramadol is an opiate.)

The primary care physician is a big player as addiction specialists often refer people back to their primary physician. Often, we like to let the primary doctor know we don't want them to prescribe benzodiazepines, stimulants or opioids when the patients allow continuity of care.

When the PCP is the main provider of care, he or she should be sure that patient is attending support groups, counseling and psychiatric care, if indicated.

Approximately 50 percent of people with substance use disorders have a co-occurring mood disorder. However, that doesn't give the psychiatrist who is the treating provider a green light to use inappropriate medicines, such as benzodiazepines or stimulants.

If the patient isn't on medication-assisted treatment and has a pain issue, it's high risk to use these opiates; using them for longer than three or four days places this patient at great risk. This patient again should be followed with urine drug screens and MAPS.

These days, it's going to be harder for physicians to prescribe medication for acute pain for longer than seven days. To continue it in these patients is high risk.

I can't stress enough how problematic benzodiazepines are; these aren't indicated for anything more than detoxification from alcohol and for no longer than about five days.

There are many medications we can use for anxiety and ADD. Some SSRIs are "on label" for this purpose and work well as do other classes of antidepressants. Strattera and Intuniv work well for ADD. Gabapentin, trazodone, propranolol and other anticonvulsants can be used off label for anxiety, along with some alternative compounds such as valerian and chamomile for anxiety and protracted anxiety after treatment for alcohol withdrawal. Mirtazapine can be used for anxiety symptoms, especially if accompanied by a co-occurring mood disorder.

Remember that anxiety can manifest itself not only from post-traumatic stress syndrome, which is often treated with SSRIs, but also bipolar disorder, which is a diagnosis that is often missed for at least 10 years with failed response to medications. Mood stabilizers are indicated to reduce anxiety for patients with bipolar, but benzodiazepines are essentially contraindicated.

When in doubt, contacting a certified expert in addiction medicine is your best route; addiction specialists can be found at treatment centers. These doctors want to help you help these patients. They'd prefer not to have them readmitted to their facilities because their relapse begins with a provider's prescription.



## BCN Chronic Condition Management Program overview

Blue Care Network delivers an innovative chronic condition management and registry program for our members and their physicians. Chronic condition management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions.

Chronic condition management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based guidelines and patient empowerment strategies such as self-management. We continuously evaluate clinical, humanistic and economic outcomes with the goal of improving overall health.

BCN's chronic condition management programs focus on improving the health status of members with certain chronic conditions. These programs teach members how to manage certain diseases, empower members and families on self-management and how to avoid exacerbation and complications of the diseases. We also remind members when to have important exams, tests and immunizations. BCN's chronic condition management programs are an opt-out design. Eligible members must elect not to receive chronic condition management services to decline participation.

BCN offers chronic condition management programs for:

- Asthma
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Heart failure
- Ischemic heart disease
- Kidney health management

The primary goals of the chronic condition management programs include:

- Increase member adherence to their treatment plan through education on their chronic condition and associated self-management tools
- Increase practitioner awareness of current treatment modalities and maximizing use
- Improve the rate of appropriate pharmaceutical use according to current clinical practice guidelines
- Decrease unnecessary inpatient admissions and emergency department visits
- Decrease workplace absence
- Assist practitioners in tracking and monitoring services needed by members
- Educate members on the purpose and importance of advance directives
- Encourage member communication with their practitioner about their health condition and treatment

Please see [Chronic condition management](#), continued on Page 12





**Chronic condition management**, *continued from Page 11*

Chronic condition management program content addresses:

- Condition monitoring (including self-monitoring and medical testing)
- Patient adherence to the treatment plan (including medication compliance)
- Medical and behavioral health comorbidities and other health conditions
- Health behaviors
- Psychosocial issues
- Depression screening
- Information about the member’s condition provided to caregivers that have the member’s consent
- Additional resources external to BCN

BCN uses the following sources to identify members who qualify for chronic condition management programs:

- Claims data
- Pharmacy data
- Health assessment results
- Laboratory results
- Data collected through the utilization management and case management processes
- Data from health management, wellness or health coaching programs
- Information from electronic health records, if available
- Member and practitioner referrals

**Gaps in care initiatives**

BCN also delivers targeted outbound calls for diabetic members with no A1C and diabetic members with high A1C. Nurses also deliver targeted outreach for beta blocker after a cardiac event.

**WebMD**

We maintain a partnership with WebMD Health Service that facilitates member engagement. Members with chronic conditions can easily take advantage of a plethora of electronic resources.

Members with chronic conditions who register on the site can read health articles and watch videos specific to health conditions, check symptoms and learn about medications, access and use a personal health record and sync fitness and medical devices with apps to keep information in one convenient place. Interactive quizzes, tracking monitors and professionally-monitored message boards are also included. Finally, upon completion of the health assessment, members can receive emails about specific preventive and care gap reminders.

**Follow MQIC blood lead testing guidelines**

Michigan Quality Improvement Consortium guidelines recommend blood lead level testing at ages 9 months and 18 months. The **guidelines** can be found at the Michigan Quality Improvement Consortium website.

The Michigan Department of Community Health has a Lead Poisoning Prevention Program. Michigan’s Childhood Lead Poisoning Prevention Program provides education and outreach regarding lead hazards and the effects of lead poisoning. Prevention strategies are included in a state work plan for preventing childhood lead poisoning. It also offers information on the number of children with elevated blood lead levels and the percentage of children tested. The program includes training on in-office lead level testing and a questionnaire on lead exposure.

For more information on this program, visit the **Michigan Department of Health and Human Services** website.

The Centers for Disease Control and Prevention offers a **fact sheet** for parents and information on their **website** for providers.



## 2018 InterQual® criteria became effective Aug. 6

Blue Care Network’s utilization management and behavioral health staffs use Change Healthcare (formerly called McKesson) InterQual criteria when reviewing requests for Blue Care Network and BCN Advantage<sup>SM</sup> members.

InterQual criteria have been a nationally recognized industry standard for more than 20 years. BCN may use other criteria resources for appropriate levels of care, including BCN medical policies, the member’s specific benefit certificate and clinical review by the BCN medical directors.

Change Healthcare (McKesson Corporation's CareEnhance™) solutions include InterQual clinical decision support tools. Change Healthcare (McKesson) is a leading provider of supply, information and care management products and services designed to manage costs and improve health care quality.

BCN began using the following criteria on August 6, 2018. The 2018 Local Rules in the PDF below are effective in October.

Criteria/Version	Application
InterQual® Acute – Adult and Pediatrics	<ul style="list-style-type: none"> <li>• Inpatient admissions</li> <li>• Continued stay discharge readiness</li> </ul>
InterQual® Level of Care – Subacute and Skilled Nursing Facility	<ul style="list-style-type: none"> <li>• Subacute and skilled nursing facility admissions</li> </ul>
InterQual® Rehabilitation – Adult and Pediatrics	<ul style="list-style-type: none"> <li>• Inpatient admissions</li> <li>• Continued stay and discharge readiness</li> </ul>
InterQual® Level of Care – Long-Term Acute Care	<ul style="list-style-type: none"> <li>• Long-term acute care facility admissions</li> </ul>
InterQual® Level of Care – Home Care	<ul style="list-style-type: none"> <li>• Home care requests</li> </ul>
InterQual® Imaging	<ul style="list-style-type: none"> <li>• Imaging studies and X-rays</li> </ul>
InterQual® Procedures – Adult and Pediatrics	<ul style="list-style-type: none"> <li>• Surgery and invasive procedures</li> </ul>
Medicare Coverage Guidelines <i>Applies to BCN Advantage only</i>	<ul style="list-style-type: none"> <li>• Services that require clinical review for medical necessity and benefit determinations</li> </ul>
Blue Cross/BCN medical policies	<ul style="list-style-type: none"> <li>• Services that require clinical review for medical necessity</li> </ul>
BCN-developed imaging criteria	<ul style="list-style-type: none"> <li>• Imaging studies and X-rays</li> </ul>
BCN-developed Local Rules	<ul style="list-style-type: none"> <li>• Exceptions to the application of InterQual criteria that reflect BCN’s accepted practice standards</li> </ul>
Behavioral Health Utilization Management Clinical Criteria	<ul style="list-style-type: none"> <li>• Behavioral health services that require clinical review for medical necessity</li> </ul>

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## Intimate partner screening is part of MQIC preventive service guidelines

Domestic violence, also referred to as intimate partner violence, is a repetitive pattern of behaviors used to maintain power and control over an intimate partner. These are behaviors that physically harm, arouse fear, prevent a partner from doing what he or she wishes or force him or her to behave in unwanted ways. Abuse includes the use of physical and sexual violence, threats and intimidation, emotional abuse and economic deprivation. Many of these different forms of abuse can be going on at one time.

Domestic violence is an epidemic that affects individuals in every community, regardless of age, economic status, sexual orientation, gender, race, religion or nationality. It can result in physical injury, psychological trauma and even death.

Domestic violence often intensifies gradually over time so it isn't always easy to determine in the early stages of a relationship if a person is abusive. Often the abusive behaviors are dismissed or downplayed in the beginning of a relationship. It's important to note that domestic violence doesn't always manifest as physical abuse. Emotional and psychological abuse can often be just as damaging to the victim as physical abuse.

Many times, domestic abuse intensifies when the victim attempts to escape the abuser, terminate the relationship or seek help as the abuser feels a loss of control over the victim.

Anyone can be a victim of domestic violence.

The same can be said of abusers – there is no typical abuser. It's important to note that most abusers are only violent with their current or past intimate partners. One study found that 90 percent of abusers don't have criminal records, and are generally law-abiding outside of the home.

Intimate partner violence screening is part of the **Michigan Quality Improvement Consortium Adult Preventive Services (ages 18-49)** guideline.

If you think one of your patients is a victim of domestic violence, encourage the patient to talk to someone he or she trusts or call the National Domestic Violence Hotline, which is available 24 hours a day, seven days a week, 365 days a year. Online chat is available every day from 8 a.m. to 3 a.m. Eastern time at 1-800-799-7233 (SAFE).



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# Opioid roundup

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Here's a roundup of articles about the opioid crisis, including general information, statistics and Blue Cross efforts.

#### Impacts from the \$570,000 Blue Cross Blue Shield of Michigan opioid grant partnership

The MI Blues Perspective blog features three articles about how the impact of the \$570,000 in Blue Cross Blue Shield of Michigan opioid grants are affecting the state.

- [Taking Action: Prevention Driving U.P. Coalition Efforts to Combat Opioids](#)
- [Taking Action: Multi-prong approach fighting opioids in Northern Michigan](#)
- [Taking Action: The Power of Putting "Hope Before Handcuffs"](#)

#### CEO Loepp discusses opioid crisis with business leaders

Blue Cross Blue Shield of Michigan President and CEO Daniel J. Loepp shared some of the results of the company's efforts in battling the opioid epidemic during the state's Mackinac Policy Conference in late May. This annual event is sponsored by the Detroit Regional Chamber, and gathers prominent state and national speakers to discuss topics important to Michigan.

Loepp was a featured panelist in a discussion titled "Opioids in the Workplace: Impacting Michigan." He was joined by Penske Corp. President Bud Denker Gallagher Benefit Services Health Management Director Jenny Love and former U.S. Attorney Barbara McQuade. For more information, see the article, [Opioid in the workplace](#), on our MI Blues Perspective blog.

#### New Michigan law limits amount of opioids doctors can prescribe

A new state law limits the amount of opioids that doctors are allowed to prescribe patients who have acute pain, the Detroit Free Press reported June 28. Effective July 1, 2018, doctors are prohibited from prescribing more than a seven-day supply of opioid medication for patients in acute pain — pain from broken bones, bad backs, short illnesses and most surgeries — pain that's relatively short term.

Doctors can't write refills for the medications until the seven-day period has elapsed. To read more, see the [Detroit Free Press article](#).

#### Study says number of opioid overdose deaths undercounted

According to a University of Pittsburgh study, 216 opioid overdose deaths likely went unreported in 2015. That brings the total up to 1,402 accidental opioid overdose deaths in 2015, 14th in the nation. For more about the study, see the [Detroit Free Press article](#).

#### Blue Cross efforts to reduce opioid use

Blue Cross Blue Shield of Michigan is expanding access to resources and treatment for individual and families. Through statewide partnerships, Blue Cross saw a 34 percent decrease in opioid prescriptions per 1,000 members between 2013 and 2017.

For more information, see the [MI Blues Perspectives blog](#).

#### How Blue Cross plans are working to improve addiction treatment

A recent article by our CEO Dan Loepp features what Blue Cross plans are doing to improve treatment for addiction.

One initiative includes a new designation for effective treatment programs. It builds on the existing Blue Distinction system that evaluates and identifies the highest quality doctors and hospitals.

See the complete [article](#) on MI Blues Perspectives blog.



## Campaign created to raise awareness of prescription drug abuse

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Blue Cross Blue Shield of Michigan, the Michigan Health & Hospital Association, Michigan Osteopathic Association, the Michigan Open Prescribing Engagement Network and the Michigan State Medical Society recently teamed up to announce the “Be Rx SAFE” opioid awareness campaign. The campaign was created to raise awareness about the dangers of prescription drug abuse and overuse and encourage prescribers and patients to do their part in addressing the opioid crisis.

To learn more, read the [MI Blues Perspective blog](#).

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## SAMHSA offers opioid prevention toolkit



The Substance Health and Mental Services Administration, or SAMHSA, has a toolkit that offers strategies to health care providers, communities and local governments for developing practices and policies to help prevent opioid-related overdoses and deaths.

Access reports for community members, prescribers, patients and families and those recovering from opioid overdose at the [SAMHSA website](#).

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## Talk with your patients about importance of complying with statin therapy

Several modifiable risk factors for cardiovascular disease are well-known and can be treated, including hyperlipidemia, or high cholesterol. Although treatments for hyperlipidemia, such as statin therapy, are effective and relatively inexpensive, many people aren't controlling their condition adequately.

Talk with your patients about their risk factors associated with cardiovascular disease and the importance of complying with their statin treatment.

To read more about the use of statin therapy for patients with cardiovascular disease, see the **article** in the July – August 2017 issue of *Hospital and Physician Update*.

### Did you know?

According to the Centers for Disease Control and Prevention:

- Heart disease is the leading cause of death for men and women in the U.S.
- An estimated one in every seven U.S. dollars spent on health care goes toward cardiovascular disease.
- This expenditure totals more than \$300 billion in annual health care costs and lost productivity from premature deaths each year.



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## Tell us what you think about Blue Cross and BCN utilization management services – You could win a prize!

Blue Cross Blue Shield of Michigan and Blue Care Network want to know how satisfied you are with utilization management services and how we can improve to better meet your needs.

Your feedback is important to us. Please complete the 2018 Utilization Management **Survey** and encourage your office colleagues to do so as well, including physicians, nurses and referral coordinators. Your input will help us evaluate our efforts and determine other improvements to enhance our care management processes.

The survey will be available online October through Dec. 31, 2018.

As a token of our appreciation, those who respond and provide their contact information following the survey will be entered in a drawing to win one of two \$250 gift certificates.\* All survey responses must be submitted *no later* than Dec. 31, 2018, in order to be eligible for the random drawing.

\*Two winners will be selected in a random drawing at the end of the survey from among all eligible entries. The winners will receive a \$250 gift certificate. No participation is necessary. The drawing will take place approximately one month following the closure of the survey. The winners will be notified by telephone or email following the drawing.

This drawing is open to all contracted Blue Cross and BCN providers. If you do not wish to participate in the survey but want to be included in the drawing, you may enter by emailing [BCBSMandBCNPhysicianSurvey@bcbsm.com](mailto:BCBSMandBCNPhysicianSurvey@bcbsm.com) with your entry request. Please include your name, phone number, office name and address. All requests must be emailed no later than Dec. 31, 2018.

## Medical policy updates

Blue Care Network’s medical policy updates are posted on web-DENIS. Go to *BCN Provider Publications and Resources* and click on *Medical Policy Manual*. Recent updates to the medical policies include:

### Noncovered services

- Autografts and allografts for nerve repair
- Interferon lambda 3 (IFNL3) testing to predict response to treatment of Hepatitis C virus (HCV) infection
- Molecular testing (proteomic and gene expression) in the management of pulmonary modules
- Urinary tumor markers for bladder cancer

### Covered services

- Autografts and allografts in the treatment of focal articular cartilage lesions
- Genetic testing-molecular markers in fine needle aspirates (FNA) of the thyroid
- Intraoperative neurophysiologic monitoring
- Pulmonary rehabilitation
- Reconstructive breast surgery/management of breast implants





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## Help male patients make informed decisions about prostate cancer screening

The Michigan Quality Improvement Consortium Guidelines recommends against prostate-specific antigen-based screening for prostate cancer. It’s recommended that men make an informed decision with their health care providers about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks and potential benefits of the screening. Men shouldn’t be screened unless they have received this information.

The discussion about screening should take place at:

- **Age 50 for men who are at average risk** of prostate cancer and are expected to live at least 10 more years
- **Age 45 for men a high risk** of developing prostate cancer, including African Americans and men who have a first degree relative (father, brother or son) diagnosed with prostate cancer at an early age (younger than 65)
- **Age 40 for men at even higher risk** (those with more than one first degree relative who have prostate cancer at an early age)

As new information about the benefits and risks of testing becomes available, the discussion about the pros and cons of testing should be repeated. It’s also important to consider changes in the patient’s health, values and preferences. Overall health status, and not age alone, is important when making decisions about screening.

Sources:  
 Michigan Quality Improvement Consortium: [http://www.mqic.org/pdf/mqic\\_adult\\_preventive\\_services\\_ages\\_50\\_to\\_65plus\\_cpg.pdf](http://www.mqic.org/pdf/mqic_adult_preventive_services_ages_50_to_65plus_cpg.pdf)  
 American Cancer Society: <https://www.cancer.org/cancer/prostate-cancer.html>



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## Well-child visits present opportunities for physicians

A well-child visit is the perfect opportunity to monitor the physical, emotional and psychological well-being as a child grows and develops. From birth through early childhood, a child will have more frequent well-child visits offering excellent opportunities for physicians to communicate information about normal growth and development as well as education on immunizations, safety, exercise and nutrition with the parents.

Providers should record the child’s weight, height, and head circumference on a growth chart and keep information in the child’s medical record. Well-child visits also include opportunities to provide BMI screenings and discussions about many topics:

- Nutrition
- Sleep
- Safety
- Physical activity
- Violence, abuse and bullying
- Sexually transmitted infection prevention
- Suicide threats
- Alcohol and drug abuse
- Behavioral and other emotional problems
- Anxiety, stress reduction, coping skills
- Immunizations
- Skin cancer prevention
- Risk assessments including tobacco use and secondhand smoke exposure
- Poison prevention
- Burn prevention
- Injury prevention

Family relationships, school, and access to community services can also be discussed and documented at these visits.

The American Academy of Pediatrics **Bright Future guidelines** (includes three additional screenings):

- Autism screening at 18 and 24 months of age
- Cholesterol screening from ages 9 to 11
- Annual screening for high blood pressure beginning at age 3

Find recommended routine preventive services for infants, children and adolescents at **Michigan Quality Improvement Consortium** site. Also review the American Academy of Pediatrics **Bright Future** guidelines.



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## Starting Aug. 6, updated utilization management criteria used for behavioral health

On Aug. 6, 2018, Blue Care Network and Blue Cross Medicare Plus Blue<sup>SM</sup> PPO started using the 2018 InterQual<sup>®</sup> criteria for behavioral health utilization management determinations.

For certain services, we base utilization management decisions on modified 2018 InterQual criteria, local rules or medical policies, instead. These changes also began Aug. 6. The services affected by these changes are outlined in this table.

Line of business	Modified 2018 InterQual criteria for:	Local rules or medical policy for:
BCN HMO <sup>SM</sup> (commercial) and BCN Advantage <sup>SM</sup>	Substance use disorders: partial hospital program and intensive outpatient program  Residential mental health treatment (adult/geriatric and child/adolescent) – for BCN HMO only	Autism spectrum disorder / applied behavior analysis (local rules)  Neurofeedback for attention deficit disorder / attention deficit hyperactivity disorder (medical policy)  Transcranial magnetic stimulation (medical policy)
Medicare Plus Blue PPO	Substance use disorders: partial hospital program and intensive outpatient program	None

**Note:** Determinations on Blue Cross PPO (commercial) behavioral health services are handled by New Directions, a Blue Cross vendor.

Links to the updated versions of the modified criteria, local rules and medical policies are available on the [Blue Cross Behavioral Health page](#) and the [BCN Behavioral Health page](#) at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com).

## Reminder: BCN offers incentive for primary care physicians to provide medication assisted treatment

Blue Care Network is offering a new incentive for primary care physicians to provide medication assisted treatment for patients with opioid use disorders. We’re providing the incentive as a pilot in 2018. See the [article](#) in the July-August issue for details.

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## Physicians can help prevent suicide

The recent tragic deaths of designer Kate Spade and chef and television host Anthony Bourdain by suicide have placed a spotlight on suicide prevention.

The U.S. Centers for Disease Control and Prevention issued a **report** in June showing suicide deaths have increased in nearly every state over the past two decades and across all ages, races, genders and ethnicities. The CDC also found suicide often happens without warning; 54 percent of people don't have a previously known mental health issue.

The CDC recommends, among other things, that states and communities identify and support people at risk of suicide and teach coping skills to help them manage challenges.

Providers are an important resource to help identify patients suffering from depression or considering suicide.

Below are some resources to help assess and treat your patients.

- The American Academy of Family Physicians offers a **tool** to help your practice assess suicidal patients.
- The Joint Commission has published an **Sentinel Alert** about detecting and treating suicidal ideation.
- The American Academy of Pediatrics provides **information** about suicide in teen and adolescent populations.

## AMA adopts policy to increase suicide awareness among physicians and public

According to recently released data from the Centers for Disease Control and Prevention, suicide rates in the United States have risen nearly 30 percent since 1999. To help address this growing epidemic, the American Medical Association adopted a policy aimed at increasing awareness about the risks for suicide among the public, medical students, physicians and other health care professionals by using an evidence-based, multi-disciplinary approach. The new policy calls for providing training for physicians to help them assess suicide risk and conduct lethal means safety counseling.

Because suicides by firearms make up approximately 60 percent of all firearm deaths in the U.S. each year, the new policy aims to ensure physicians are aware of the significant role of firearms in suicides and are trained to assess whether a person at risk for suicide has access to a firearm. The policy encourages physicians to discuss firearm and lethal means safety and work with at-risk patients and their families to reduce access to lethal means of suicide.

More information is available at the **AMA website**.

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## Best Practices

### Flint physician makes cervical cancer screening a priority

An interview with Dr. Teresa Sherman

#### How do you make sure all your eligible patients are screened for cervical cancer?

We emphasize prevention in our office. We have lists that we review monthly of the screenings each patient needs. And we stay on top of contacting those patients – mostly by phone – to encourage them to get in. If we don't do the screening in office, we make sure we get the results from a gynecologist.

#### Do you have any challenges making sure your patients get regular screening?

The only challenge is making sure the results come back to us if the screening was done elsewhere. We've worked hard to educate patients about our Patient-Centered Medical Home designation and tell them to make sure their results are forwarded to our office. We also have good relationships with most area gynecologists.

If patients present an occasional challenge, we talk to them about why we do the screening and try to discover what their fears are.



Standing: (from left) Teresa Sherman-Gach M.D., Denise Rogers, Samantha Leonard, Crystal Hill. Seated: Stacey Abram

Photo credit: James Butler

#### Do you provide any patient education about cervical cancer screenings?

We have a lot of discussions in our office about screening tests, the reason we do them and what we're looking for. We also do a lot of one-on-one consulting. Our reinforcement with phone calls is also important.

#### If there's one thing you can point to that helps you stay on top of cervical cancer screenings what would it be?

We have put a lot of effort in building our database in our electronic medical records that tracks all health measures. We always know when a cervical cancer screening or other preventive test is due. It took some effort to get it done, but it's been helpful.

We also have a dedicated medical assistant and two front office staff who help with reminder calls. The medical assistant reviews the health maintenance grid for every patient.



# How to comply with HEDIS measure for controlling high blood pressure

Accurate blood pressure readings mean more personalized care, which can help patients better reach their goals for controlling high blood pressure.

The Centers for Medicare & Medicaid Services uses the Healthcare Effectiveness Data and Information Set to measure health care quality. The HEDIS® measure for controlling high blood pressure includes patients who:

- Are ages 18 to 85 as of Dec. 31 of the measurement year
- Have a diagnosis of hypertension, after at least two visits (Telehealth/telephone visit can count as **one** visit) on different dates of service during the measurement year or prior to the measurement year

A member is compliant if his or her last blood pressure reading of the year is in control.

## How is a patient included in the measure?

The patient is included in the measure after at least two visits on different dates of service during the measurement year or prior to the measurement year.

Patients are excluded from the measure if they:

- Have evidence of end stage renal disease or had a kidney transplant or dialysis on or prior to Dec. 31 of the measurement year
- Have a diagnosis of pregnancy during the measurement year
- Have a non-acute inpatient admission during the measurement year
- Are in hospice or a skilled nursing facility at any point in the measurement year

## What are the criteria for blood pressure control?

Although the American Heart Association and the American College of Cardiology have recently updated their blood pressure guidelines, the 2019 HEDIS measure for controlling blood pressure control is:

- < 140/90 mm Hg for patients ages 18 to 85

Readings may be higher at the beginning of the office visit, so take another reading at the end of the visit as it may be lower. It's important to not round up readings.

Blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider counts for numerator compliance.

## Submit blood pressure CPT II codes on each office visit claim

HEDIS requires a medical record review to determine blood pressure compliance. However, when you submit blood pressure CPT Category II codes, it will help support member-facing programs and outcomes:

- 3074F — Most recent systolic blood pressure < 130 mm Hg
- 3075F — Most recent systolic blood pressure 130 – 139 mm Hg
- 3078F — Most recent diastolic blood pressure < 80 mm Hg
- 3079F — Most recent diastolic blood pressure 80 – 89 mm Hg

## Questions about HEDIS compliance?

Visit [bcbsm.com/providers](http://bcbsm.com/providers) for additional resources.

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## Preventive services guidelines

The Michigan Quality Improvement Consortium updated the adult preventive guidelines for ages 18 and older for 2017-2018. Blue Care Network follows the MQIC guidelines that support several Healthcare Effectiveness Data and Information Set® measures. These HEDIS® measures are used by the National Committee for Quality Assurance and the Centers for Medicare and Medicaid Services to determine quality health care practices. You can download the guidelines from the Michigan Quality Improvement Consortium [website](#).

The following preventive care guidelines were updated in 2017:

- Adult Preventive Services Ages 18-49
- Adult Preventive Services Age  $\geq$  50

The updated recommendations for ages 18 to 49 are listed below.

### Immunizations:

- For up-to-date recommendations and vaccine indicators, consult Advisory Committee on Immunization Practices [website](#).

The updated recommendations for age  $\geq$  50 are outlined below.

### Immunizations:

- Pneumococcal before age 65: If risk factors present, consult ACIP website.
- Pneumococcal age 65 and older: Give PCV13 first and PPSV23 at least one year later. If the patient already received PPSV23, give PCV13 at least one year later.

These guidelines are based on several sources with levels of evidence provided for the most significant recommendations. The grade definitions used for these guidelines are defined by the United States Preventive Services Task Force.

Other MQIC guidelines updated in 2018 include:

- Advance Care Planning
- Management of Acute Low Back Pain in Adults
- Management of Uncomplicated Acute Bronchitis in Adults
- Primary Care Diagnosis and Management of Adults with Depression
- Management of Diabetes Mellitus
- Management and Prevention of Osteoporosis
- Prevention and Identification of Childhood Overweight and Obesity Treatment
- Routine Prenatal and Postnatal Care
- Prevention of Pregnancy in Adolescents 12-17 Years

BCN values its partnership with practitioners in promoting quality health care outcomes for its members. These guidelines were developed as a resource to assist practitioners and aren't intended to be a substitute for medical judgment. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.



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## Effective Oct. 1, Prolia and Xgeva are subject to a site-of-care requirement for BCN HMO members

As a reminder, starting October 1, 2018, BCN is adding the following two medical benefit drugs to its site-of-care optimization program:

Brand name	HCPCS code	Generic name
Prolia®	J0897	Denosumab
Xgeva®	J0897	Denosumab

This requirement applies only to BCN HMO<sup>SM</sup> (commercial) members. It does not apply to BCN Advantage<sup>SM</sup> members. This information was first communicated in June, in a web-DENIS message and a news item at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com).

If you feel a member is not a candidate to receive these drugs at a site other than the outpatient hospital, you must provide documentation supporting medical necessity to the plan for review. Those requests will be evaluated on a case-by-case basis.

Requests for Prolia and Xgeva must meet applicable authorization criteria in addition to the site-of-care requirement. This applies to first-time and current issues of these medications.

The site-of-care program redirects members receiving select medical benefit drugs in an outpatient hospital setting to a lower-cost, alternate site of care, such as the physician’s office or the member’s home.

For additional requirements related to drugs covered under the medical benefit, including all drugs identified as subject to site-of-care requirements, refer to the **Medical Benefit Drugs – Pharmacy page** in the BCN section at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Click **Requirements for drugs covered under the medical benefit – BCN HMO** under the heading “For BCN HMO (commercial) members.”

The new site-of-care requirement for Prolia and Xgeva have been added to the list.

## Clarification: Vivaglobin does not require authorization

We published an article in the **July-August issue** announcing that additional specialty medications covered under the Medicare Part B medical benefit require authorization for BCN Advantage members, starting Oct. 1.

Vivaglobin® (HCPCS code J1562) won’t require authorization because it’s been discontinued.

See the article on **Page 8** for details.

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## A dangerous duo: Understanding the risks associated with concomitant opioid and benzodiazepine use



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While benzodiazepines have received less public attention than opioids, it's estimated that nearly 30 percent of fatal opioid overdoses also involved benzodiazepines. According to the Food and Drug Administration, concomitant use of these two medications increased by 41 percent from 2002 through 2014.

Benzodiazepines may be co-prescribed due to their anxiolytic and skeletal muscle relaxant effects, but combining these medications can be dangerous. Benzodiazepines potentiate the respiratory depressant effects of opioids which can lead to overdose and death. This drug class also carries similar risks of tolerance and dependence as opioids. Additional concern is that benzodiazepines can enhance the euphoric effects of opioids making them a prime candidate for misuse or abuse.

Due to the rise in prevalence and potentially fatal consequences of co-ingestion, the FDA and Centers for Disease Control and Prevention have taken action. Both drug classes now carry a **"boxed warning"** to caution patients and providers about the concomitant use of these medications which may result in profound sedation, respiratory depression, coma and death. The **CDC recommends** clinicians avoid prescribing opioids and benzodiazepines concurrently whenever possible.

Patients suffering from anxiety may be prescribed benzodiazepines due to their sedative effects and fast results. However, clinical guidelines recommend against their use for treatment of generalized anxiety disorder except in limited circumstances on a short-term basis. Antidepressants, specifically selective serotonin reuptake inhibitors and serotonin and norepinephrine reuptake inhibitors, are first-line treatments when medications are needed for anxiety.

### First-line antidepressants for GAD

- SSRI (escitalopram and paroxetine)
- SNRI (duloxetine and venlafaxine)

If benzodiazepines are prescribed with opioids, limit dosages and durations to the minimum required, follow patients for signs and symptoms of respiratory depression and sedation and provide education about the increased risks of overdose, death and addiction. For questions or additional information, email [RxOpioidTaskForce@bcbsm.com](mailto:RxOpioidTaskForce@bcbsm.com).

**Benzodiazepines combined with opioids nearly quadruples the risk of an overdose-related death compared to opioid use alone.**

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## Drug exclusions effective Oct. 1, 2018

We have made some changes to the drugs we cover as detailed in the tables below.

Our goal at Blue Cross Blue Shield of Michigan and Blue Care Network is to provide our members with safe, high-quality prescription drug therapies. We continuously review prescription drugs to provide the best value for our members, control costs and make sure our members are using the right medication for the right situation.

### Acne drugs

We'll stop covering the acne drugs listed below — and their generic equivalents — because there are safe, effective and less-expensive choices available:

Product	Drugs not covered as of October 1	Average cost of drugs not covered as of October 1	Covered alternatives	Average cost of covered alternatives
Topical	Evoclin®	\$572 per package	Cleocin-T®	\$22 to \$115 per package
	Retin-A® Micro®	\$500 to \$950 per package	Atralin® Avita® Retin-A®	\$110 to \$200 per package
	Veltin®, Ziana®	\$763 to \$906 per package	Cleocin-T®	\$22 to \$115 per package
Atralin® Avita® Retin-A®			\$110 to \$200 per package	
Oral	Absorica®	\$42 per capsule	Claravis® Myorisan® Zenatane®	\$7.50 per capsule
	Acticlate®	\$32 per tablet	Avidoxy® Monodox® Vibramycin®	\$0.20 to \$0.90 per tablet or capsule
	Solodyn®	\$47 to \$49 per tablet	Minocin®	\$0.03 to \$2.50 per tablet or capsule

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**Drug exclusions**, continued from Page 28

**Migraine, pain and skin condition drugs**

We'll stop covering the various drugs listed below – and their generic equivalents -- because there are safe, effective and less-expensive choices available:

Drugs not covered as of October 1	Average cost per unit	Common uses	Covered alternatives	Average cost per unit
Cambia®	\$83	Migraine	Ecotrin®	\$0.03
			Voltaren®	\$0.09
			Motrin®	\$0.05
			Anaprox®, Naprosyn®	\$0.23
			Relpax®	\$15.25
			Imitrex®	\$0.70
			Maxalt®, MLT®	\$1.35
			Zomig®, ZMT®	\$9.75
Naprelan®	\$15 - \$28	Pain	Cataflam®; Voltaren®, ER®	\$0.53
			Lodine®	\$0.95
			Motrin®	\$0.04
			Toradol®	\$1.25
			Mobic®	\$0.03
			Relafen®	\$0.26
			Anaprox®, Naprosyn®	\$0.06 - \$1.35
			Clinoril®	\$0.19

Drugs not covered as of October 1	Average cost per package	Common uses	Covered alternatives	Formulation	Average cost per package
Prudoxin® Zonalon® cream	\$711	Short-term treatment of itchy skin conditions	Elidel®	Cream	\$185
			Protopic®	Ointment	\$170
			Topical corticosteroids:	-Cream	Multiple options for less than \$10 per package
			Diprosone®	-Ointment	
			Kenalog®	-Lotion	
			Locoid®	-Solution	
Elocon®	-Foam				
Valisone®					

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**Drug exclusions**, *continued from Page 29*

**Cough and cold drugs not approved by the FDA**

We'll also stop covering the cough and cold drugs listed below for members under the age of 18. These contain codeine or hydrocodone and have not been approved by the U.S. Food and Drug Administration for use in members under the age of 18.

Generic drug	Example brand name
Codeine/brompheniramine/pseudophedrine	M-End® PE, Poly-Tussin® AC
Codeine/chlorpheniramine	Tuzistra® XR
Codeine/chlorpheniramine/pseudophedrine	Capcof®
Codeine/guaifenesin	Cheratussin® AC, G Tussin® AC, Guaiatussin® AC, Guaifenesin AC, Virtussin AC
Codeine/dexchlorpheniramine/phenylephrine	Pro-Red® AC
Codeine/phenylephrine/promethazine	Promethazine® VC w/codeine
Codeine/phenylephrine/triprolidine	Histex® AC
Codeine/pseudophedrine/guaifenesin	Cheratussin® DAC, Guaifenesin® DAC, Virtussin® DAC
Hydrocodone/chlorpheniramine	Tussionex®
Hydrocodone/chlorpheniramine/pseudophedrine	Zutripro®
Hydrocodone/guaifenesin	Obredon®
Hydrocodone/homatropine	Hycodan®, Hydromet®

## Pulmozyme will require prior authorization, beginning Oct. 1

Effective Oct. 1, 2018, Blue Cross Blue Shield of Michigan and Blue Care Network will add Pulmozyme (dornase alfa) to the pharmacy benefit drug prior authorization program for commercial PPO and HMO members.

Pulmozyme is used to improve lung function in people with cystic fibrosis, in conjunction with standard therapies.

Members should have their prescribers submit a request for authorization from us before payment is approved for this medication.

Members who have an existing prior authorization for any of the following drugs aren't required to get a prior authorization for Pulmozyme:

- Orkambi®
- Symdeko®
- Kalydeco®

If we don't authorize this drug in advance, it may cost the member more or not be covered.



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## Shingrix versus Zostavax: Preventing administration error

*Joseph Galanto, a clinical pharmacist with Medical Drug Management, recently completed his residency at Blue Cross Blue Shield of Michigan. In his new role, he'll review requests for medical drugs that require prior authorization to determine if medication is clinically appropriate for our members. In this article, he shares information and recent recommendations about these vaccines.*

The Centers for Disease Control and Prevention released a monitoring report on the approved recombinant zoster vaccine, Shingrix®, manufactured by GlaxoSmithKline. From October 2017 to February 2018, the Vaccine Adverse Events Reporting System received 155 reports involving RZV.<sup>1</sup> Of the reported events, 13, or 8 percent, were attributed to administration error. These errors include:

- Subcutaneous administration rather than intramuscular administration
- Inappropriate age
- Wrong vaccine information statement
- No instructions to return for the second RZV dose
- Administration of the wrong vaccine
- Administration without reconstitution of the vaccine

This early monitoring report shows that providers may be confusing the recombinant zoster vaccine, or RZV, with Zostavax®, or ZVL, the older live zoster vaccine that's manufactured by Merck. With supporting evidence of the efficacy of RZV and the Advisory Committee on Immunization Practices recommending RZV over ZVL, providers should familiarize themselves with the differences between the two vaccines and how they should be stored and administered to decrease errors.

### ACIP recommendation<sup>2</sup>

The Advisory Committee on Immunization Practices, or ACIP, now recommends RZV over ZVL. Additionally, it recommends that RZV be used in immunocompetent adults:

- Age 50 or older
- Age 50 or older who were previously vaccinated with ZVL



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**Shingrix vs. Zostavax**, continued from Page 31

**Administration and storage<sup>3,4</sup>**

Although both vaccines require reconstitution, there are some differences between the two. Unlike ZVL, which is a single-dose, live vaccine administered subcutaneously and stored in the freezer, the RZV dosing schedule requires two doses, is administered intramuscularly and kept in the refrigerator. After the initial dose of RZV, a second dose should be administered two to six months later. Confusion over the differences in dosing schedule, administration and storage may be the reason for many of the events that were reported to Vaccine Adverse Events Reporting System.

	Shingrix	Zostavax
<b>Type</b>	Recombinant adjuvanted	Live-attenuated virus
<b>Storage location</b>	Refrigerator ( <b>do not</b> freeze)	Freezer
<b>Dosage</b>	0.5 mL IM x 2 doses (Two to six months apart)	0.65 mL SC x 1 dose
<b>How supplied and administration</b>	2 components: <ul style="list-style-type: none"> <li>• Vial 1: Single-dose vial of adjuvant suspension component (blue-green cap)</li> <li>• Vial 2: Single-dose vial of lyophilized gE antigen component (brown cap)</li> </ul> All of vial 1’s contents (adjuvant) should be withdrawn and transferred in entirety to vial 2 (antigen). Gently shake until powder is completely dissolved. Withdraw 0.5 mL from vial 2 and administer intramuscularly.	Single-dose vial of lyophilized vaccine and a vial of sterile water diluent

References

1. Shimabukuro TT, Miller ER, Strikas RA, et al. Notes from the Field: Vaccine Administration Errors Involving Recombinant Zoster Vaccine — United States, 2017–2018. MMWR Morb Mortal Wkly Rep 2018;67:585–586. DOI: <http://dx.doi.org/10.15585/mmwr.mm6720a4>
2. Dooling KL, Guo A, Patel M, et al. Recommendations of the Advisory Committee on Immunization Practices for Use of Herpes Zoster Vaccines. MMWR Morb Mortal Wkly Rep 2018;67:103–108. DOI: <http://dx.doi.org/10.15585/mmwr.mm6703a5>
3. Food and Drug Administration. Shingrix [package insert]. Silver Spring, MD: US Department of Health and Human Services, Food and Drug Administration; 2017. <https://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM581605.pdf>
4. Food and Drug Administration. Zostavax [package insert]. Silver Spring, MD: US Department of Health and Human Services, Food and Drug Administration; 2006. <https://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM132831.pdf>

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# Medical drug prior authorization and site of care programs to expand

Blue Cross Blue Shield and Blue Care Network are expanding their medical drug management programs for commercial members. We encourage proper utilization of high-cost specialty medications administered by a health care provider.

For dates of service on or after Oct. 1, 2018, Trogarzo™ and Zilretta® will be added to the medical drug prior authorization program for BCN HMO<sup>SM</sup> (commercial) and Blue Cross PPO (commercial) lines of business. Trogarzo will also be added to the site of care program for BCN HMO (commercial) members, effective Oct. 1, 2018.

Trogarzo is used to treat human immunodeficiency virus type-1 infection in heavily treatment-experienced adults with multi-drug resistant HIV-1 infection failing their current antiretroviral regimen. Zilretta is a single dose intra-articular injection. It is FDA- approved for the management of osteoarthritis knee pain.

Brand name	HCPCS code	Prior authorization requirement	Site-of-care requirement
Trogarzo (ibalizumab-uiyk)	J3590	Blue Cross PPO (commercial) and BCN HMO (commercial)	BCN HMO (commercial) only
Zilretta (triamcinolone acetonide extended release)	Q9993		No

Members currently on Trogarzo do not have to do anything.

Members currently on Zilretta need a prior authorization for dates of service on or after Oct. 1, 2018.

A prior authorization approval isn't a guarantee of payment. Health care practitioners must verify eligibility and benefits for members. Members are responsible for the full cost of medications not covered under their medical benefit coverage.

Refer to the opt-out list for the Blue Cross PPO (commercial) groups that don't require members to participate in the programs.

To access the list, follow these steps:

1. Log in to Provider Secured Services.
2. Click *BCBSM Provider Publications and Resources*.
3. Click *Newsletters & Resources*.
4. Click *Forms*.
5. Click *Physician administered medications*.
6. Click *BCBSM Medical Drug Prior Authorization Program list of groups that have opted out*.

These changes do not apply to BCN Advantage<sup>SM</sup>, Blue Cross Medicare Plus Blue<sup>SM</sup> PPO or Federal Employee Program<sup>®</sup> members.

For a full list of drugs in the prior authorization program:

## BCN

1. Go to [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com)
2. Select *BCN* at the top.
3. Click *Medical Benefit Drugs – Pharmacy*.
4. Click *Requirements for drugs covered under the medical benefit – BCN HMO (underneath For BCN HMO (commercial) members)*.

## Blue Cross

1. Log in as a provider at [bcbsm.com/providers](http://bcbsm.com/providers).
2. Click *BCBSM Provider Publications and Resources* on the lower right side of the page.
3. Click *Newsletters and Resources*.
4. Click *Forms*, in the left navigation.
5. Click *Physician administered medications*.



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Patients with diabetes require ongoing medical care and monitoring to reduce the risk of complications, such as diabetic retinopathy, and improve outcomes. Clinical interventions go far beyond glycemic control.

**Diabetic retinopathy**

Diabetic retinopathy is caused by persistent high blood sugar levels that, over time, cause damage to the blood vessels in the retina. The blood vessels can swell, leak or close, which impairs the blood supply to the retina. In advanced cases, abnormal new blood vessels can grow on the retina, a process known as neovascularization, which results in loss of vision.

**What should primary care providers do?**

Ensure your diabetic patients have an annual screening for diabetic eye diseases to prevent or delay blindness. Also, obtain a copy of the eye exam report from the optometrist or ophthalmologist and include it in the patient's medical record.

**Stages of diabetic eye disease**

- Non-proliferative diabetic retinopathy: In this early stage, the blood vessels leak, making the retina swell and resulting in blurred vision
  - Swelling of the macula (the central part of the retina) is known as macular edema; it's the most common reason for vision loss among diabetics.
  - Macular ischemia results when the blood supply to the macula is interrupted.
  - Stages of NPDR range from mild to severe, with or without macular edema.
- Proliferative diabetic retinopathy: This advanced stage includes neovascularization, where the retina grows new, abnormally fragile blood vessels, resulting in loss of vision.
  - These new blood vessels often bleed into the vitreous, causing floaters or varying degrees of vision loss.
  - The new blood vessels can also cause scar tissue to develop, resulting in problems with the macula and can lead to a detached retina.

**Accurate documentation and coding**

Health care providers should use the ICD-10-CM code Z13.5 (Encounter for screening for eye and ear disorders) until a definitive diagnosis has been determined by an eye care professional. Once definitively diagnosed, documentation and coding should be to the highest specificity of the disorder.

If primary care providers receive no communication from the eye care professional but are aware of the presence of diabetic eye disease, they should document and code the condition to the highest specificity known to them. See the chart below for some examples.

Condition	ICD-10 code
Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema	E11.311
Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema right eye	**E11.3211
Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema left eye	**E11.3492
Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula bilateral	**E11.3523
Type 2 diabetes mellitus with stable proliferative diabetic retinopathy unspecified eye	**E11.3559
Type 2 diabetes mellitus with diabetic cataract	E11.36
Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment bilateral	**E11.37X3

\*\*The seventh character is required for subcategories E11.32, E11.33, E11.34, E11.35 and E11.37 to designate laterality.

Please see [Coding Corner](#), continued on Page 35

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**Coding Corner**, *continued from Page 34*

**2018 updates to ICD-CM-10 Official Guidelines for Coding and Reporting**

In Chapter 7, “Diseases of the Eye and Adnexa, Disorders of the Globe,” you’ll see a change to H42, *Glaucoma in diseases classified elsewhere*. The manual deletes the “excludes 2” note for glaucoma in diabetes mellitus and replaces it with an instructional note for appropriate sequencing that follows familiar coding conventions. The new note reads: “Code first glaucoma (in) diabetes mellitus (E08.39, E09.39, E10.39, E11.39, E13.39).”

*None of the information included in this article is intended to be legal advice and, as such, it remains the provider’s responsibility to ensure that all coding and documentation are done in accordance with all applicable state and federal laws and regulations.*

## BCN clinic code policy clarified

We’ve received questions about clinical code billing requirements. Here’s some information to help clarify the requirements for billing clinical visits for your BCN patients.

It’s Blue Care Network’s policy not to pay facilities for clinical visits. UB-04 claims with a revenue code of 0510-0529 will be denied with a request that the service be billed on a CMS-1500 claim form. Revenue code 0516 is exempt from clinical billing; it’s classified as urgent care.

Hospitals may continue to bill for clinic services related to surgeries. Surgeries billed in conjunction with clinic codes are allowed on UB-04. Surgeries will be processed and paid.

### Filing requirements

All clinical claims must be received on a CMS-1500. All claims must be submitted using the appropriate procedure code.

You must also bill specific revenue codes for services provided. For example, cardiac rehabilitation should be reported with revenue code 0943. Don’t submit a 0510-0519 clinic code.

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## Improve HEDIS scores, reduce medical record requests through proper claims coding

Submitting claims with CPT® Category II and ICD-10 codes can help Blue Cross Blue Shield of Michigan and Blue Care Network determine if certain HEDIS® measures are met without needing to review medical records. This lessens the administrative burden on office staff because it reduces the need for them to pull medical records for Blue Cross' review.

### CPT II codes that support HEDIS measures include:

HEDIS measure	CPT II code	Description
Medication reconciliation post discharge	*1111F	Discharge medications reconciled with the current medication list in outpatient medical record
Comprehensive diabetes care – eye exam (The patient’s eye exam report must be included in your medical record)	*2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
	*3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)
Comprehensive diabetes care – HbA1c control	*3044F	Most recent HbA1c level < 7.0%
	*3045F	Most recent HbA1c level 7.0-9.0%
	*3046F	Most recent HbA1c level > 9.0%
Comprehensive diabetes care – medical attention for nephropathy	*3066F	Documentation of treatment for nephropathy (includes visit to nephrologist, receiving dialysis, treatment for end stage renal disease, chronic renal failure, acute renal failure or renal insufficiency)
	*4010F	Angiotensin converting enzyme inhibitor or angiotensin receptor blocker therapy prescribed or currently being taken
Comprehensive diabetes care – controlling blood pressure**	*3074F	Most recent systolic blood pressure <130 mm Hg
	*3075F	Most recent systolic blood pressure 130 – 139 mm Hg
	*3077F	Most recent systolic blood pressure ≥ 140 mm Hg
	*3078F	Most recent diastolic blood pressure <80 mm Hg
	*3079F	Most recent diastolic blood pressure 80 - 89 mm Hg
	*3080F	Most recent diastolic blood pressure ≥ 90 mm Hg

\*\*The National Committee for Quality Assurance requires medical record review for the controlling blood pressure measure. However, for the comprehensive diabetes care – controlling high blood pressure measure, CPT Category II codes can be used to identify compliant members through claims data when the member’s latest blood pressure reading is compliant (<140/90).

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Claims coding, continued from Page 36

ICD-10 codes that support HEDIS exclusion criteria include:

Patients won't be identified for certain HEDIS measures when ICD-10 exclusion codes are submitted on a claim. These include:

Measure	ICD-10 code	Description
<b>Breast cancer screening</b> Patients who have bilateral or two unilateral mastectomies	Z90.13	Acquired absence of bilateral breasts and nipples
	Z90.12	Acquired absence of left breast and nipple
	Z90.11	Acquired absence of right breast and nipple
<b>Colorectal cancer screening</b> Patients who currently have or with a history of colorectal cancer (cancer of the small intestine doesn't count)	Z85.038	Personal history of other malignant neoplasm of large intestine
	Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus

ICD-10 codes that support the adult BMI assessment measure include:

HEDIS measure	ICD-10 code	Description
<b>Adult BMI</b>	Z68.1	BMI of 19.99 or less
	Z68.20	BMI 20.0-20.9
	Z68.21	BMI 21.0-21.9
	Z68.22	BMI 22.0-22.9
	Z68.23	BMI 23.0-23.9
	Z68.24	BMI 24.0-24.9
	Z68.25	BMI 25.0-25.9
	Z68.26	BMI 26.0-26.9
	Z68.27	BMI 27.0-27.9
	Z68.28	BMI 28.0-28.9
	Z68.29	BMI 29.0-29.9
	Z68.30	BMI 30.0-30.9
	Z68.31	BMI 31.0-31.9

HEDIS measure	ICD-10 code	Description
<b>Adult BMI</b>	Z68.32	BMI 32.0-32.9
	Z68.33	BMI 33.0-33.9
	Z68.34	BMI 34.0-34.9
	Z68.35	BMI 35.0-35.9
	Z68.36	BMI 36.0-36.9
	Z68.37	BMI 37.0-37.9
	Z68.38	BMI 38.0-38.9
	Z68.39	BMI 39.0-39.9
	Z68.41	BMI 40.0-44.9
	Z68.42	BMI 45.0-49.9
	Z68.43	BMI 50.0-59.9
	Z68.44	BMI 60.0-69.9
	Z68.45	BMI 70.0 or greater

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## You can now search clinical editing billing tips

Looking for a specific clinical editing billing tip? Now you can search all the billing tips that were published in *BCN Provider News* for a specific year. Previously, you'd have to open each *BCN Provider News* issue and look at the billing tips that were published in that issue.

We've included links to three years of clinical editing billing tips on BCN's Billing / Claims page within Provider Secured Services.

To find them:

- Visit [bcbsm.com/providers](http://bcbsm.com/providers).
- Log in to Provider Secured Services.
- Click *BCN Provider Publications and Resources*.
- Click *Billing / Claims*.

Under the Clinical Editing Resources heading, you'll see tips for 2016, 2017 and 2018. Open the tips for one of those years and search for the information you need.

To search, hold down the CTRL key on your keyboard and then press the "F" key. Enter the word you're searching for in the "Find" field and press "Enter" on your keyboard.

As more clinical editing billing tips are published in the upcoming 2018 *BCN Provider News* issues, we'll add those to the 2018 billing tips collection.

Clinical editing billing tips help ensure that Blue Care Network pays your claims accurately and that the procedure you performed is correctly reported to us. Remember, clinical editing billing tips are current as of the date published.

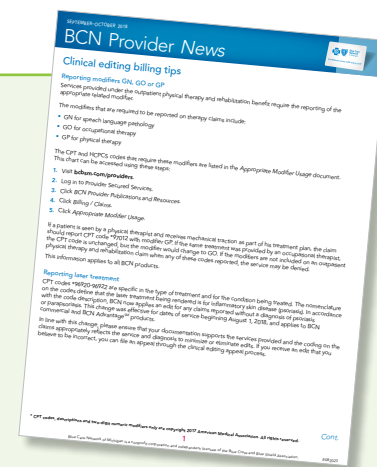
## Clinical editing billing tips

In most issues we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that the performed procedure is correctly reported to us.

This issue's billing tips include:

- Reporting modifiers GN, GO or GP
- Reporting laser treatment
- Diagnosis requirements when reporting psychological and neuropsychological testing

To view the full content of the tips, click on the *Clinical editing billing tips* at the right.



*Clinical editing  
billing tips*

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## BCN clinical editing system updates

As we noted in a previous issue, Blue Care Network is in the process of replacing the current Change Healthcare (previously McKesson) ClaimCheck® software with their enhanced clinical editing solution, ClaimsXten. We'll be continuing to implement the updated tool in the third quarter of 2018.

ClaimsXten help us to continue to meet the ever-changing needs in the health care industry, while aligning to national coding guidelines. The changes you will see won't affect how you submit claims or appeals. In fact, most of the clinical edits that you're familiar with will remain unchanged, as our processes are currently based on national coding guidelines.

Some of the changes you will notice include:

- **New explanation codes on your explanation of payment or remittance advice.** The current explanation codes, N01-N94, will remain for claims processed prior to the go live, but new ones, beginning with a variety of lower case letters, such as e, f, g, h, j, k, and l. As with the current explanation codes, a brief narrative will be provided giving the reason for the edit.
- **Professional reimbursement based on place of service.** Previously, the reimbursement was based primarily on the professional fee schedule in the office location, unless a manual adjustment was made. With ClaimsXten, the system will identify whether the location is outpatient or office as reported on the claim.
- **Multiple radiology reduction on the professional component.** BCN has been following CMS guidelines and reducing the technical component when multiple radiology procedures are reported on the same date of service. Due to system limitations, we haven't been able to implement the CMS professional reductions. Functionality within ClaimsXten will allow this.
- **Bundled procedures.** In line with CMS guidelines, BCN will consider most claims lines containing these procedure codes as bundled and not separately payable. There are some exceptions to this policy, such as with CPT code \*99080 as it's required for reporting completion of the Healthy Blue Qualification form.

We'll continue to provide updates on the ClaimsXten implementation and ongoing clinical editing updates in future issues of *BCN Provider News* or on web-DENIS.

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## How to submit a replacement or void claim

We're clarifying when and how to submit a replacement or void claim.

### Filing a replacement claim, also known as a corrected, TOB XXX7 or Frequency 7 claim

A replacement, or corrected, claim replaces a previously submitted claim that contains changes or corrections to previously submitted charges, clinical or procedure codes or dates of service, for example.

When filing a replacement claim, submit a corrected claim with all line items that were billed on the original claim. It should never be filed with *only* the line items that are being corrected. In addition:

- If services previously billed are being deleted (that is, if the corrected claim has fewer lines than the original claim), include a note to confirm that the deleted codes were originally billed in error.
- If the member information needs to be updated, don't submit a replacement (corrected) claim. Instead, submit a void claim and then bill the services on a new claim that includes the correct member information.

### Filing a void claim, also known as a TOB XXX8 or Frequency 8 claim

When filing a void claim, rebill all services that were billed on the original claim that's being voided. These include both paid and denied services that were on the original claim. Submit a TOB 8 (void) claim only when voiding the entire original claim.

### Additional information

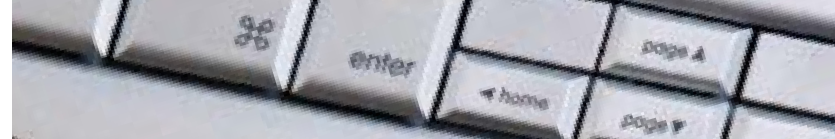
We've updated the Claims chapter of the *BCN Provider Manual* with these clarifications. To view the Claims chapter:

1. Visit [bcbsm.com/providers](http://bcbsm.com/providers).
2. Log in to Provider Secured Services.
3. Click *Provider Manuals*.
4. Click *BCN Provider Manual*.
5. Click *Claims (Billing)*.

You can also refer to the BCN page in the Claims Troubleshooting document to find additional information on submitting these types of claims.

To find the *Claims Troubleshooting* document:

1. Visit [bcbsm.com/providers](http://bcbsm.com/providers).
2. Log into Provider Secured Services.
3. Click *BCN Provider Publications and Resources*.
4. Click *Billing / Claims*.
5. Click *Claims troubleshooting*.



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**Question:**

When we report an evaluation and management service based on time in our office, our physicians document how much time they spend with the patient. Frequently we have been asked for additional information. What should we be documenting or sending for review?

**Answer:**

Billing evaluation and management services based on time seems like it should be simple. Just document the amount of time spent with the patient. Right?

More is needed, but it doesn't need to be overly complex or burdensome. Our response will focus on time based reporting in the office setting.

Time based reporting of E&M services is considered a key factor in those visits where counseling or coordination of care dominates (more than 50 percent of) the visit with the patient and family (face-to-face time in the office).

When the level of service reported is using time as a key component, documentation needed in the record should include:

- The total length of time of the encounter and percentage of time for counseling/coordination of care
- Description of the counseling and activities to coordinate care

The documentation for the time services does not eliminate or minimize the need to include the basic components typically noted in an E&M visit.

These components include the following, but the extent and amount of documentation may vary depending on the reason for the visit:

- Nature of presenting problem
- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Time

As with any medical record documentation, ensure that it is complete, accurate, clear and concise. Does it answer the question, "Does my documentation support the care I provided to the patient?"

**Question:**

If documentation supports a provider performing an EGD (\*43235) then withdrawing the scope and performing a Maloney dilation (\*43450), can you bill them both using the same diagnosis? The Maloney dilation is under a different section in the CPT book and I would bill it with a separate code.

**Answer:**

In situations where a patient has a diagnostic endoscopy and a dilation of the esophagus on the same day, they are typically performed for different and distinct clinical indications. In other words, it's not expected that the Maloney dilation is performed to gain access to a surgical site, which in the case of these codes could be for a brushing or biopsy. Therefore, an edit does not exist between these codes. As both codes are subject to a multiple procedure reduction, the procedure that is valued lower will receive a payment reduction in accordance with the multiple procedure payment guidelines.

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Have a billing question?



If you have a general billing question, we want to hear from you. Click on the envelope icon to open an email, then type your question. It will be submitted to *BCN Provider News* and we will answer your question in an upcoming column, or have the appropriate person contact you directly. Call Provider Inquiry if your question is urgent or time sensitive. Do not include any personal health information, such as patient names or contract numbers.

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## Where to get diabetic supplies for BCN members

We've received questions recently about where to order diabetic supplies. Providers can order diabetic supplies for BCN HMO<sup>SM</sup> and BCN Advantage<sup>SM</sup> members (except diabetic shoes and inserts) from J&B Medical Supply. Call 1-888-896-6233 or fax 1-800-737-0012.

For durable medical equipment, prosthetics, custom orthotics and diabetic shoes and inserts, contact Northwood to identify a contracted supplier near you. Call 1-800-393-6432 or fax 586-755-3878.

This information is available in the **BCN Provider Resource Guide At a Glance** and in the *BCN Provider Manual*.

You can also refer to the **BCN Provider Resource Guide**. See the DME, Medical Supplies and P&O page.



## Where to submit appeals of eviCore healthcare's decisions

Providers must submit appeals of eviCore healthcare's decisions on BCN Advantage<sup>SM</sup> authorization requests to the BCN Advantage Grievances and Appeals Unit and not to eviCore. This was effective June 22.

Here's where to submit:

**By mail:**

Blue Care Network  
 ATTN: BCN Advantage Grievances and Appeals Unit  
 P.O. Box 284  
 Southfield MI 48076-5043

**By fax:** 1-866-522-7345

BCN will process these appeals using the normal BCN Advantage appeal process for standard and expedited appeals. For information on that process, refer to the BCN Advantage chapter of the *BCN Provider Manual*. Look in the section titled "BCN Advantage provider appeals."

Appeals of eviCore decisions on BCN HMO<sup>SM</sup> (commercial) authorization requests should continue to be submitted to eviCore.

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## Reminder: Starting Oct. 1, AIM Specialty Health to manage cardiology and high-tech radiology services for Blue Care Network

As a reminder, for dates of service on or after Oct. 1, 2018, AIM Specialty Health® will manage the authorization process for cardiology and high-tech radiology procedures for BCN HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members. We first communicated about this in the article **AIM Specialty Health to manage cardiology and high-tech radiology procedures for BCN starting Oct. 1** in the July-August 2018 issue of *BCN Provider News*, Page 33.

AIM will accept authorization requests starting Sept. 17, 2018. You can submit these requests either through the *AIM ProviderPortal<sup>SM</sup>* or by calling AIM at 1-844-377-1278.

For dates of service prior to Oct. 1, continue to submit your authorization requests to eviCore healthcare.

### Webinars still available in September and October

We've scheduled training webinars so you can learn how to register for and use the AIM provider portal, an online tool used to request authorization from AIM.

These training dates are still available:

September 2018	October 2018
<ul style="list-style-type: none"> <li>• Wednesday, Sept. 5, 10-11 a.m.</li> <li>• Thursday, Sept. 6, 2-3 p.m.</li> </ul>	<ul style="list-style-type: none"> <li>• Wednesday, Oct. 3, 10-11 a.m.</li> <li>• Thursday, Oct. 4, 2-3 p.m.</li> </ul>

To register for a webinar, complete the **AIM webinar registration** form and submit it in one of the following ways:

- Fax it to 1-866-652-8983
- Email it to [providerinvitations@bcbsm.com](mailto:providerinvitations@bcbsm.com)

The instructions for logging in and calling in to the webinar will be emailed to you a day or two prior to the webinar.

### Codes for procedures AIM will manage

Click **here** for a list of the procedure codes AIM will manage. The list shows the following categories of procedures:

- **Category 1:** Procedures that require authorization by eviCore healthcare for dates of service through Sept. 30, 2018, and will continue to require authorization by AIM for dates of service on or after Oct. 1, 2018
- **Category 2:** Procedures that require authorization by eviCore healthcare for dates of service through Sept. 30, 2018, but will not require authorization by AIM for dates of service on or after Oct. 1, 2018
- **Category 3:** A few procedures that require authorization by eviCore healthcare for dates of service through Sept. 30, 2018, will require authorization by BCN for dates of service on or after Oct. 1, 2018. Submit authorization requests for these procedures directly to BCN through the e-referral system. Don't submit them to AIM.
- **Category 4:** Procedures that do not require authorization by eviCore healthcare for dates of service through Sept. 30, 2018, but will require authorization by AIM for dates of service on or after Oct. 1, 2018

You'll be able to find the list of codes on our **[ereferrals.bcbsm.com](http://ereferrals.bcbsm.com)** website by the end of September.

### Additional information

Additional information about submitting authorization requests is available on the **AIM Specialty Health website**, including:

- AIM's **clinical guidelines**
- **Frequently asked questions** about the AIM provider portal
- **Additional information** about the AIM provider portal

Once you're registered to use the AIM provider portal, you'll also be able to access AIM's **tutorials** about using their provider portal.

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## Gastric pacing / stimulation questionnaire updated in e-referral system

The gastric pacing / stimulation questionnaire in the e-referral system was updated in late June. The questionnaire opens when an authorization request for gastric pacing / stimulation for a BCN Advantage<sup>SM</sup> or Blue Cross Medicare Plus Blue<sup>SM</sup> PPO member is submitted.

### How the questionnaire works

If your responses to the questionnaire indicate that the procedure meets criteria, the authorization request will automatically be approved. If the criteria aren't met, we'll hold the request for clinical review by BCN's Utilization Management staff.

For cases that aren't automatically approved by e-referral after you complete the questionnaire, you must include additional clinical information. You can type the information directly into the Case Communication section in the e-referral system or attach it to the case. The instructions for attaching clinical information to the case are outlined in the [article](#) "How to attach clinical information to your authorization request in the e-referral system," on page 44 in the November-December 2016 *BCN Provider News*.

### Preview questionnaire is available

The [gastric pacing / stimulation preview questionnaire](#) posted at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) has been revised to reflect the questions in the e-referral questionnaire. We suggest using the preview questionnaire for this service and for other services to help you prepare in advance. This can reduce the time it takes to complete the authorization request in the e-referral system. To access the preview questionnaire for this or other services, visit [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com), click *BCN* and then click [Authorization Requirements & Criteria](#).

You'll also find the questionnaire on the [Authorization Requirements & Criteria](#) page in the Blue Cross section of that website.

### List of updated preview questionnaires and authorization criteria

See the [list of other questionnaires](#) and authorization criteria that have been recently updated.

## Tips for selecting a provider in e-referral

When populating the Servicing Provider field in e-referral, remember the following tips:

- Start by entering the group NPI for an exact match.
- If the NPI is unknown, you can search by the provider's name.
- If you choose to search for the provider by name, keep in mind the provider may be listed in the results several times. A provider may have several locations or addresses or multiple group affiliations.
  - If a provider has a group affiliation, select that listing not the individual. Use his or her NPI to ensure you're choosing the correct group affiliation.
  - If the provider has multiple locations and no group affiliation, choose the one with the correct NPI and that has a Preferred (Pref) or In status listed in the Network column.

Entering an incorrect servicing provider will result in a rejected claim.

For help using e-referral, see the user guides and online training available at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) under *Training Tools*.

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## Utilization management programs summary now available

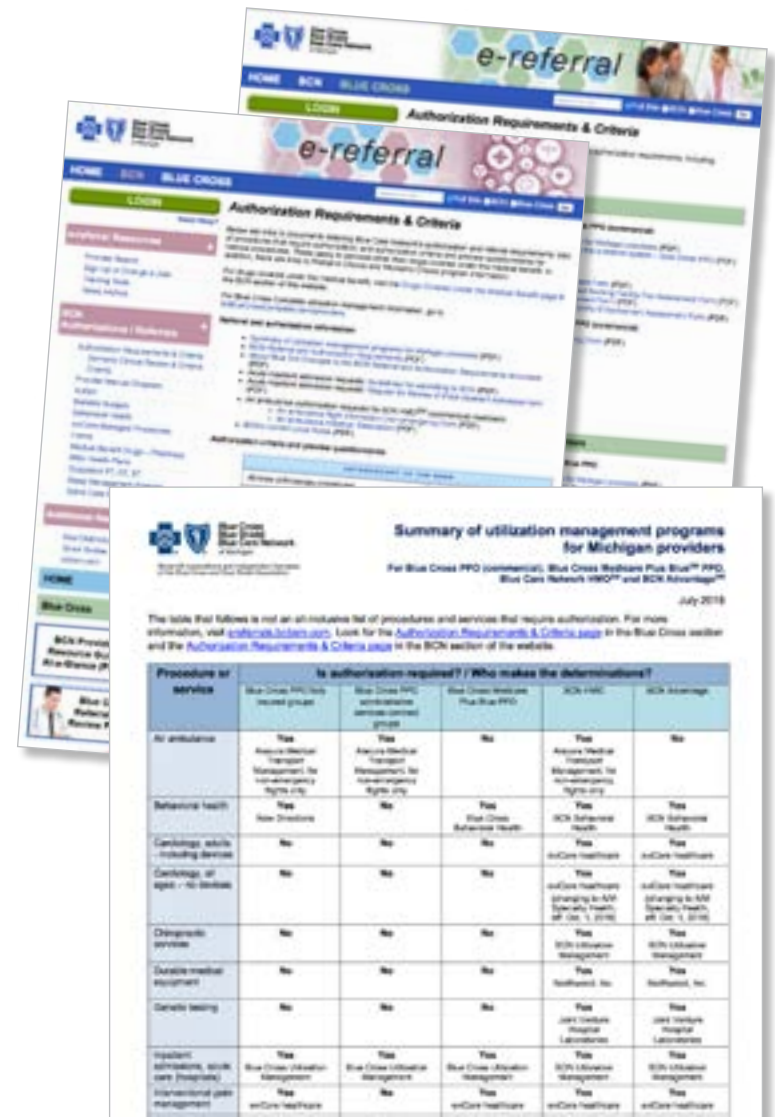
Do you ever get confused as to which products require authorization? We've put together a handy document that helps you find out whether a service you're providing requires an authorization and how to get it.

The document for Michigan providers includes all lines of business for Blue Cross Blue Shield of Michigan and Blue Care Network and lists who manages the authorizations. It will be updated from time to time.

The **utilization management programs summary document** has been posted online at these locations:

- At [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com)
  - On the **BCN Authorization Requirements & Criteria** page
  - On the **Blue Cross Authorization Requirements & Criteria** page in both the Blue Cross PPO and Medicare Plus Blue PPO sections
- On the Blue Cross Clinical Criteria & Resources page within Provider Secured Services

The document is not an all-inclusive list of procedures and services that require authorization, but we hope it's a way to help you keep straight the requirements for some of the most frequently performed services.



**Summary of utilization management programs for Michigan providers**  
 For Blue Cross PPO (commercial), Blue Cross Medicare Plus Blue™ PPO, Blue Care Network VMO™ and BCN Advantage™  
 July 2018

The table that follows is not an all-inclusive list of procedures and services that require authorization. For more information, visit [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Look for the [Authorization Requirements & Criteria](#) page in the Blue Cross section and the [Authorization Requirements & Criteria](#) page in the BCN section of the website.

Procedure or service	Is authorization required? / Who makes the determinations?				
	Blue Cross PPO (commercial)	Blue Cross PPO Medicare Plus Blue™ PPO	Blue Cross Medicare Plus Blue™ PPO	BCN VMO™	BCN Advantage™
All ambulatory	Yes Alliance Medical Management for non-emergent (NME) only	Yes Alliance Medical Management for non-emergent (NME) only	No	Yes Alliance Medical Management for non-emergent (NME) only	No
Behavioral health	Yes New Directions	No	Yes Blue Cross Behavioral Health	Yes BCN Behavioral Health	Yes BCN Behavioral Health
Cardiology, adult - including echocardiography	No	No	No	Yes eCore Healthcare	Yes eCore Healthcare
Cardiology, all ages - all services	No	No	No	Yes eCore Healthcare (changing to AM Specialty Health, effective Jan. 1, 2019)	Yes eCore Healthcare (changing to AM Specialty Health, effective Jan. 1, 2019)
Chiropractic services	No	No	No	Yes WPA Behavioral Management	Yes WPA Behavioral Management
Durable medical equipment	No	No	No	Yes Wellness, Inc.	Yes Wellness, Inc.
Genetic testing	No	No	No	Yes Genetics Hospital Laboratories	Yes Genetics Hospital Laboratories
Hospital admission, discharge (Pre-admission) and readmission	Yes Blue Cross Utilization Management	Yes Blue Cross Utilization Management	Yes Blue Cross Utilization Management	Yes BCN Utilization Management	Yes BCN Utilization Management
International joint management	Yes eCore Healthcare	No	Yes eCore Healthcare	Yes eCore Healthcare	Yes eCore Healthcare

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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.

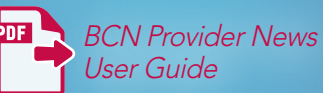
Please see [Marketplace](#), continued on Page 2

## Award recognizes providers' roles in star-ratings success

Providers who have made outstanding contributions to the BCN Advantage<sup>SM</sup> and Blue Cross Medicare Plus Blue<sup>SM</sup> 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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# Network Operations

## 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 Blue<sup>SM</sup> PPO
- BCN HMO<sup>SM</sup>
- BCN Advantage<sup>SM</sup>

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 Diagnostics<sup>TM</sup> — 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-Blue<sup>SM</sup>
- BCBSM Health e-Blue<sup>SM</sup>
- 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](http://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-Blue<sup>SM</sup>** to generate reports about patient health. Primary care physicians can also use it to fill out Healthy *Blue Living<sup>SM</sup>* 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.

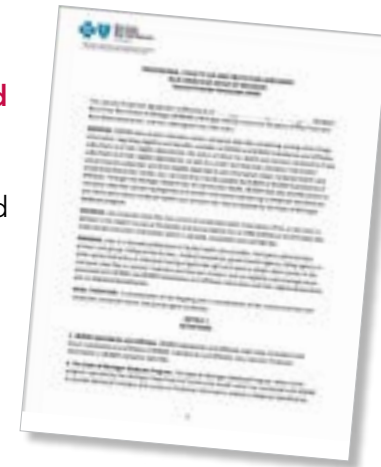
**Get started here.**

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.*

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## 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"> <li>• It will give you clearer understanding of the question</li> <li>• It will route your call correctly</li> </ul>
"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"> <li>• It will give you clearer understanding of the question</li> <li>• It will lessen the amount of time you need to spend in the automated response system</li> </ul>

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 HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members.

Here's what you need to know about submitting inpatient authorization requests when our corporate offices are closed.

### Acute initial inpatient admissions

Submit these authorization requests through the e referral system, which is available 24 hours a day, seven days a week.

**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 Advantage<sup>SM</sup> 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 Advantage<sup>SM</sup> 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 Advantage<sup>SM</sup> HMO-POS Elements
- BCN Advantage<sup>SM</sup> HMO-POS Basic
- BCN Advantage<sup>SM</sup> HMO-POS Classic
- BCN Advantage<sup>SM</sup> HMO-POS Prestige
- BCN Advantage<sup>SM</sup> HMO MyChoice Wellness
- BCN Advantage<sup>SM</sup> HMO ConnectedCare
- BCN Advantage<sup>SM</sup> HMO HealthySaver
- BCN Advantage<sup>SM</sup> 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

For several years now, BCN Advantage<sup>SM</sup> 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 Advantage<sup>SM</sup> 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](http://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.

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## Renflexis requires authorization for BCN Advantage starting Oct. 1

For dates of service on or after Oct. 1, 2018, Renflexis® requires authorization for BCN Advantage<sup>SM</sup> 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 Advantage<sup>SM</sup> and Medicare Advantage PPO plans will begin offering Blue Cross Online Visits<sup>SM</sup> 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 Visits<sup>SM</sup> app
  - Visit [bcbsmonlinevisits.com](http://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 Blue<sup>SM</sup> PPO and BCN Advantage<sup>SM</sup> 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 Advantage<sup>SM</sup> plan.

The plan is called ConnectedCare: Henry Ford Health System. Please note that this plan is **not** affiliated with our existing plan, BCN Advantage<sup>SM</sup> 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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### 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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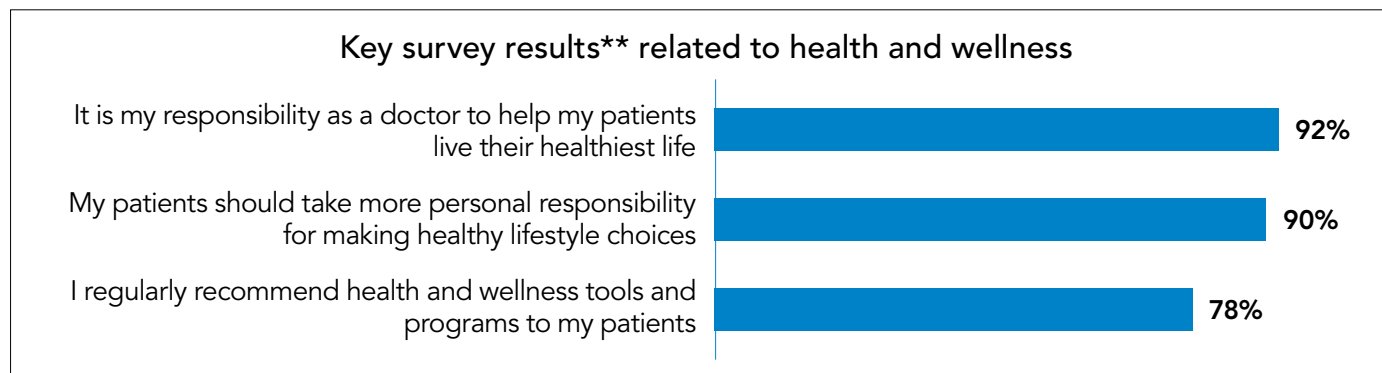
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## Physicians, Blue Cross and BCN agree that healthy lifestyles are key to living well

*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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**Lifestyles**, continued from Page 22

### 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](http://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](http://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



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## 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](mailto: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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## 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.

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## 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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## 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](http://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.



## 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.

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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 Advantage<sup>SM</sup> and Medicare Plus Blue<sup>SM</sup> 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



Please see [HEDIS Results](#), continued on Page 35

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## HEDIS Results, continued from Page 34

### 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-Blue<sup>SM</sup> 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<sup>®</sup>, 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<sup>®</sup>
- Pneumovax<sup>®</sup> 23
- Boostrix<sup>®</sup> and Boostrix<sup>®</sup> TDAP
- Gardasil<sup>®</sup> and Gardasil<sup>®</sup> 9
- Havrix<sup>®</sup> (adolescent dose)
- Vaqta<sup>®</sup> (adolescent dose)
- Havrix<sup>®</sup> (adult dose)
- Vaqta<sup>®</sup> (adult dose)
- Prevnar<sup>®</sup>
- Adacel<sup>®</sup> TDAP
- Menveo<sup>®</sup> (effective Aug. 1)

## Renflexis requires authorization for BCN Advantage starting Oct. 1

For dates of service on or after Oct. 1, 2018, Renflexis<sup>®</sup> requires authorization for BCN Advantage<sup>SM</sup> 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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## Coding Corner, continued from Page 39

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

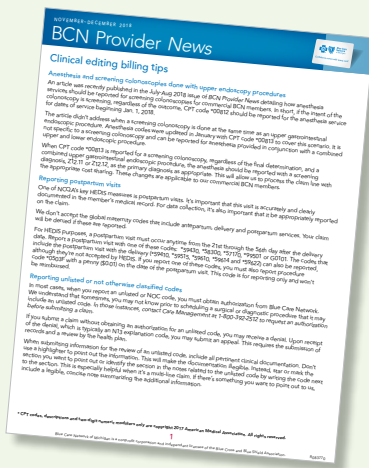
## Clinical editing billing tips

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.



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.

## Billing Q&amp;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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## Billing Q&amp;A, continued from Page 41

**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 Advantage<sup>SM</sup> 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 HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> 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](http://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 HMO<sup>SM</sup>
- BCN Advantage<sup>SM</sup>
- Blue Cross Medicare Plus Blue<sup>SM</sup> 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](http://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 HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> 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 Blue<sup>SM</sup> 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 HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> 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](http://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](http://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 HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members and to the following providers:

- Facilities
- Therapists performing physical, occupational and speech therapy
- Chiropractors performing physical medicine services
- Referring physicians
- Podiatrists

In addition, BCN is working with eviCore to implement the corePath<sup>SM</sup> authorization model for these requests for BCN HMO (commercial) and BCN Advantage members. corePath will streamline the authorization process and make it easier for providers to submit authorization requests. It's the same model that was implemented for Blue Cross Medicare Plus Blue<sup>SM</sup> PPO authorization requests starting Jan. 1, 2018.

Look for more details about these changes in the coming months.



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