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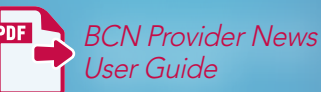
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Depression screening and treatment are important steps to wellness

By Dr. William Beecroft, medical director of behavioral health for Blue Care Network

Diagnosing depression can be subjective and primary care providers may not consider the diagnosis if they don't get clear information from patients. Patients who have had symptoms for a long time, particularly if their symptoms are physical, may not recognize they have a problem. These factors lead to underdiagnosis.

Yet 8.1 percent of American adults ages 20 and older had depression in a given two-week period during 2013 to 2016. And women (10.4 percent) were almost twice as likely as men to have had depression, according to the Centers for Disease Control and Prevention.

Because there is no biologic test or biomarker reliable enough to make a clear diagnosis of major depression, the clinical diagnosis is the best we have.

Please see [Depression](#), continued on Page 17

Best Practices

Antidepressant medication management

An interview with Rhoda Beltran, M.D., Grand Rapids

What are some of the challenges you face with keeping patients on antidepressant medication long term and how do you overcome them?

First, we realize that depression is getting to be common problem. Research has shown that this is something we have to be diligent in recognizing, especially in patients with chronic medical conditions. As a primary care provider, we face many challenges in taking care of these patients, such as having the patients comply with taking their medications as prescribed. That is why education is very important. These patients need to understand why treatment is necessary, what these medications are, possible side effects and what to expect with their

Please see [Best Practices](#), continued on Page 22

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Blue Care Network changes process for requesting a member transfer

Blue Care Network has changed the process a primary care physician should use when requesting that a member be removed from his or her practice and assigned to another primary care physician. This applies to both BCN HMOSM (commercial) and BCN AdvantageSM members.

What the new process involves

The member's current primary care physician must complete and submit the *Member Transfer Request Form* to BCN. The form is on the last page of a frequently asked questions document and is available on BCN's Forms page:

1. Visit bcbsm.com/providers.
2. Log in to Provider Secured Services.
3. Scroll down and click *BCN Provider Publications and Resources*, on the right.
4. Click *Forms*.
5. Click *Member Transfer FAQ and Request Form*, under the "Member transfer" heading.

You'll also find a link to the *Member Transfer FAQ and Request Form* on the Health e-BlueSM home page and in the BCN System of Managed Care chapter of the *BCN Provider Manual*.

Criteria for requesting a member transfer and other things you should know

Before submitting a request to transfer a member, review the FAQ to make sure your request meets the member transfer criteria. The criteria involve a member's:

- Financial obligations
- Behavior
- Geographic distance from the physician office
- Seeing a primary care physician in a different office
- Lack of response to outreach by your office

The FAQ also outlines details for submitting the request and your responsibilities once the request has been submitted.

Remember, BCN must approve the request before the member can be transferred.

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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 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 20**.

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:

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

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

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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:

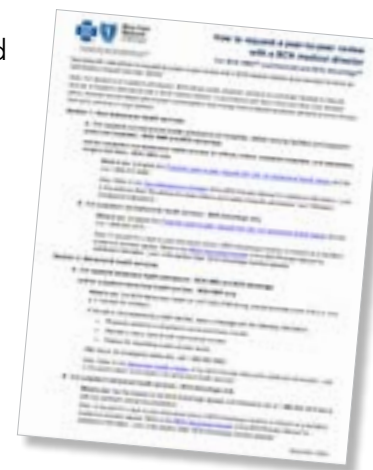
- Provide clinical support for utilization management activities, including investigation and adjudication of individual cases
- Assist in the design, development, implementation and assessment of clinical protocols, practice guidelines and criteria that support the appropriate use of clinical resources
- 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

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 of BCN's plan medical directors to discuss the decision.

If you're a practitioner and would like to discuss a denial of an authorization request with one of our plan medical directors, follow the process outlined in the document titled **How to request a peer-to-peer review with a BCN medical director** to request a phone appointment. To discuss an urgent case with one of our plan medical directors after normal business hours, call 1-800-851-3904. This number is for non-behavioral health cases only.



How to obtain a copy of utilization management criteria

Upon request, Blue Care Network provides the criteria used in the decision-making process for a specific authorization request. To obtain that, call Utilization Management at 248-799-6312 from 8:30 a.m. to 5 p.m. Monday through Friday. In the future, you'll fax in a request for the criteria instead of calling. Look for information on the fax form in an upcoming issue of *BCN Provider News*.

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.

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You don't need to reset your password as often

We've changed our password reset requirement to every 60 days for the Blue Cross secure website. In the past, you had to change your password every 30 days.

We made this change to make it easier for you to do business with us. Resetting your password is still important because it is a key step in securing patient information. Here are a few additional tips for keeping office information secure:

- **Don't share user IDs.** Each employee who needs access should have an individual ID.
- **Protect your passwords.** The safest passwords are hard to guess, never shared and never posted where others can see them.
- **Disable access when employees depart.** When a user no longer needs access to our system, notify us right away. You can fax a request on your company's letterhead to 1-800-495-0812. Include the name and user ID of the employee who no longer requires access, and the signature of the current authorized employee.
- **Secure your workstation.** When you're not at your workstation, secure your computer and lock your screen.

If you need technical assistance to access our website, contact the Blue Cross Web Support Help Desk at 1-877-258-3932.

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Our RA Limited Choice program gets new name — CA Limited Choice

Blue Cross Blue Shield of Michigan and Blue Care Network have renamed their Religious Accommodation Limited Choice program. It will now be called Contraceptive Accommodation Limited Choice, or CA Limited Choice. We originally offered the program to comply with the Affordable Care Act's contraception exemption for religiously-accommodated groups.

Members who enroll in the program on or after Feb. 1, 2019, will receive new ID cards. Members who are already enrolled may continue to use their RA Limited Choice ID cards.

Blue Cross and BCN members must use either their CA Limited Choice ID card or their RA Limited Choice ID card to obtain contraceptive services at no cost share from an in-network provider. Contraceptive coverage for office procedures and prescription drugs are included in the program. However, a member is only eligible for prescription drug coverage if the member's group purchases prescription drugs through Blue Cross or BCN.

Sign up to receive *Blues Brief* electronically

As announced in the January-February 2019 **BCN Provider News**, *Blues Brief* has a new look and is now available via email subscription. *Blues Brief* contains Blue Cross Blue Shield of Michigan and Blue Care Network articles.



You can choose from the monthly physician office version, quarterly hospitals and facilities version and the specialty-specific versions coming this year for chiropractic, behavioral health and physical, occupational and speech therapy offices.

To sign up and avoid possible subscription errors, add *Blues Brief* to your subscriptions by clicking the Manage Subscriptions link at the bottom of your *BCN Provider News* or *The Record* newsletter emails. You can also visit the **subscription page** to choose your preferred *Blues Brief* versions.

Clarification: We're removing providers on the CMS preclusion list from our commercial and Medicare Advantage networks

We ran an article in the **January-February issue** of *BCN Provider News* notifying providers that we're required by the Centers for Medicare & Medicaid Services to remove providers from our Medicare Advantage networks if they are on the CMS preclusion list. According to CMS, we're not allowed to pay member claims for medical and pharmacy Part D services for providers on the CMS list.

We're also removing providers who are on the Medicare preclusion list from all Blue Cross commercial PPO and BCN HMO provider networks. These providers will be removed from our online provider directory. In addition, providers on the preclusion list won't be permitted to enroll in any of our commercial or Medicare Advantage networks.

For more information about the preclusion list, go to **cms.gov*** and type *Preclusion list* in the search box.

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BCN no longer accepts referrals for BCN Advantage members staying in-network

Beginning in the second half of March, BCN will no longer accept referrals for BCN AdvantageSM members to see a provider in their health plan's network. These referrals are no longer needed. We told you referrals are not needed for BCN Advantage members in the **Jan.-Feb. 2019 issue** as well as the **Nov.-Dec. 2018 issue**.

If you submit a referral for a BCN Advantage member through e-referral beginning near the end of March you will receive the following message:

Referrals are not accepted or needed for BCN Advantage members seeing providers in their health plan's network, but authorizations and plan notifications are still required for certain services. For more information, go to **ereferrals.bcbsm.com**.

If you submit a referral through a 278 electronic transaction you will receive an error code 33 with the description "Input Errors."

Remember: Authorizations and plan notifications are still required. Also, all services with a provider who's not in the member's health plan network require an authorization. Refer to the **BCN Referral and Authorization Requirements document** (PDF) in the BCN section at **ereferrals.bcbsm.com** on the Authorization Requirements & Criteria page for more details.

How to use the e-referral tool for your BCN Advantage patients

You no longer need to use the "Submit a global referral" or "Submit a referral" drop-down menus in the e-referral tool for your BCN AdvantageSM patients. These members don't need a referral to see a specialist within their plan's provider network.

However, you'll still need to submit requests for authorization.

- You should submit a request for an inpatient authorization for all inpatient services.
- Submit a request for an outpatient authorization in the following two circumstances:
 - The procedure requires clinical review
 - The provider is not part of the provider network for the member's health plan and the procedure is performed in an outpatient location.

Refer to the **BCN Referral and Authorization Requirements** document (PDF) in the BCN section of **ereferrals.bcbsm.com** (Authorization Requirements & Criteria page) for the list of outpatient services that require clinical review or authorization

For more information about referrals and authorizations, see the section titled, "The BCN referral process," in the **Care Management chapter** of the *BCN Provider Manual*.

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

BCN Advantage uses Medicare funds to pay doctors, hospitals, pharmacies, clinics and other health care providers to provide care to patients eligible for Medicare benefits. 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.

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. This definition applies to health care programs such as Medicare and Medicaid.

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.

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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 contracted insurers like BCN Advantage, can provide more care to more people and make the Medicare program stronger. Together, all of us can work to find, report and investigate fraud, waste and abuse.

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-POSSM and BCN Advantage HMOSM 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:

Phone: 1-800-HHS-TIPS (1-800-447-8477)

Website: [Medicare.gov/fraud](https://www.medicare.gov/fraud).

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

Effective June 1, new vendor for Medicare Advantage patients transferring to post-acute care facilities

BCN Advantage and Blue Cross Medicare Advantage members who are transferred from acute inpatient to skilled nursing, long-term acute care and inpatient rehabilitation facilities will be managed by naviHealth, effective June 1, 2019. naviHealth will be reviewing both in- and out-of-state cases.

Look for articles in future issues of *The Record* and *BCN Provider News* for information on how to submit requests to naviHealth and training opportunities.

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Blue Cross and BCN offer several diabetes prevention and management programs for members

In the face of sobering statistics about diabetes from the Centers for Disease Control and Prevention, Blue Cross Blue Shield of Michigan and Blue Care Network are working to help members who currently have diabetes or are at risk of getting it.

Consider the following statistics:

- More than 30 million people have diabetes. That's one in 10 individuals — and one of four don't know they have it.
- Eighty-four million people are prediabetic. That's one in three people — and nine out of 10 aren't aware that they are.
- Diabetes is the seventh leading cause of death in the U.S.
- Medical costs for people with diabetes are more than twice the cost for those without it.

Here's a summary of programs available in 2019. Two are focused on diabetes prevention, while the others are for patients who currently have diabetes.

Diabetes prevention

We've joined forces with two independent companies, Solera and Omada, to offer diabetes prevention programs.

- Solera manages the Medicare Diabetes Prevention Program for BCN AdvantageSM and Medicare Plus BlueSM members who are prediabetic.

It's a structured intervention program with the goal of preventing progression to Type 2 diabetes in individuals with prediabetes. The program, which launched in April 2018, includes education and support, and is proven to help participants lose weight, adopt healthy habits and reduce their risk of Type 2 diabetes.

For details, see the article on Page 7 of the **January-February 2018** issue of *BCN Provider News*.

- Omada offers a diabetes prevention program for our HMO and PPO commercial populations. Like the Livongo program described on the next page, self-funded groups must opt in to offer it to their employees.

The program, which began Jan. 1, 2019, uses coaches from Omada, along with digital health tools, such as wireless digital scales and online resources, to help members lose weight. It's a technology-driven, intensive behavioral counseling program focused on reducing the risk of obesity-related chronic disease. As part of the program, participants make incremental changes to their nutrition, physical activity, sleep and stress management patterns.

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Diabetes management

The following programs include education and insulin or glucose monitoring.

- The Fit4D program provides education and coaching services to select members who meet certain criteria. They must:
 - Be fully insured Medicare Plus BlueSM members, BCN AdvantageSM members, commercial fully insured members or URMBS members
 - Have a diagnosis of Type 1 or 2 diabetes
 - Be 18 or older
 - Have an A1c of 8.0 or above

The program supports members with diabetes as they self-manage their conditions and follow treatment and care plan recommendations. It includes phone communication, optional text messages and email. It also includes optional online group webinars. There's no cost for the member.

See the article on Page 15 of the **November-December 2018** issue of *BCN Provider News* for details.

- Livongo, an independent company that focuses on helping people with chronic conditions, is working with Blue Cross and BCN to offer a program for members with diabetes that features blood glucose monitoring and coaching. It's for commercial HMO and PPO members who have Type 1 or Type 2 diabetes, and whose employer group is self-funded and has opted in to the program. It includes:
 - High-tech remote monitoring that transmits data in real time
 - Meter and strips (Test strips only work with Livongo's device.)
 - Certified diabetes educators on call 24/7 for acute events
 - Access to education and free diabetic supplies (lancets and test strips)
 - Personalized coaching, blood glucose level trend management
 - Phone calls from a coach, triggered by out-of-range glucose readings

In addition, members can get their own clinical data in a user-friendly format to share with their primary care physician and family members. Neither Blue Cross nor Livongo shares information with physicians directly. It's the member's responsibility to discuss their glucose readings with the primary care doctor. However, Livongo encourages members to share information with their providers and sends them automated reminders to do so.

- Hygieia, an insulin guidance service, offers a program that's free for commercial HMO and PPO members who have Type 2 diabetes and live in southeast Michigan. It includes individual meetings to help patients make better use of their insulin, which includes getting the right dose between doctor visits.

Participants receive a hand-held device and d-Nav[®] software, which provide insulin dose recommendations when the member is due to take an insulin dose. It adjusts the recommended dosage as necessary so the patient's blood sugar remains under control.

- Members receive the d-Nav device, blood glucose test strips, control solution and lancets at no extra cost.
- To initiate the d-Nav service, members must visit a Hygieia clinic. Clinics are only located in southeast Michigan at this time.

This program requires participants to follow up in person and by phone as appropriate. Hygieia reaches out to the member's primary care physician to communicate anticipated outcomes. Hygieia also informs the member's physician of any significant changes and gives the provider access to a secure physician portal to follow the progress of his or her patients.

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



Suicide, overdose deaths continue to rise, *USA Today* reports

Suicide and drug overdose rates continued to rise in 2017, driving the number of U.S. deaths to the highest total in more than 100 years, *USA Today* reported on Nov. 29, 2018. The newspaper based its report on a series of reports from the Centers for Disease Control and Prevention. Here are some key statistics:

- Drug overdose deaths among U.S. residents exceeded 70,000 in 2017, nearly 6,600 more than in 2016, the CDC said.
- In 2017, 47,000 people committed suicide, a rate of 14 per 100,000 people. That's up from 10.5 in 1999. The total number of suicide deaths was the highest in a half century.

For more details are available in the *CDC report*, "Mortality in the United States, 2017."

Pharmaceutical manufacturer exploiting opioid crisis, *60 Minutes* reports

On Nov. 18, *60 Minutes* aired an investigative piece about the abusive pricing practices of pharmaceutical manufacturer kaléo, Inc., which produces EVZIO®, an auto injector that administers naloxone during an opioid overdose. Kaléo has increased the price by more than 600 percent since February 2016 amid the national opioid epidemic. American's Health Insurance Plans, a national association whose members provide coverage for health and health-related services, worked closely with the producers of *60 Minutes* to provide extensive educational assistance about out-of-control drug prices, the role of insurance providers in making care and medications accessible, and insights into the relationship between pharmacy benefit managers, insurers and drug manufacturers.

Nearly 11 million pounds of pills collected during Drug Take Back Day

During the 16th National Prescription Drug Take Back Day on Oct. 27, the Drug Enforcement Agency and federal, state and local partners disposed of more than 900,000 pounds of potentially dangerous, unused prescription medications collected at nearly 6,000 sites across the country. These twice-yearly events play a key role in removing opioids and other medications from the country's homes where they could be stolen or abused by family members and visitors.

As the state's largest health insurers, Blue Cross Blue Shield of Michigan and Blue Care Network support these twice-yearly events in various ways: through blogs, Twitter chats and resources offered through its *Opioids 101* site. Drug take-back events are part of a larger, corporate-wide effort to battle the opioid epidemic.

The next Drug Take Back Day is scheduled for Saturday, April 27, 2019, so mark your calendar. But your patients don't need to wait until then to dispose of unwanted prescription drugs. They can find a nearby drug disposal facility by using the DEA's *search tool* or Michigan OPEN's *Opioid Disposal Map*.

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Opioid epidemic, continued from Page 12

Some opioid deaths may be suicides

An op-ed published in *The New England Journal of Medicine* in April 2018, estimated that as many as 30 percent of opioid overdoses may be suicides rather than unintentional deaths

According to the article, which analyzed Centers for Disease Control and Prevention data from 2000 to 2017, about 10 percent of suicides were from intentional overdose. Of those, a third involved opioids.

In that period, deaths from suicide rose 60 percent, from 29,319 to 47,173, and the opioid-related suicide rate nearly doubled. In 2017, 1,887 Americans died of reported intentional opioid overdoses.

M-OPEN updates opioid prescribing recommendations for specific surgeries

Recommendations for opioid prescribing for specific surgical procedures were updated for 2019 by Michigan OPEN.

M-OPEN originally developed the recommendations, based on patient-reported data from the Michigan Surgical Quality Collaborative and published studies. According to M-OPEN, studies have shown that when patients are prescribed fewer pills, they consume fewer pills with no changes in pain or satisfaction scores. Recommendations are for patients with no preoperative opioid use.

Medical policy updates

Blue Care Network's medical policy updates are posted on Provider Secured Services. Go to *BCN Provider Publications and Resources* and click on *Medical Policy Manual*. Recent updates to the medical policies include:

Noncovered services

- Genetic and protein biomarkers for the diagnosis and cancer risk assessment of prostate cancer
- Genicular nerve blocks
- Patient-specific cutting guides and custom knee implants

Covered services

- Ambulatory event monitors and mobile cardiac outpatient telemetry
- Amniotic membrane and amniotic fluid
- Genetic testing for BRCA1 or BRCA2 for hereditary breast/ovarian cancer syndrome and other high-risk cancers
- Genetic testing for Lynch syndrome and other inherited colon cancer syndromes
- Genetic testing-molecular analysis for targeted therapy of non-small cell lung cancer
- Implantable bone-conduction and bone-anchored hearing devices
- Intermittent (72 hours or greater) or continuous invasive glucose monitoring
- Laboratory testing for heart and kidney transplant rejection
- Stereotactic radiosurgery and stereotactic body radiotherapy
- Medical formula for inborn errors of metabolism
- Focal treatments for prostate cancer



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Criteria corner

Blue Care Network uses Change Healthcare'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 Change Healthcare on various topics.

Question:

How is "Failed Observation" criteria applied?

Example: Acute criteria for Dehydration or Gastroenteritis, Failed Observation treatment.

Answer:

To apply "Failed Observation Treatment" criteria, the patient must have been in Observation status with InterQual criteria met for Observation and have failed the treatment attempted while in Observation status. Emergency room treatment cannot be applied as Observation treatment. The length of time that Observation criteria must be applied depends on the subset and will usually be defined in that subset.

BCN Local Rule:

In applying InterQual criteria to different benefit packages, we've adopted local rules. These local rules apply to all BCN commercial and BCN AdvantageSM members statewide. Our local rule for "Failed Observation Treatment" states that BCN requires 48 hours of observation to complete workup and initiate treatment and/or to stabilize member for discharge.

- If after 48 hours the member still requires treatment for a known diagnosis, then an inpatient stay may be approved.
- If the member has a diagnosis that does not require further treatment and is stable for discharge within 48 hours or less, then the observation status will remain authorized.

Know member rights and responsibilities

Blue Care Network members have certain rights and responsibilities. Providers should be aware of these rights. They are available on our [website](#).

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Uninsured rate hits four-year high

The United States uninsured rate has risen steadily since 2016 according to the Gallup National Health and Well-Being Index.

Women, younger adults and lower income people have the greatest increases.

In the fourth quarter of 2018, the adult uninsured rate was 13.7 percent, the highest level since the first quarter of 2014. The numbers represent a net increase of about 7 million adults without health insurance.

A **Gallup article** cited several factors that may be responsible for the increases:

- Insurance premiums have increased on the Health Insurance Marketplace.
- Some enrollees have incomes that don't qualify for subsidies.
- Insurers have withdrawn from the marketplace, decreasing choices and competition.
- Policy decisions and political forces may have increased uncertainty surrounding the Affordable Care Act marketplace.

About the Gallup National Health and Well-Being Index

In 2008, Gallup began measurement for the Gallup National Health and Well-Being Index, merging decades of clinical research, health leadership and behavioral economics research to track and understand the key factors that drive well-being. The Index provides an in-depth view of Americans' well-being and offers insights into their attitudes and behaviors at the national, state and community levels.



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Quality corner: Antidepressant medication management

What is the antidepressant medication management measure, according to the Healthcare Effectiveness Data and Information Set guidelines?

The percentage of members 18 years or older with a diagnosis of major depression who are newly treated with antidepressant medication, and who remained on the medication for at least:

- 84 days for the acute period measure
- 180 days for the continuous period measure

Why is it important?

Major depressive disorder¹:

- Can impair daily activities, as well as disrupt eating habits, sleep patterns, and concentration
- Affects nearly 15 million adults in the United States
- Results in lost work productivity
- Can lead to suicide or attempted suicide

How can I ensure my patients adhere?

Know the common barriers to adherence²:

- Regimen complexity
- Medication beliefs
- Cost

Educating your patients is very important. Advise them on when and how antidepressants should be taken, and how long they can expect to take them. Be prepared for questions about cost as well. Please remember that the members pay the least for drugs on the lowest tier of their drug list. Drugs on higher tiers cost the member more and may require prior authorization.

Blue Care Network has **information about depression for members** at **bcbsm.com**.

See the *Best practices* interview on **Page 1** for a look at how one doctor manages patients taking antidepressant medications.

References

¹<http://www.qualitymeasures.ahrq.gov/content.aspx?id=48934&search=antidepressant+medication+management>

²http://adhereforhealth.org/wp-content/uploads/pdf/RAND_TR765_AReviewofBarrierstoMedicationAdherenceAFrameworkforDrivingPolicyOptions.pdf

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Depression, continued from Page 1

The use of screening tools can be efficient and lead to the best diagnostic impression of your patient. Screening tools are used for a variety of illnesses and can also be helpful in picking up on subtle symptoms as well as monitoring the progress of treatment.

There are a couple of useful screening tools that are easy to administer. Giving patients screening tools in the waiting room can make their wait time go faster and starts them thinking about their medical and mental health concerns before they see the clinical team.

It's critical to measure depression using objective evidence-based tools. Subjective assessment of a member's mood is inaccurate and ineffective.

- The Patient Health Questionnaire (PHQ-9) developed by Robert Spitzer, leader of the DSM taskforce through DSM-IV-TR, has a substantial evidence base for specificity and sensitivity (88 percent each).¹
- There is a quicker PHQ-2 that is easy to administer as it only has two questions focused only on depression and not the somatic symptoms that are often associated with depression.
- The geriatrics depression scale, or GDS, is useful to screen for depression in geriatric patients, now defined as anyone over 55. There are subtle differences in this population that this screening captures. It also helps give more information to the provider to consider a more thorough evaluation for this problem.



Clinical diagnosis

Screening tests focus on the potential diagnosis of depression. The clinical diagnosis is based on history, physical examination and available testing using both laboratory and screening tools. Major depressive disorder has long been underdiagnosed and undertreated in our society.

Generally, this is due to the subjective symptoms: One person's normal mood is different than others. However, there are limits to normal. For example, major depression is one of several mood disorders.² The criteria for major depression are outlined in the *Diagnostic and Statistical Manual of Mental Disorders 5th edition*. If a person has five or more of the following symptoms for at least two weeks, they likely suffer from major depression:

- Depressed mood most of the day every day
- Marked diminished interest in all, or almost all, activity most of the day nearly every day
- Significant weight loss or gain when not dieting or trying to gain weight
- Slowing of thoughts and reduction of physical movement
- Fatigue or loss of energy nearly every day
- Feeling of worthlessness or excessive guilt
- Diminished ability to think, or concentrate or being severely indecisive
- Recurrent thoughts of death, suicidal ideation with or without a plan or actual suicide attempt



William Beecroft, M.D.

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Treatment

Once you've screened or initially diagnosed for depression, the current physician standard of care is to use your first go-to treatment and remeasure its efficacy in four to six weeks. When there isn't a 50-percent improvement of the PHQ-9 score, you need to change interventions. An improvement of 50 percent means that patients are in remission.

The STAR-D trials of the 1980s showed the importance of changing medications and psychotherapy intervention if the treatment plan is not showing improvement (25 percent or less improvement) within four to six weeks — not months.³ In our example above with medications, that would include changing to a different class of medication. With psychotherapy, it would mean changing to a different style. (Cognitive behavioral therapy is shown to be the most effective) or referring the member to a psychiatrist for initiation of medication if it had not been started initially. More of the same intervention is bound to fail.

Remeasuring the new intervention at four to six weeks continues to be important because if there is no improvement (50 percent reduction of the PHQ-9), the intervention would need to be changed again. Examples include changing to a different class of medication or adding more vigorous diet, exercise and ensuring that the member isn't using substances. Psychoeducation (12 to 18 weeks of treatment—likely four to six months of illness) that includes member participation and adherence to recommendations is imperative since members risk becoming fatigued from being depressed and lose hope that they will get any better.

If a patient hasn't shown significant improvement after 12 to 18 weeks of treatment (including eight to 12 weeks of psychotherapy or cognitive behavioral therapy), you should consider consulting with a psychiatrist to review such options as pharmacologic augmentation or referral for neuromodulation. Transcranial magnetic stimulus, or TMS, is an effective treatment of individuals who aren't responding to attempted forms of treatment.

Electroconvulsive therapy, or ECT, is also effective and done much differently today, minimizing the memory side effects. ECT is the first-line treatment of depression with psychosis so it doesn't need to be a last resort. ECT is also very effective in geriatric patients due to the high likelihood of drug interactions and the generally frail nature of the elderly when severely depressed. ECT provides a faster response and has fewer side effects than medications in this population.

Many illnesses have significant comorbid depression. Diabetes, chronic pain and fibromyalgia are just a few that have high incidence of depression. If the depression is not treated, the underlying medical problem is more refractory to remission and very costly overall in both medical spending and quality of life for the member. Medical groups participating in a capitated fee arrangement with Blue Care Network or Blue Cross Blue Shield of Michigan should pay particular attention to this fact to improve the care of their members.

Blue Care Network offers a tip sheet (see PDF at the right) for providers to encourage the use of step progression in the treatment of depression.



¹J Gen Intern Med. 2001 Sep; 16(9): 606–613.
doi: 10.1046/j.1525-1497.2001.016009606.x

²<https://www.verywellmind.com/mood-disorder-1067175>

³<http://www.nimh.nih.gov/funding/clinical-research/practical/stard/allmedicationlevels.shtml>

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Reminder: Blue Care Network to continue Behavioral Health Incentive Program in 2019

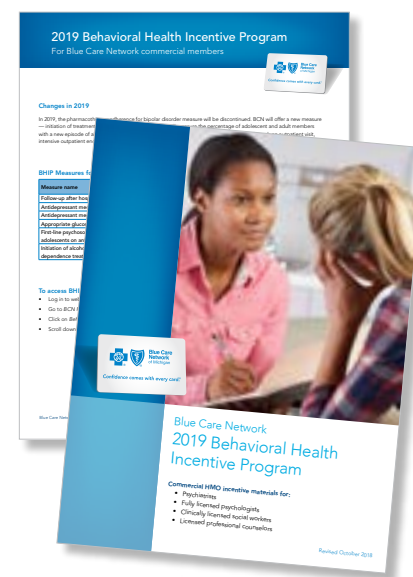
Our Behavioral Health Incentive Program for 2019 offers six BCN-assessed measures.

The measures require no formal data submission on the part of the behavioral health provider. We'll capture and analyze information for the measures through claims data. There are no requirements to opt in or volunteer for BHIP.

For details, see the BHIP booklet and flyer on web-DENIS.

To access BHIP documents:

1. Visit bcbsm.com/providers.
2. Log in to Provider Secured Services.
3. Click *BCN Provider Publications and Resources*.
4. Click *Behavioral Health* under the Other Resources heading.
5. Scroll down to the Behavioral Health Incentive Program heading.



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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 and a phone number for BCN's behavioral health physician.

Practitioners may discuss any decision with a BCN behavioral health physician reviewer. Call Behavioral Health at 1-877-293-2788 Monday through Friday from 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.



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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.

Updated clinical practice guidelines now available

The Michigan Quality Improvement Consortium has released the following updated clinical practice guidelines:

- Opioid Prescribing in Adults Excluding Palliative and End of Life Care
- Management of Diabetes Mellitus
- Adolescent and Young Adult Health Risk Behavior Assessment
- Diagnosis and Management of Adults with Chronic Kidney Disease
- Medical Management of Adults with Hypertension

Visit **MQIC** to see the guidelines. To access them on Android and iOS devices, an MQIC app is available at Google Play and the App Store.



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Best Practices, continued from Page 1

treatment plan. We make sure that cost is not going to be a hindrance in getting their prescriptions. We try to follow up with these patients on a regular basis, checking if they are taking their medication and if they are having any problems with it.

I also recommend therapy in conjunction with medication. Medication and counseling work best together. This also helps them understand what depression is and what coping skills they can develop to get better. Coverage for counseling can be a challenge for some patients. They may not have the copay or even transportation or child care to go to their therapy sessions.

How do you deal with medication cost as a challenge?

A lot of antidepressants are available in a generic. I try to choose the ones I know insurance will cover. Our electronic medical records give me some idea of what's covered by a specific formulary. If medication is costing the patient more than they can afford, I encourage them to call me right away so I can work with them and their insurance to find a suitable alternative drug.

You mentioned education. How important is that to keeping patients on their medications long term?

I tell them antidepressants aren't short-term medications and I give them timelines. I encourage patients to take their medication for at least six months, preferably one year. I reassure them that these medications are safe to take for long periods of time. I tell patients that antidepressants may take a while to take effect. It's not like a cold pill. Some patients may see improvement of symptoms right away, but for some it may take a few weeks to get the full effect of the medication.

I also tell patients that it's not a good idea to stop their medication once they start feeling better. They may have worse symptoms if they stop abruptly, and we discuss withdrawal symptoms. I emphasize the need to wean themselves from most of these medications.



Rhoda Beltran, M.D.

Side effects are a frequent challenge to keeping patients on medications long term. How do you deal with that issue?

I have one patient who I've been seeing for 20 years. Last April, I diagnosed her with diabetes. She had episodes where she felt down and didn't go to work for days. She wasn't getting out of bed. Her family was getting concerned about the change in her behavior. We realized that the diabetes diagnosis was causing her depression. So, I had to explain to her why we needed to start her on medication and that her depression was starting to affect her work and relationships.

The patient is overweight, so she was concerned about weight gain associated with antidepressants. When she agreed to be treated for depression, I prescribed Wellbutrin, which was once thought of as a weight loss medication. Choosing the right medication for the patient is important for them to improve their compliance and allow them to take it for a longer period of time.

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We now have more choices for treating depression. Choosing the right drug for the right patient most often can minimize the side effects. We try to start slow with a low dose and slowly increase the dose until we reach the desired effect. The good thing about the antidepressants we now have is that the goal is complete remission. We want these patients to go back to their baseline.

I encourage my patients to call the office for any side effects they may be having. We try to make recommendations. For example, if they have nausea, we have them take their medication with food; if the drug causes them sleepiness, we have them take it at night.

Side effects of antidepressants can be as simple as nausea, dizziness, to as serious as seizures and suicidal thoughts. We make sure we're available to answer questions. We try to provide office visits for those who need to be seen face to face. We have same-day appointments for those patients who are having more challenges. Ten percent of our visits are for same-day appointments.

Let's talk about follow up. How often do you want to see patients on medication?

I usually want to see a patient after four weeks, and then follow up every three months after that. If I'm concerned about their progress, I'll see them in two weeks instead of four and then more frequent follow-up, if needed.

Is there anything unique in the way your office treats patients with depression?

The good thing about my office is our teamwork. We have care managers who call patients the day after being prescribed new medication to check on how they're doing. The care managers make sure patients have filled their prescription and taken the medication. Depending on how that conversation goes, we decide if they need to be called again the next day or the next week.

These care managers meet once a week with a group of providers, including a psychiatrist. The care managers present difficult cases during these meetings. They discuss these patients and bring back recommendations to me. It is up to me then to decide if these recommendations are appropriate for the patients. More often than not, I find their suggestions very helpful.

Our phone nurses are also trained to handle calls when patients have worsening symptoms of depression, reactions to medications or problems getting their medications filled. The nurses have resources that they can go to in order to answer patients' concerns.

We also have a nurse practitioner who works side by side with me and is available for urgent visits if I don't have openings. She knows my patients well.

We are fortunate to have an in-house psychologist who is available for urgent consults. If there's a patient who I think needs counseling services right away, I can have the counselor see that patient the same day he or she is in the office.

We also have a social worker who is available to address social determinants of health, that is, a patient's ability to get his or her medication or help with transportation for their office visits. We are aware that depression is very much impacted by what is happening in our daily life. We worry about finances, job and taking care of our family. The social worker gives our patients resources to help them take care of some of these things.

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Fasenra and Radicava are subject to a site-of-care requirement for BCN HMO members, effective April 1

Effective April 1, 2019, BCN is adding the following medications to its site-of-care optimization program, for BCN HMOSM (commercial) members only:

- FasenraTM (benralizumab, HCPCS code J0517)
- Radicava[®] (edaravone, HCPCS code J1301)

This requirement does not apply to BCN AdvantageSM members.

The site-of-care program redirects members receiving select 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.

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

Requests for Fasenra and Radicava must meet applicable authorization criteria in addition to the site-of-care requirement.

For a list of requirements related to drugs covered under the medical benefit, including all drugs identified as subject to a site-of-care requirement, do the following:

1. Visit the **Medical Benefit Drugs – Pharmacy page** in the BCN section at ereferrals.bcbsm.com.
2. Click **Requirements for drugs covered under the medical benefit – BCN HMO and Blue Cross PPO** under the heading "For BCN HMO (commercial) members."

The new site-of-care requirement for Fasenra and Radicava will be reflected in the requirements list before the April 1 effective date.

We first communicated about this new requirement in late December through a web-DENIS message and a news item at ereferrals.bcbsm.com.

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We'll change how we cover some infertility treatment drugs, starting April 1

Our goal at Blue Cross Blue Shield of Michigan and Blue Care Network is to provide our members with safe, high-quality, cost-effective prescription drugs. To accomplish this, we're making some changes to the drugs we cover.

Starting April 1, 2019, Blue Cross Blue Shield of Michigan and Blue Care Network will change how we cover some infertility treatment drugs, as described below:

Drug	Standard coverage changes starting April 1, 2019	Covered preferred alternative
Endometrin®	Requires prior approval Cost: Nonpreferred brand copayment <i>If coverage requirements are not met, the member may be responsible for the full cost.</i>	Crinone® 8% Cost: Preferred brand copayment
Ganirelix Acetate	No longer covered Cost: Full cost	Cetrotide® Cost: Preferred brand copayment or preferred specialty copayment if member has a benefit with specialty tiers

Members who have an approved prior authorization can continue to fill their prescriptions until the prior authorization end date but may have a higher copayment.

We notified affected members of these changes and encouraged them to discuss treatment options with their doctors.

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We've changed how we cover some diabetes drugs effective Jan. 1

Our goal at Blue Cross Blue Shield of Michigan and Blue Care Network is to provide our members with safe, high-quality prescription drugs while also controlling costs. To accomplish this, we're making some changes to some diabetes drugs we cover.

The following tables list the drug that have a higher copayment and drugs that aren't covered as of Jan. 1.

Members can continue to fill their current prescriptions until March 1, 2019, so they have time to discuss treatment options with their doctors. If members fill their prescriptions on or after this date, it will cost more or no longer be covered.

Members who have an approved prior authorization can continue to fill their prescriptions until the prior authorization's end date but may have a higher copayment.

Drug that will have a higher copayment

Drug class: Insulins		
Nonpreferred drug	Member cost	Preferred alternatives
Basaglar® Kwikpen U-100	Nonpreferred brand copayment	Lantus® (all forms) Levemir® (all forms) Toujeo® (all forms) Tresiba® Flextouch®

Drugs that won't be covered

Drug class: Glucagon-like peptide-1 (GLP-1) receptor agonists		
Excluded drugs	Member cost starting March 1, 2019	Preferred alternatives
Bydureon® (all forms) Byetta®	Full cost	Ozempic® Trulicity® Victoza®
Drug class: Dipeptidyl peptidase 4 (DPP-4) inhibitors		
Excluded drugs	Member cost starting March 1, 2019	Preferred alternatives
Alogliptin* Onglyza® Nesina®	Full cost	Januvia® Tradjenta®
Drug class: Dipeptidyl peptidase 4 (DPP-4) inhibitors combinations		
Excluded drugs	Member cost starting March 1, 2019	Preferred alternatives
Alogliptin/Metformin* Alogliptin/Pioglitazone* Kazano® Kombiglyze® Oseni® Steglujan®	Full cost	Glyxambi® Janumet® Janumet® XR Jentadueto® Jentadueto® XR Qtern®

*These are *not* generic drugs. These are considered brand drugs and don't have generic equivalents.

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Reminder: New clinical editing system changes

Although we've delayed our upgrade to a new clinical editing system — from ClaimCheck to ClaimsXten — we want to remind you about key changes. It's possible that our system will be up and running by the time this issue is posted.

We'll continue to review our system edits, based on national coding standards, including American Medical Association CPT codes and Centers for Medicare & Medicaid guidelines, to remain focused on correct coding.

Here are the key changes that we've told you about in past issues:

1. **New explanation codes.** You should always review the EX code on the claim. With a system upgrade and enhancements planned in the first quarter, you'll see multiple new codes.
 - a. Our current EX codes that begin with the letters N, a or d will be converted to a new range of EX codes. These will now begin with lower case letters e, f, g, h, i, j, k or l. It's important to review the wording to identify those related to clinical edits.
 - b. There will new EX codes effective in the first quarter, beginning with the letter Q, that are related to clinical editing. An example is QV1 — an EX code related to an age edit. There are some Q codes that may not be related to clinical editing, so please review the reason behind the EX code.
2. **The clinical editing form has been updated.** Make sure to use the most current form. There is now **one form** for BCN HMO, BCN Advantage, Blue Cross PPO and Medicare Plus Blue PPO clinical editing appeals. It's located in Provider Secured Services. You must complete the required fields on the appeal form, including one to mark that you are appealing an HMO clinical editing appeal. Incomplete forms may be returned.
 - a. For BCN, visit bcbscm.com/providers and log in to Provider Secured Services.
 - b. Click *BCN Provider Publications and Resources*.
 - c. Click on *Billing/Claims* in the left-hand navigation.
 - d. Click on *Clinical Editing Appeal Form* under the Clinical editing resources heading.

There are no changes to the clinical editing appeal process. Remember to:

1. Submit your appeal within 180 days of the original clinical editing denial.
2. Include all related documentation supporting your position on the appeal. This may include office records, surgical reports, radiology notes or other records, depending on the service being appealed.
3. There is only one level of appeal, so it's important to ensure that it's complete and timely.

Look for additional information on clinical editing and the appeals process on the Billing/Claims page, including:

- The Claims chapter of the *BCN Provider Manual*, which contains a section on clinical editing
- Additional links to clinical editing resources, which include information on:
 - Modifier usage
 - EX codes
 - An appeal quick guide
 - Links to previous clinical editing articles

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Billing Q&A

Question:

I read the Billing Q&A in the January-February 2019 *BCN Provider News* and I want to know BCN's solution for the gastroenterology observation issue. The question was clear in regard to providers receiving a "NO AUTH" rejection but I do not see where BCN gave a solution.

I am a billing manager for an 11-physician gastroenterology group and have tackled this exact scenario with both BCN and Medicaid HMOs. We are not getting any type of resolution. The hospital has already submitted their UB04 claim as Emergency or Observation, but we are still receiving these "NO AUTH" rejections.

Answer:

For evaluation and management services that are reported in location 22, the claim should process according to the member's benefits — as long as the hospital has submitted the claim for the observation services and it has been processed on our system when the professional claim is received and processed.

When we don't have a processed facility claim, we don't know that it is observation and may be looking for a referral. Unfortunately, there is nothing on a professional claim, such as a location code or modifier, that definitively tells us the patient is in observation.

If procedures are performed in observation, there is an added guideline. Procedures require a referral or authorization as they would in the outpatient setting, unless the observation stay is related to an emergency visit — in other words, the patient's admission to observation started with an emergency visit and the hospital reports it as such on their claim. Therefore, the hospital claim must still be on our system and processed prior to receiving your claim, and it must also contain a 0450-revenue code indicating the patient came into the facility through the emergency room. If any of those do not occur a referral or authorization may be required depending on the procedure.

Question:

How do I get the fee schedule on medications based off NDC?

Answer:

We don't post the fee schedule for medications based on the NDC pricing. We essentially use the fee reported to us by Blue Cross Blue Shield of Michigan. We recommend that you refer to the NDC pricing schedule published by Blue Cross. If you find a discrepancy, contact Provider Inquiry.

Question:

I read about the new e-referral continued stay process, and it doesn't specify whether we can request an extension of days on pre-approved elective surgical procedures through e-referral. I would assume this means we can, but we rarely receive a response via e-referral when we do this. Would you clarify the appropriate process?

Answer:

E-referral isn't ready to handle these requests right now. We're asking facilities to request extensions by fax for BCN and BCN Advantage members having elective surgery. We're making changes to the process to allow you to submit extensions through e-referral. We'll keep you updated through this newsletter and web-DENIS messages.

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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Blue Care Network evaluates appropriateness of E&M coding

Blue Care Network continues our commitment to correct coding and the implementation of programs that support nationally recognized and accepted coding policies and practices. The Centers for Medicare & Medicaid Services has identified evaluation and management coding as an area with significant error rates.

Twice a year, we'll be sending letters to physicians identified as outliers. Letters have been mailed in January to physicians. Physicians who have received this current mailing, as well as those who received earlier mailings advising them of the outlier program, may receive an edit on a higher level E&M code when the diagnoses on the claim do not appear to support the level reported. The claim is not denied, but rather repriced to the level supported.

If you disagree with a clinical edit on an evaluation and management service, you have the 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, assess the intensity of service and complexity of decision-making for the evaluation and management service documented.

BCN will make a determination based on the documents and the medical necessity of the evaluation and management service.

Using nationally recognized sources, including those from CMS, the American Medical Association and other specialty academies' policies and procedures, we'll continue to evaluate the appropriateness of E&M coding reported to ensure they are supported by the AMA's E&M documentation criteria. This analysis will take place twice a year and providers may be added or removed from the program based on the outcome of this evaluation. We'll continue to send letters when we add a provider to the program.

We recommend that physicians carefully code each service provided according to national guidelines and to ensure that the office documentation supports the code reported.

Learn more about coding guidelines, including the evaluation and management documentation, by referencing the CMS ***Evaluation and Management Services Guide***.

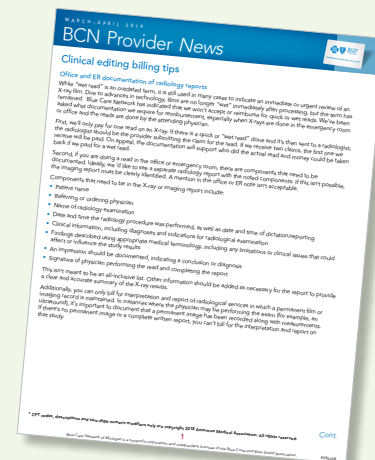
Clinical editing billing tips

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 tip includes:

- Office and ER documentation of radiology reports
- Modifier 59 review

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



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

Later this year, you'll need to change the way you submit initial authorization requests for physical, occupational and speech therapy, and for physical medicine services by chiropractors. Instead of using the e-referral system, you'll need to submit requests through eviCore healthcare's provider portal instead.

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

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

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

We posted an article about this change in the **November-December 2018** issue (Page 48) of *BCN Provider News*.

Watch for information on the date of the change and provider training opportunities on ereferrals.bcbsm.com and through a web-DENIS alert.

Starting May 1, additional radiology services require authorization by AIM for BCN and Blue Cross members

For dates of service on or after May 1, 2019, for both BCN HMOSM (commercial) and BCN AdvantageSM members, AIM Specialty Health[®] will require authorization for radiology procedures associated with the following codes:

- *77046
- *77047
- *77048
- *77049

You must request authorization for these services when they are delivered in either an office setting or a hospital outpatient location. Submit your authorization requests through AIM's provider portal at aimspecialtyhealth.com or by calling AIM at 1-844-377-1278.

The list of procedures that require authorization by AIM Specialty Health for BCN HMO and BCN Advantage members will be updated in April to include these codes. To access this list:

1. Visit ereferrals.bcbsm.com.
2. Click *BCN*.
3. Click *AIM-Managed Procedures*.
4. Click **Procedures that require authorization by AIM Specialty Health**.

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Complete new questionnaires in e-referral for BCN members

New questionnaires are open for BCN authorization requests in the e-referral system for the following outpatient procedures:

- Abdominoplasty (procedure codes *15830 and *15847)
- Otoplasty (procedure code *69300)
- Rhinoplasty (procedure codes *30400, *30410, *30420, *30430, *30435, *30450, *30460 and *30462)

In addition, updated or new questionnaires for the following services began opening for BCN authorization requests in the e-referral system on Nov. 25, 2018:

- Arthroscopy, knee, diagnostic (procedure code *29870)
- Arthroscopy, knee (surgical) for chondroplasty (procedure codes *29877, *29879 and G0289)
- Arthroscopy, knee (surgical) for removal of loose body or foreign body (procedure code *29874)
- Arthroscopy, knee (surgical) for removal or stabilization of intra-articular osteochondral lesion (procedure codes *29885, *29886 and *29887)
- Arthroscopy, knee, synovectomy, limited (procedure code *29875)

You must complete the questionnaire when submitting a request to authorize these procedures for the following members:

- BCN HMOSM
- BCN AdvantageSM

We've made preview questionnaires available at ereferrals.bcbsm.com. To find them, click BCN, then click **Authorization Requirements & Criteria**. Next, look in the "Authorization criteria and preview questionnaires" section.

You can look over the preview questionnaire for a procedure to see what questions you'll need to answer for each service. Once you know the questions, you can prepare your answers in advance. This can cut down on the time it takes to submit the authorization request.

We've also posted links to the medical policies or authorization criteria related to these procedures on the Authorization Requirements & Criteria page.

We use our medical policies, our authorization criteria and your answers to the questionnaires when making utilization management determinations for the authorization requests you submit.

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