MAY–JUNE 2019

BCN Provider News

Dr. Thomas Selznick with patient, Tonya Lara Keller

photo by Deepa Elangainathan

BCN Provider News User Guide

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Best Practices

Comprehensive diabetes care

An interview with Thomas Selznick, D.O., Livonia Family Physicians

What's the key to making sure all your diabetes patients get all their tests completed (A1c test, eye exam and nephropathy testing, blood pressure)?

For me, the key is micromanaging patients and frequent follow-up. If a patient is on insulin, I see him or her every month. If I don't hit all the testing on one visit, I can do it on follow-up visits.

It's important to check a patient's A1c frequently. You have to check their numbers and call them to change medication if their blood sugar is too high. As a general rule, I'll see patients every three or four months, unless they're on insulin. In that case, I see them every month or two. I micromanage so I don't have to deal with too many problems in one visit.

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Blue Care Network announces new leadership

Robert Coscione has joined Blue Cross Blue Shield of Michigan as vice president, Provider Network Evaluation and Management. His responsibilities will include provider financial analysis for all products, hospital and physician servicing and education; risk model development and reporting; physician network performance improvement for commercial and Medicare business, and physician organization contracting. He replaces Alison Pollard, who retired after 20 years of service.

Coscione previously served as regional vice president at Anthem Blue Cross, where he was responsible for provider engagement and contracting and managed specific statewide services, including provider contracting, provider relations and education,

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Network Operations

Leadership, *continued from Page 1*

innovation programs, trend management and local cost of care. He also served as market director for Aetna for 11 years. Coscione reports to Steve Carrier, senior vice president, Network Management and Provider Partnership Innovation.

Carrier joined Blue Cross in March 2018 and is responsible for providing expertise, leadership and strategy on network management, partnerships and solutions. He's also leading efforts to create innovative solutions that promote the strength of our network and meet current and emerging market needs.

Previously, Carrier served as senior vice president, Strategy and Operations, Aetna Accountable Care Solutions, and as vice president, Product Management, Cigna. Carrier reports to Todd Van Tol who was recently named senior vice president, Health Care Value. Van Tol replaces Kevin Klobucar, who is retiring at the end of the year.

Van Tol's experience in managing our group business provides him with a detailed understanding of customer expectations as we develop our next level of provider partnerships and medical and pharmacy management programs. He joined Blue Cross in 2017 as senior vice president, Health Plan Business, and has led the Key and Large Group, and middle and small group segments, as well as the operational and strategy areas of Health Plan Business.

Through these leadership changes, Blue Care Network and Blue Cross are poised to continue a long-standing commitment to strong provider partnerships.

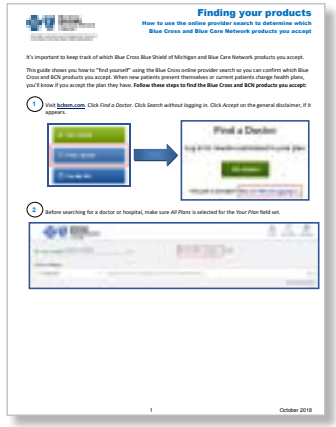
Here's how to confirm the networks you participate in

Blue Care network has a document that helps providers find the Blue Cross Blue Shield of Michigan and Blue Care Network products they participate in. It's called *Finding your Blues plans* and is posted on our website.

This guide shows you how to use the online provider search to confirm which Blue Cross and BCN products you accept. When new patients present themselves or current patients change health plans, you'll know if you accept the plan they have.

Here's how to find the document:

- Log in to Provider Secured Services.
- Go to BCN *Provider Publications and Resources*.
- Go to the *BCN Products* page and click on *Finding your Blues plans*.


Finding your products

How to use the online provider search to determine which Blue Cross and Blue Care Network products you accept

October 2018

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Network Operations

Rollout of CAQH Direct Assure helps increase accuracy of provider data

We're continuing our phased rollout of Direct Assure to increase the accuracy of provider data.

CAQH Direct Assure allows you to see specific group affiliation information in our system so you can make updates and add group information to an individual provider's CAQH record. Direct Assure also allows certain group changes made in CAQH to update the Blue Cross Blue Shield of Michigan system so you no longer need to make updates in both areas – the CAQH and Blue Cross systems.

We rolled out the first phase to 4 percent of our practitioners in June 2018 and the second phase to an additional 11 percent in January 2019.

Progress to date

Providers who participated in the first phase had higher-than-average accuracy scores for demographic data and better alignment of information between our data and CAQH data. We continue to work closely with the physician organizations and groups to obtain feedback, educate them on how to manage their data in Direct Assure and provide updates on the project.

Next steps

Phase III of Direct Assure came in late March to help our behavioral health providers manage their demographic data and improve the data accuracy of behavioral health practitioners in the directory.

Phase IV is scheduled for rollout in late June for specialties likely to be audited by the Centers for Medicare & Medicaid Services. This will include primary care physicians, cardiologists, oncologists and ophthalmologists.

Phases V and VI will be rolled out the last month of each of the last two quarters of 2019.

If you have any questions, contact Provider Enrollment at 1-800-822-2761.

Network Operations

Virtual program focuses on improving member well-being, resilience

Blue Cross Blue Shield of Michigan has launched the innovative Blue Cross® Virtual Well-Being program to help your patients learn how to improve their overall well-being and increase resilience. Virtual Well-Being is available for all Blue Cross and Blue Care Network members.

It features live weekly webinars and downloadable content for members that focuses on helping them on their personal journeys toward well-being. Topics include resilience, emotional health, financial wellness, mindfulness, gratitude, meditation and physical health. Webinars are also available to help our group customers develop, deliver and enhance their worksite well-being programs.

Members can register for Virtual Well-Being webinars at **bluecrossvirtualwellbeing.com**. They can also watch past webinars on this website at any time, and download content they can share with their family and friends.

Well-being focuses on a person's holistic health, and it's a measure of a person's perception of how his or her life is going. Research has shown that people with a greater sense of well-being are more resilient, happier, more engaged and productive, make healthier choices and have reduced stress.

Blue Cross also offers its members online resources to help them improve their health and well-being on the Blue Cross® Health & Wellness website, powered by WebMD®. This includes an interactive health assessment, Digital Health Assistant programs, a personal health record, health trackers, videos, healthy recipes and more.

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

Important change to provider secured services access requests

We're always looking for ways to protect our member's information and keep your account secure. To do so, we'd like to connect your online account to an email address that is related to your business rather than a public email provider like Hotmail, Gmail or Yahoo.

If you have a company email address, please include it on your request for access or changes to your provider secured services account. If you're not sure whether a company email address is available to you, please check with your website administrator. Most websites offer domain email free with your account. If you are a smaller practice that does not host a website, we will accept your request with the email you use to conduct your business.

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

During holiday closures, Blue Care Network's inpatient utilization management area remains available to accept inpatient authorization and concurrent review requests for BCN HMO℠ (commercial) and BCN Advantage℠ 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. Discharge dates can also be submitted via e-referral.

During e-referral system down time, authorizations and continued stay requests can be faxed to BCN HMO (commercial) at 1-866-313-8433 and BCN Advantage requests to 1-866-526-1326.

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. Refer to the document, **Post-acute care admissions: Submitting authorization requests to BCN for additional information**.

Other authorization requests

The requests listed below must be submitted by fax. Fax BCN HMO (commercial) requests to 1-866-313-8433. Fax BCN Advantage requests to 1-866-526-1326.

- Authorization requests for sick or ill newborns
- Requests for enteral and total parenteral nutrition

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
- Handing 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.

Medicare Advantage post-acute care training dates set

Authorizations for Medicare Plus Blue℠ PPO and BCN Advantage℠ members who are moving into skilled nursing, long-term acute care and inpatient rehabilitation facilities will be managed by naviHealth, effective for authorization requests submitted on or after June 1, 2019, for both in-state and out-of-state cases. This includes members moving from acute care facilities and from any other type of care. Sign up for one of the training sessions listed below.

In choosing naviHealth, we want to standardize the management of authorizations for post-acute care for Medicare Advantage members. In addition, we hope to improve members' experiences by offering a more coordinated, patient-focused approach — one that's aimed at improving outcomes and reducing the likelihood of readmissions to an acute care setting.

What's changing

For Medicare Plus Blue and BCN Advantage authorization requests submitted on or after June 1, 2019, you'll submit requests to naviHealth for skilled nursing, long-term acute care and inpatient rehabilitation.

You should submit these requests through the naviHealth provider portal.

1. Visit **bcbsm.com/providers**.
2. Log in to *Provider Secured Services*.
3. Click *Medicare Advantage Post-Acute Care Authorization* on the Provider Secured Services home page.
4. Enter your NPI.
5. Click *Go*.

If you can't access the naviHealth provider portal through Provider Secured Services, contact the Blue Cross Web Support Help Desk at 1-877-258-3932.

There are other ways to submit these authorization requests to naviHealth:

- Log on to the naviHealth provider portal at **access.navihealth.com** (This option will not be available until June 1. You must first register with naviHealth for access to their portal. We'll let you know how to do that in the training webinars.)
- Call: 1-855-851-0843
- Fax:
  New authorization requests: 1-844-899-3730
  Continued stay requests: 1-844-736-2980
  Discharges: 1-844-729-2591
- Email (for discharges only):
  mid-west_discharge_info@navihealth.com

You can also submit these requests through Allscripts®. Follow your current process for submitting to Allscripts.

You'll use these methods to submit authorization requests for both in-state and out-of-state members covered by Medicare Plus Blue PPO and BCN Advantage.

Refer to the **Post-acute care services: Frequently asked questions for providers** document for more detailed information.

Join us to learn more

Training sessions will include information about the naviHealth clinical model and provider portal. Administrators, case managers, discharge planners, rehabilitation directors, nursing directors and others involved in post-acute patient care are encouraged to attend a webinar. Even if you are already familiar with naviHealth, we hope you'll attend to learn how naviHealth will work with Medicare Plus Blue PPO and BCN Advantage patients.

Please see Training, continued on Page 7

Training, *continued from Page 6*

Register for a webinar. See the table for the webinar dates and times.

Acute care hospitals	• Tuesday, May 21, 8 to 9:30 a.m. • Wednesday, May 22, 11:30 a.m. to 1 p.m. • Wednesday, May 29, 8 to 9:30 a.m. • Wednesday, June 5, 8 to 9:30 a.m.
Skilled nursing facilities	• Tuesday, May 21, 11:30 a.m. to 1:30 p.m. • Thursday, May 23, 11:30 a.m. to 1:30 p.m. • Wednesday, May 29, 11:30 a.m. to 1:30 p.m. • Wednesday, June 5, 11:30 a.m. to 1:30 p.m.
Inpatient rehabilitation facilities and long-term acute care hospitals	• Thursday, May 23, 8 to 9:30 a.m. • Thursday, May 30, 11:30 a.m. to 1 p.m. • Thursday, June 6, 11:30 a.m. to 1 p.m.

Note: In an article on this topic in the April 2019 issue of *The Record*, we provided a separate registration link for each webinar. You can register using those links, but we encourage you to use this **registration link** to find all the information in one location.

Skilled nursing facility in-person forums

Skilled nursing facilities are invited to attend in-person forums the week of May 13 in Traverse City, Grand Rapids, Saginaw and Southfield. **Register** for the location, date and time convenient for you.

Traverse City	• Monday, May 13, 2 to 4 p.m.
Grand Rapids	• Tuesday, May 14, 9 to 11 a.m. • Tuesday, May 14, 1 to 3 p.m.
Saginaw	• Wednesday, May 15, 9 to 11 a.m. • Wednesday, May 15, 1 to 3 p.m.
Southfield	• Thursday, May 16, 9 to 11 a.m. • Friday, May 17, 9 to 11 a.m.

BCN Advantage

Remember to discuss fall risk, urinary incontinence and physical activity with Medicare patients

The Centers for Medicare & Medicaid Services is always looking for ways to improve health and its programs. One way CMS does this is through the Medicare Health Outcomes Survey. Based on information supplied by the National Committee for Quality Assurance, a random sample of Medicare Advantage members are surveyed to find out how providers talk to them about these HEDIS® effectiveness of care measures:

- Fall risk management
- Management of urinary incontinence in older adults
- Physical activity in older adults

The survey will be from April through July 2019.

In previous surveys, CMS found that:

- Falls are the leading cause of death by injury in people 65 and older; every year, one in three older adults falls.
- Urinary incontinence is significantly underreported and underdiagnosed.
- Any amount of physical activity reduces the risk of developing certain chronic conditions and increases quality of life.

Review the HOS tip sheet to learn more about the survey, including what questions are asked and how you can address care opportunities with patients.

For more information about the Health Outcomes Survey, go to the **CMS website**.

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

Discuss social isolation and depression with your older patients

Social isolation in older adults can be linked to depression, cognitive decline and increased mortality, according to the Centers for Disease Control and Prevention.

Doctors should discuss social isolation with their patients and suggest ways for them to stay in touch. Learning a new activity can provide some assurance against memory loss.

You can suggestion that your patients consider:

- Joining a walking hiking or bird watching group
- Auditing a class at a local college
- Taking music lessons
- Joining or starting a book club
- Volunteering

It's also important to recognize the symptoms of depression in older adults, which can be linked to isolation or a chronic disease. Some older adults may suffer from vascular depression, according to the National Institute on Aging. This is more common in older adults experiencing depression for the first time later in life. The depression can be related to changes occurring in the brain and body, such as restricted blood flow. These older adults may also be at risk for heart disease, stroke or other vascular illness.

Motivational Interviewing – A technique to facilitate behavior change

By Felecia Williams. M.D.

As a physician, I find it rewarding to motivate patients to make lifestyle changes as well as support those who want to improve their health status. Patients often vow to lose weight, begin exercising, stop smoking, avoid alcohol, decrease stress, increase medication adherence or improve self-management of their chronic conditions. While achieving these goals can improve health outcomes, change is difficult.

Motivational interviewing is a technique that health care providers can incorporate into their practices to help patients who are trying to change old behaviors and habits. The method is a directive, patient-centered approach that attempts to foster behavior change by helping patients explore and resolve ambivalence.

The goal is to assist each patient in developing the internal motivation required to change behaviors that adversely impact his or her health or interferes with optimal management of chronic conditions. The health care provider becomes the patient's coach using active, reflective listening and asking open-ended questions during encounters.

It's important that health care providers understand the stages of readiness explained next.*

Precontemplation

- Patient doesn't believe there's a problem. Patient doesn't see the negative effects of his or her behavior. Denial and ignoring obvious risks are common.
- Health care providers should encourage patient to consider the risks and negative effects of behaviors and the positive impact of making changes. Encouraging self-awareness and introspection are important during this stage.

Contemplation

- Patient is aware that a problem exists and is considering making behavioral changes or seeking treatment. Conflicts and ambivalence are often present during this stage.
- Providers should discuss barriers to change and risks of current behavior and the benefits of change.

Preparation

- Patient is aware of the negative impact of existing behaviors, believes that now is the time for change and seeks to make changes.
- Health care providers can help the patient develop a written action plan with specific goals incorporating positive affirmations.

Action

- Patient takes steps to change behavior or engages in treatment. There may still be ambivalence at this stage; it's important to note that patients are at significant risk of relapse at this stage.
- Encourage rewards when goals are on target and continue to encourage positive affirmations to avoid relapse and set-backs. Discuss the importance of support systems.

Felecia Williams is a medical director for Blue Care Network.

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Patient Care

From the medical director, *continued from Page 9*

Maintenance

- Patient has adopted the behavior change or treatment and has developed coping skills to deal with temptations.
- Encourage patient to celebrate success and stay focused on goals.

Relapse

- Change is difficult, and patients often revert to previous behaviors. Patients may express disgust, disappointment and failure for not having maintained behavioral change.
- Determine what factors contributed to the relapse and what obstacles interfered with success. Relapses will occur and can be particularly painful. When they do, it's important to reassess the patient's motivation and restart at the preparation stage.

Once the patient establishes a goal or outcome, the following motivational interviewing principles can be used to facilitate behavior change.

Express empathy and avoid arguments

For example, if a patient has a sedentary lifestyle but expresses an interest in increasing physical activity, the provider might say, "I understand that it has been difficult for you to engage in physical activity for various reasons. I often hear this from many of my patients. Let's discuss ways you can make some incremental changes to increase your physical activity. What are some ways you become more active?"

Develop discrepancies

Patients need to be aware of the difference between their behavior and their goals. For the patient who is concerned about weight gain due to lack of exercise and poor eating habits, the provider might say, "I understand you're concerned about your recent weight gain and lack of physical activity. You believe that increasing your physical activity and eating healthier could result in weight loss. Why do you think it's been difficult for you to find time to exercise and make healthier food choices?"

Deal with resistance and provide individualized feedback

When patients identify barriers or obstacles that prevent them from achieving their goals, providers can offer suggestions and feedback that might increase the likelihood of success. If a patient has a sedentary lifestyle and enjoys watching television but has difficulty finding time to exercise, the provider might say, "I know you enjoy watching television and feel it interferes with your ability to exercise. Would it be possible to engage in some physical activity while watching television? Perhaps walk on a treadmill or ride an exercise bike during this time. Or listen to the audio of your favorite television programs while walking outside perhaps?"

Support self-efficacy and autonomy

Understand the patient's strengths and challenges and how best to engage him or her so he or she will own the process. Communicate your belief in the patient's ability to achieve success. The provider might say, "I believe you're capable of achieving your goal. Let's talk about what you can do to incorporate regular physical activity into your life and make better food choices."

Take time to hone your skills and support patients who have expressed interest in making lifestyle changes. There are resources and videos on the web to help you support your patients as they begin their journey on the road to change.

Resources

Encourage Patients to Change Unhealthy Behaviors with Motivational Interviewing
Elizabeth E. Stewart, PhD, and Chester Fox, MD
Fam Pract Manag. 2011 May-June;18(3):21-25
https://www.aafp.org/fpm/2011/0500/p21.html

ACOG Motivational Interviewing – A Tool for Behavior Change
https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co423.pdf?dmc=1&ts=20190122T1410037781

*The 6 Stages of Behavior Change – Kendra Cherry
https://www.verywellmind.com/the-stages-of-change-2794868

Using Motivational Interviewing to Improve Medication Adherence
Allister Duff and Gary Latchford
The Pharmaceutical Journal – May 17, 2016
https://www.pharmaceutical-journal.com/learning/learning-article/using-motivational-interviewing-to-improve-medicines-adherence/20200954.article?firstPass=false

Patient Care

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:

The note under the TIA subset on Acute, all, high risk, states, "*Crescendo TIAs are characterized by TIAs that occur over a relatively short period of time (days to weeks) and may occur as a series of attacks.*" Does this have to be a physician documented condition?

Answer:

To apply criteria related to a specific diagnosis, the diagnosis must be documented in the medical record. In the absence of documentation, the reviewer should obtain additional information from a medical practitioner.

Question:

If there is no note for a drug related to frequency, does that mean that one IV dose of the drug would meet criteria? For example, in the Arrythmia subset, under intervention Antiarrhythmic, the note associated doesn't address frequency.

Answer:

A specific frequency for medication is not required at the Intermediate or Critical level on Episode Day 1.

Level of Care depends on the patient's findings (signs/symptoms onset, co-morbid conditions, risk factors, hemodynamic stability, interventions to date) versus frequency of administered antiarrhythmics. For example:

OBSERVATION: arrhythmia onset equal to or less than 48h; no comorbid conditions

INTERMEDIATE: onset more than 48h, co-morbid conditions / risk factors, and/or prior interventions indicating sicker patient

CRITICAL: unstable hemodynamics, wide-complex tachyarrhythmias

Question:

The note that explains the IV antihypertensive administration under the Hypertension subset, Critical, states "*Medication administration includes continuous infusion and titration of medications. For medications that are titrated, the rate and dose are adjusted based on clinical monitoring and laboratory results.*"

Would receiving bolus doses of the medications meet the criteria point?

Answer:

Generally, IV bolus medication given every one to two hours would be appropriate for the Critical level of care.

However, there is a gap as the criteria are written. This will be addressed in the annual release.

Currently, if the patient was receiving both frequent IV boluses and hemodynamic monitoring, it would be appropriate to apply the Critical level of care as written now.

Patient Care

Join us in celebrating men's health in June

Men's Health Week, June 11 through 17, honors 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.

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

- Gene expression profile analysis for risk stratification for prostate cancer management
- Genetic testing — Molecular testing for the diagnosis and management of pancreatic cysts, Barrett's esophagus, and solid pancreaticobiliary lesions (PathFinderTG®, PancraGEN™, BarreGEN™)
- Genetic testing (single nucleotide variants) to predict risk of nonfamilial breast cancer
- Measurement of lipoprotein-associated phospholipase A2 (Lp-PLA2) and secretory Type II phospholipase A2 (sPLA-IIA) in the assessment of cardiovascular risk
- Near infrared spectroscopy for wound examination
- RELiZORB™

Covered services

- Obstructive sleep apnea and snoring — surgical treatment
- Transgender services

Medical Policy Updates

Opioid news roundup

Opioid crisis may be here to stay, new analysis shows

An examination of nearly two decades of drug overdose deaths shows that shifts in the year-to-year death toll, marked by relatively predictable peaks and valleys, mask the true magnitude of the opioid epidemic in America, which now appears mired in a deadly **new normal** for years to come, according to a ***U.S. News & World Report*** analysis. The analysis states: "Trends that seem apparent in hindsight escaped notice for years, with the failure to recognize a climb in deaths at the turn of the millennium — along with a subsequent slowdown — raising a compelling question: Did policymakers, law enforcement and public health officials miss chances to curb the opioid epidemic before it became a full-blown emergency?"

Pain management task force outlines gaps in treatment of chronic pain

In December, the U.S. Department of Health and Human Services' Pain Management Interagency Task Force released a **draft report** outlining current gaps and preliminary recommendations for the treatment of acute and chronic pain. Following a 90-day comment period, the report will be finalized and submitted to Congress later this year. The task force was established by the Comprehensive Addiction and Recovery Act of 2016 and is tasked with determining whether gaps in or inconsistencies between best practices for acute and chronic pain management exist and to present updates and recommendations.

Data shows rural patients more likely to receive an opioid prescription

A *Morbidity and Mortality Weekly Report* from the Centers for Disease Control and Prevention in January 2019 addressed opioid use in rural, non-metropolitan counties. Researchers tracked opioid prescribing rates in counties across the country over a three-year period, from 2014 to 2017. The review found that over that time, general prescribing of prescription opioids fell while rates in rural, non-metropolitan counties declined at a slower rate. In the years following the implementation of the **CDC's chronic pain opioid prescribing guidelines**, the data demonstrated that rural patients were 87 percent more likely to receive an opioid prescription as compared to metropolitan patients.

Patient Care

Drug Take Back Day scheduled for April 27

Let your patients know that National Prescription Drug Take Back Day is April 27 from 10 a.m. to 2 p.m. These twice-yearly events, coordinated by the U.S. Drug Enforcement Administration, are a key tool in our efforts to battle the opioid epidemic.

They provide a safe, convenient and responsible means of disposing of prescription drugs, while also educating the public about the potential for abuse of medications. At the most recent Drug Take Back Day on Oct. 27, 2018, 914,236 pounds of drugs were collected nationwide.

As we've done previously, Blue Cross Blue Shield of Michigan supports Drug Take Back Day in various ways. For example, we:

- Post blogs on **MI Blues Perspectives**.
- Promote resources on our **Opioids 101** site.
- Hosted a Twitter chat during the week of April 22.

To find a participating drug disposal facility near your patients, check out the DEA's **search tool** or see Michigan OPEN's **Opioid Disposal Map**.

Keep in mind that people who miss the April 27 Take Back event don't need to wait until the next event in October to safely dispose of unused drugs. For tips on how to safely dispose of unused drugs year-round, see the **May 2018 *Record* article**.

Also, Meijer recently launched its new **Consumer Drug Take-Back Program** in all Midwest stores. And you can dispose of unused prescription drugs at select Walgreens locations across the state.

Read more about Blue Cross' partnership with Walgreens by clicking **here**.

For more information on disposing of prescription drugs, visit the **DEA Diversion Control Division website** or Michigan OPEN's **Opioid Disposal Information and Resources page**.

Patient Care

Blue Care Network promotes coordination of care between practitioners

Blue Care Network has a process to promote continuity and coordination of care among specialists and primary care physicians and behavioral health and primary care physicians.

We collect and analyze data each year to assess the exchange of information between specialists, behavioral health 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 confuses members and increases 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 HIPAA 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 reviews of our contracted health provider offices who are seeking credentialing, recredentialing, or providers with three or more substantiated complaints to monitor compliance with our policies.

The performance expectation is an overall score of at least 80 percent.

Information regarding screening guidelines can be found on the **MQIC** website.

Patient Care

Blue Care Network promotes continuity of care in some situations

Continuity of care services are available for the following members:

- 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 continuity of care notification to members at least 30 days prior to the practitioner's termination date.

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	Up to 90 days after the practitioner's termination date.
This 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.

Blue Care Network offers office posters and tip sheets about depression

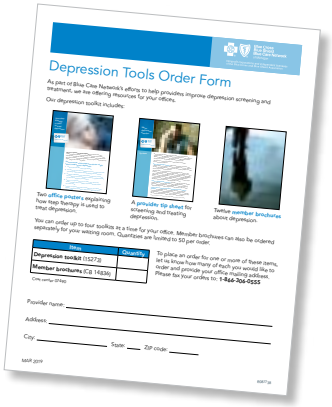
Depression is associated with high societal costs and greater functional impairment than some chronic diseases, including diabetes, according to the Centers for Disease Control and Prevention.

Primary care physicians treat 85 percent of patients with depression and are usually in the best position to screen and diagnose patients during annual exams. **MQIC guidelines** recommend that doctors screen adults 18 and older for depression annually.

Blue Care Network has a toolkit about depression for providers that includes an office poster and tip sheet about treating depression with step therapy. You can order the complete toolkit (which includes two posters, a tip sheet and 12 brochures for members) using the order form below.

You can order up to 50 brochures for members for your office waiting area. There's a separate line on the form to order brochures only.

For more information about depression screening, see the **article**, **Depression screening and treatment are important steps to wellness**, in the March-April issue.


Depression Tools Order Form

Depression Tools Order Form

Behavioral Health

Quality corner: Follow up after hospitalization

What is the follow-up after hospitalization for mental illness (seven days) measure, according to the Healthcare Effectiveness Data and Information Set® guidelines?

The percentage of members 6 years or older who were hospitalized for treatment of a selected mental disorder and who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within seven days of discharge.

Why is it important?

Getting a follow-up in a timely manner may:

- Lower the chance of re-hospitalization
- Detect adverse responses to medications early on
- Ensure progress made during hospitalization is retained
- Provide continued support

How can I ensure my patients are getting follow-up visits?

- If you are the discharging hospital, make sure the patient has a follow-up visit scheduled before leaving your facility.
- If you are the mental health practitioner accepting the patient for follow-up, make sure that your office has the capacity to see the patient within seven days.

Please remember that patients are vulnerable after discharge. Continued care after stabilization in the hospital setting is important for them to maintain stability as they transition back into their environment.

Blue Care Network is offering an incentive for this measure as part of its Behavioral Health Incentive Program. Each time an office completes the measure according to HEDIS guidelines, they qualify to receive $200.

References

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2. **http://www.qualitymeasures.ahrq.gov/content.aspx?id=48642&search=follow+up+after+hospitalization**
3. **http://ps.psychiatryonline.org/doi/full/10.1176/ps.2008.59.9.982**

Behavioral Health

May is Mental Health Month

The National Alliance on Mental Illness works to raise the awareness of mental health, especially in May, which is Mental Health Month.

According to NAMI, one in five people is affected by mental illness in his or her lifetime.

Primary care physicians can take extra time to discuss mental health with their patients and provide resources, if needed. You can find resources on the **NAMI website**.

Blue Care Network has posted articles about depression and suicide awareness in recent issues and the current issue of *BCN Provider News*.

- "Depression screening and treatment are important steps to wellness" in the **March-April 2019 issue**.

- "Teen suicide: Factors that influence adolescent behavior and how they may be mitigated" in the **July-August 2017** issue

- "Discuss social isolation and depression with your older patients," on **Page 8** of this issue.

Perinatal depression is a far-reaching health issue

Dr. Kristyn Stewart is a medical director at Blue Care Network.

Perinatal depression also commonly called postpartum depression, or PPD, is one of the most common medical complications of childbirth and may be one of the most disabling disorders among women of childbearing age due to its effect on overall maternal as well as infant and childhood health.[1] It is a condition associated with significant adverse maternal, fetal, neonatal and early childhood outcomes and negative sequelae including poor maternal-fetal attachment, low birth weight, preterm birth, poor infant attachment, early childhood developmental delays and relationship issues.

Expert opinions vary as to the timing of the onset of PPD. For example, according to the American College of Obstetricians Gynecologists, perinatal depression includes major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery.[2] The Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5) qualifies a major depressive episode as peripartum if it occurs during pregnancy or in the four weeks following delivery.[3] It's different from the so-called "baby blues" which generally peaks within the first few days post-delivery and resolves without treatment within two weeks.[4] While symptoms can overlap, they are generally less severe, shorter in duration and do not interfere or impair daily activities or maternal function. In the United States, estimates of new mothers identified with PPD each year vary by state from 8 to 20 percent, with an overall average of 11.5 percent.[5]

Symptoms:

- Feeling sad, hopeless, empty or overwhelmed
- Crying more often than usual for no apparent reason
- Worrying or feeling overly anxious
- Insomnia or hypersomnia
- Physical aches and pains
- Changes in appetite
- Feeling moody, irritable or restless
- Experiencing anger or rage
- Trouble concentrating
- Losing interest in activities that are usually enjoyable
- Withdrawing from friends and family
- Trouble bonding with baby
- Persistently doubting her ability to care for her baby
- Thoughts of harming herself or her baby
- Anxiety in the form of intrusive or obsessive thoughts about the baby

Health care providers can more easily identify women at risk for developing the condition by understanding risk factors for perinatal depression. Many risk factors have been identified in the literature. They are:

- Lifetime history of depression
- Anxiety
- Poverty
- Stress and losses
- Limited social supports
- Intimate partner violence
- Pregnancy complications

Please see Perinatal depression, continued on Page 21

Perinatal depression, *continued from Page 20*

Due to the serious consequences regarding maternal morbidity and mortality, as well as adverse neonatal and early childhood outcomes, early detection is tantamount. Screening for depression is supported by ACOG as a component of routine obstetric care at least once during the perinatal period and completion of a full assessment of mood and emotional well-being during the comprehensive post-partum visit for each patient.

Recognizing the negative effects of perinatal depression on early childhood outcomes and the role of pediatric health care providers, the American Academy of Pediatrics recommends that pediatric providers routinely screen mothers for depression during one, two and four-month well-child visits.[1]

The Edinburgh Postnatal Depression Scale, or EPDS, is a valuable and effective 10-question screening tool used to identify mothers at risk for perinatal depression. Cutoff scores range from 9 to 13, thus any women scoring 9 or more or indicating suicidal ideation on Question 10 should be referred immediately for follow up. This scale includes anxiety symptoms, but it excludes constitutional symptoms such as change in sleeping patterns which can be common in pregnancy and the post-partum period. Due to the inclusion of these symptoms in other screening instruments such as the PHQ-9, the specificity for perinatal depression is reduced somewhat but it remains a valid and useful screening tool.

Regardless of screening tool used, a positive screener isn't diagnostic for depression, though it does identify those in need of follow-up care and further diagnostic clarification.

Treatment for PPD includes pharmacologic and non-pharmacologic methods. Nonpharmacologic interventions are aimed at mitigating the effects of perinatal depression, including individual cognitive behavioral therapy and interpersonal psychotherapy. Cognitive behavioral therapy aims to reduce depression by targeting and modifying negative patterns of thinking and behavior. Interpersonal psychotherapy is designed to improve depressive symptoms by helping patients navigate changes in their personal relationships and focus on issues such as role change, support and life stress. Recent analysis provides strong support for incorporating this into the treatment plan for perinatal depression.

The current research literature on the safety of antidepressant use during pregnancy and breastfeeding has yielded mixed results. Many health care providers initiate SSRI if pharmacologic treatment is warranted, as they are generally well tolerated. Of the SSRI, fluoxetine and sertraline have more data regarding safety than the newer SSRI or SNRI. As with any medication, you must weigh the risk and benefit of such treatment.

Perinatal depression is an important and far reaching public health issue which can affect mothers, children and families. Appropriate screening and treatment can prevent long-term generational adverse effects.

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Pharmacological therapy for COPD

Chronic obstructive pulmonary disease is a leading cause of death in the United States and is the fourth leading cause of disability. COPD represents a key public health challenge that is both preventable and treatable. Although there is no cure for COPD, pharmacological therapy can reduce symptoms, reduce the frequency and severity of exacerbations and improve health status and exercise tolerance.

In 2011, the Centers for Disease Control and Prevention administered questions about COPD-related health care behaviors as a part of an **annual survey** to Michigan. The results for 995 adults in Michigan living with COPD are summarized in the table below.

Fewer than 50 percent of adults with COPD reported using a daily medication, and more than 50 percent reported that COPD negatively impacts their quality of life. These statistics offer an opportunity to improve quality of life in patients with COPD by ensuring patients who would benefit from pharmacotherapy have a prescription and use a prescription as directed. Using a controller or maintenance medication for COPD as prescribed can also reduce the frequency and severity of exacerbations from COPD.

Diagnosis	Management	Quality of Life	Emergency department
60.1 % reported being diagnosed using spirometry	44.5% reported using at least one daily COPD medication	54.8% reported that shortness of breath affected their quality of life	19.2% reported a hospital or emergency department visit for COPD symptoms in the previous 12 months

Please see COPD, continued on Page 23

CDC flyer provides prevention and treatment recommendations for acute bronchitis

Most cases of acute bronchitis clear up on their own without antibiotics. And using antibiotics when they aren't needed can do more harm than good. Rash and diarrhea are some of the unintended consequences. More serious consequences include an increased risk for an antibiotic-resistant infection or clostridium difficile infection.

The Centers for Disease Control and Prevention has put together a flyer you can give your patients to educate them about acute bronchitis.

Topics covered in the flyer include:

- Symptoms of acute bronchitis
- Causes
- When to seek medical care
- Recommended treatment
- Prevention

View the **CDC flyer** for more details about treating and preventing acute bronchitis.

Quality Counts

COPD, *continued from Page 22*

When is pharmacological treatment initiated in a patient with COPD?

The Global Initiative for Chronic Obstructive Lung Disease, or GOLD, guidelines include a proposed algorithm for the initiation and subsequent escalation or de-escalation of pharmacological therapy management of COPD. Based on individualized assessment of symptoms and exacerbation risk, patients are placed into one of four groups, A through D. The guidelines recommend adding a long-acting bronchodilator for maintenance medication starting with group B. Therapy escalates as a patient moves to group C or D. For a full explanation of how to assess patients, assign groups and when to initiate pharmacotherapy, see the **Gold Guidelines**.

Pharmacological treatment and HEDIS

HEDIS® includes two quality measures targeting pharmacotherapy specific to 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.

The BCN Performance Recognition Program offers a $200 flat fee to primary care physicians for each service completed for the Pharmacotherapy Management of COPD Exacerbation-Bronchodilator measure for BCN commercial members, defined as:

> *The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications.*

- Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event

Note: *The eligible population for this measure is based on acute inpatient discharges and emergency department visits, not members. It is possible for the denominator to include multiple events for the same individual.*

The Performance Recognition Program is providing the incentive to ensure members are on bronchodilator therapy within 30 days of an acute inpatient discharge or emergency room visit for COPD exacerbation. It is recommended to follow up with patients within seven days of their hospital discharge for COPD exacerbation, to help ensure compliance with their therapy.

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. They're available under *BCBSM Newsletters & Resources* in Provider Secured Services.

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℠.

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.

References

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2. Restrepo RD., et al. "Medication adherence issues in patients treated for COPD." International journal of chronic obstructive pulmonary disease 3.3 (2008): 371.
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Quality Counts

Best Practices, *continued from Page 1*

At the same time, checking blood pressure regularly is important. I can adjust medications when I need to. When you see patients only twice a year, it's hard to get blood pressure under control.

Is it more difficult to make sure patients get a retinal eye exam when patients have to see an ophthalmologist?

We make it easier for patients by doing a retinal exam in our office. We have a retinoscope and refer patients with abnormal results to an ophthalmologist with whom we have a relationship. It's easier to make them go when you tell them you've already detected something out of the normal range.

What about nephropathy?

It's easy to do nephropathy testing. All you need is a urine sample. We have a medical assistant and a care manager who puts the performance measures in the patient's chart for us. It's reminder to me during the office visit that the patient needs a test.

What's the biggest challenge in diabetes care?

Helping people afford their medicine, especially with Medicare patients. With oral medications there are many choices. But with insulin, patients need to hit a deductible or Medicare patients have to contend with the doughnut hole. It's a huge issue.

How do you coordinate care with specialists? Do you have a system for communicating with them?

If necessary, we refer patients to a nephrologist. We've recently partnered with one who comes to our diagnostic center once a week to see patients. But there aren't many patients who need a nephrologist.

I monitor most patients myself and seldomly refer to specialists. This way, I'm able to monitor the variety of medications they're taking and don't need to be concerned about duplicate testing. Most often, if a patient sees a specialist, they only go twice a year, but I like to manage their care by seeing them more frequently.

Do you provide special education to diabetes patients?

We have a diabetic educator in the office. She's in my office three days a week. She discusses diet and medication compliance. She also teaches patients how to use insulin. Older patients may have barriers to using insulin, such as coordination and vision. The may have trouble seeing the numbers so they need extra help.

Is there anything else we haven't discussed that you feel is important?

A doctor treating patients with diabetes has to be willing to micromanage the patient. You should see patients frequently. You don't need to spend a lot of time for each office visit if you just saw the patient in the last month or two. And you have a chance to pick up on health changes while they're in your office. Most of my diabetic patients have other chronic diseases. You need to make the time. It's a commitment.

photo by Deepa Elangainathan

Dr. Thomas Selznick with patient, Tonya Lara Keller

Inflectra to be the preferred infliximab product for adult BCN Commercial members

Blue Care Network currently includes infliximab products (Inflectra™, Remicade®, Renflexis®) in the prior authorization program under the medical benefit for BCN HMO℠ commercial members. Effective May 1, 2019, Inflectra will be the preferred infliximab product for adult BCN HMO℠ (commercial) members.

Note: This change doesn't apply to:

1. Pediatric BCN HMO℠ commercial members, defined either as members:
   a. Ages 15 and younger
   b. Ages 18 years old and younger and less than or equal to 50 kg
2. BCN Advantage℠ members

Action required

Adult BCN HMO (commercial) members with an active authorization for an infliximab product other than Inflectra must transition to Inflectra by May 1, 2019.

Drug name	Generic name	HCPCS code	Action required*
Inflectra™	Infliximab-dyyb	Q5103	No change required
Remicade®	Infliximab	J1745	Required to switch to Inflectra by May 1, 2019
Renflexis®	Infliximab-abda	Q5104	

*Applies to adult BCN HMO℠ commercial members *only*

Providers must submit an authorization request to demonstrate medical necessity:

1. Log in to Provider Secured Services.
2. Select *BCBSM Medical Benefit-Medication Prior Authorization* link on the main page.

A prior authorization approval isn't a guarantee of payment. Health care practitioners must verify eligibility and benefits for members.

To access a full list of drugs included in the medical benefit prior authorization and site of care programs, 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."

Pharmacy News

AIM Specialty Health to manage medical oncology medications for BCN starting August 1

Blue Care Network will implement a new utilization management program for medical oncology for BCN commercial members, beginning Aug. 1, 2019. Authorizations must be obtained from AIM Specialty Health® for some medical oncology and supportive care medications.

The benefits of this program include:

- Synchronization with Blue Cross Blue Shield of Michigan and Blue Care Network's medical policies
- 24/7 access to the AIM ***Provider****Portal*℠ for automated clinical appropriateness review and access to the AIM contact center personnel, including oncology nurses and oncologists, during business hours
- Actionable information — Includes a comprehensive set of current, evidence-based AIM Cancer Treatment Pathways for more than 80 clinical scenarios
- Enhanced reimbursement — By choosing an AIM Cancer Treatment Pathway regimen, when clinically appropriate, the ordering provider can receive enhanced reimbursement (to be billed using designated S-codes)

Providers can view a list of medications managed by AIM on **ereferrals.bcbsm.com**, see **BCN AIM Managed Procedures page**.

Join a webinar to learn more

Learn about the new medical oncology program and how to use the AIM ***Provider****Portal*℠ by attending a webinar (intended for non-clinical provider staff).

To attend a webinar, click on your preferred date and time below and then click *Add to my calendar*. (If the link opens for you in Pacific time, just save it to your calendar and it should automatically change to Eastern time.)

Date and time (all Eastern time)
Wednesday, June 19, 9-10 a.m.
Thursday, July 11, 12-1 p.m.
Tuesday, July 30, 9-10 a.m.
Thursday, Aug. 22, 12-1 p.m.
Tuesday, Sept. 10, 9-10 a.m.

Commercial pharmacy audits began in April

Blue Cross Blue Shield of Michigan is using SCIO Health Analytics, an independent company, to conduct compliance audits on 2018 pharmacy claims.

The audits will be claim-specific and help ensure that paid claims were accurately billed according to Blue Cross and Blue Care Network pharmacy guidelines, as well as state and federal laws.

Please be prepared to share prescription records for review. After an audit, SCIO will send the findings letter and, if necessary, information on how to seek an appeal. Any audit recoveries will be paid to Blue Cross Blue Shield of Michigan as directed in the audit letter.

Pharmacies are required to comply with audit requests from Blue Cross, BCN or its agents according to the terms and conditions of the pharmacy network participation agreement.

Questions?

Contact your SCIO provider service representative at 1-866-628-3488, ext. 7414.

Understanding statin quality measures

The benefits of statin therapy in patients with diabetes or established cardiovascular disease is well known. A recent scientific statement from the American Heart Association, titled Statin Safety and Associated Adverse Events, concluded, "Overall, patients for whom statin treatment is recommended by current guidelines, the benefits greatly outweigh the risks. And at maximum dose, statins have demonstrated a mean reduction in LDL cholesterol of 55 percent to 60 percent."[1]

With strong evidence to support statin use in patients with diabetes or established cardiovascular disease, both the National Committee for Quality Assurance and the Centers for Medicare & Medicaid Services have introduced the Healthcare Effectiveness Data and Information Set and CMS star measures related to statin therapy.

Table 1 below defines the different statin measures implemented. Both statin therapy for patients with diabetes and statin therapy for patients with cardiovascular disease are HEDIS® measures required for NCQA accreditation, and SPC (Statin Therapy for Patients with Cardiovascular Disease) and statin use in persons with diabetes are CMS star measures for the Medicare population.

Table 1: Understanding the statin quality measures — definitions

Measure	Definition
Statin Therapy for Patients with Diabetes (SPD)	The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease, or ASCVD. Two rates are reported: 1. Received statin therapy — Members who were dispensed at least **one** statin medication of **any intensity** during the measurement year. 2. Statin adherence 80 percent — Members who remained on a statin medication of any intensity for at least 80 percent of the treatment period.
Statin Therapy for Patients with Cardiovascular Disease (SPC)	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical ASCVD. Two rates are reported: 1. Received statin therapy — Members who were dispensed at least **one moderate- or high-intensity** statin medication during the measurement year. 2. Statin adherence 80 percent — Members who remained on a **moderate- to high-intensity** statin medication for at least 80 percent of the treatment period. See Table 3 for moderate- and high-intensity statins.
Statin Use in Persons with Diabetes (SUPD)	The percent of Medicare Part D beneficiaries 40-75 years old who were **dispensed at least two diabetes medication** fills who received a statin medication fill during the measurement period.
Proportion of Days Covered (PDC)	The percentage of patients ages 18 and older **with at least two fills of a statin medication** who met the Proportion of Days Covered (PDC) threshold of 80 percent during the measurement period.

The measures are all related to statin therapy in certain patient populations. However, there are important key differences, such as the inclusion and exclusion criteria, used to determine which patients belong to which measures. Understanding these differences is crucial to maximizing performance for incentives.

Please see Statin quality, continued on Page 28

Statin quality, *continued from Page 27*

Table 2 summarizes some important differences between the statin quality measures and which incentive programs include these measures.

Table 2: Understanding the statin quality measures — key measure differences

Measure	Inclusion criteria	Key exclusion criteria*	CLQI	CQ VBR	PRP
SPD: received statin	Members with diabetes are identified by **medical claims encounter data and/or by pharmacy data**.[a]	Members with cardiovascular disease, female members with a diagnosis of pregnancy, ESRD, cirrhosis, myalgia, myositis, myopathy or rhabdomyolysis	Yes (commercial PPO)	Yes (commercial PPO)	No
SUPD: received statin	Members with diabetes are identified by **pharmacy data only (at least two diabetes medication fills)**.	Members with ESRD or hospice	No	No	Yes (Medicare PPO and HMO)
SPC: received statin	Members are identified by event (MI, CABG, PCI, etc.) or by diagnosis ischemic vascular disease (IVD).	Members with diagnosis of pregnancy, ESRD, cirrhosis, myalgia, myositis, myopathy or rhabdomyolysis. Certain members 66 years or older who meet additional criteria (dispensed dementia medication, living in long term institution, etc.)	Yes (commercial PPO, Medicare PPO)	Yes (commercial PPO, Medicare PPO)	Yes (commercial HMO, Medicare HMO and PPO)
PDC adherence	Members with at least two fills of a statin medication	Members with ESRD or hospice	Yes (commercial PPO, Medicare PPO)	Yes (commercial PPO, Medicare PPO)	No

**Not all inclusive. Physician organizations are encouraged to purchase the HEDIS specifications published by NCQA.*

[a]*Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

CLQI = Clinical Quality Initiative, CQ VBR = Clinical Quality Value-Based Reimbursement, PRP = Performance Recognition Program.

SPD = statin therapy for patients with diabetes, SUPD = statin use in persons with diabetes, SPC = statin therapy for patients with cardiovascular disease; PDC = proportion of days covered

Please see Statin quality, continued on Page 29

Statin quality, *continued from Page 28*

Despite the well-documented advantages of statin therapy, many patients who meet the recommended criteria are not currently taking a statin. The Centers for Disease Control and Prevention reports only slightly more than half of U.S. adults (55 percent, or 43 million) who need cholesterol medicine are currently taking it, with statins being the effective medications for treating high cholesterol.[2]

Many patients fear side effects with statins and may refuse statin therapy. However, the actual incidence of these side effects remains low.

The risk of statin-induced serious muscle injury, including rhabdomyolysis, is < 0.1 percent, and the risk of serious hepatotoxicity is ~ 0.001 percent.[1] The risk of statin-induced newly diagnosed diabetes mellitus is ~ 0.2 percent per year depending on the underlying risk of diabetes mellitus in the population studied.[1]

In recognition of statin therapy's benefits to patients, and the additional efforts in patient counseling that may be required for patients on these benefits, Blue Cross and BCN are offering provider-level and provider-group-level incentives tied to the statin measures.

Table 3: Understanding the statin quality measures — moderate and high-intensity statin therapy

High-intensity statin	Moderate-intensity statin therapy	
- Atorvastatin 40-80 mg	- Atorvastatin 10-20 mg	- Pravastatin 40-80 mg
- Amlodipine/atorvastatin 40-80 mg	- Amlodipine-atorvastatin 10-20 mg	- Rosuvastatin 5-10 mg
- Rosuvastatin 20-40 mg	- Simvastatin 20-40 mg	- Lovastatin 40 mg
- Simvastatin 80 mg*	- Fluvastatin 40 mg bid	- Fluvastatin XL 80 mg
	- Ezetimibe-atorvastatin 20-40 mg	- Ezetimibe-simvastatin 20-40 mg

**Simvastatin 80 mg is limited to patients who have been taking this dose for more than 12 consecutive months. If patient is unable to achieve LDL-C goal with the 40 mg dose of simvastatin, increasing to 80 mg dose is not recommended. Instead, the patient should be switched to an alternate high-intensity statin providing greater LDL-C reduction.*

Questions about this article and the statin quality measures can be sent to the Pharmacy Clinical Programs & Customer Support — Clinical Services team at Rxqualityprograms@bcbsm.com

Resource materials for you and your patients are available on Provider Secured Services. Log in to web-DENIS and go to *BCN Provider Publications and Resources*. The information is on the Clinical Quality page.

References:

1. Newman CB, Preiss D, Tobert JA, Jacobson TA, Page RL 2nd, Goldstein LB, Chin C, Tannock LR, Miller M, Raghuveer G, Duell PB, Brinton EA, Pollak A, Braun LT, Welty FK; on behalf of the American Heart Association Clinical Lipidology, Lipoprotein, Metabolism and Thrombosis Committee, a Joint Committee of the Council on Atherosclerosis, Thrombosis and Vascular Biology and Council on Lifestyle and Cardiometabolic Health; Council on Cardiovascular Disease in the Young; Council on Clinical Cardiology; and Stroke Council. Statin safety and associated adverse events: a scientific statement from the American Heart Association. Arterioscler Thromb Vasc Biol. 2018;38:e1–e44. doi: 10.1161/ATV.0000000000000073.
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Billing Bulletin

Find billing help on our website

We receive a lot of questions about billing. Many times, the easiest way to get an answer is on our website. Blue Care Network offers billing resources within Provider Secured Services. Just log in to Provider Secured Services and click *BCN Provider Publications and Resources*. Then click *Billing/Claims*.

On the Billing/Claims page you'll find:

- The *BCN Provider Manual Claims* chapter
- General information and claims troubleshooting tips
- Clinical editing resources, including archived clinical editing billing tips from *BCN Provider News*
- Billing instructions
  - In this section, we've updated billing information for Healthy *Blue* Living℠ visits and forms. Look for it under the Professional Claims heading.
  - We've also added an FAQ document about billing for rural health clinics, federally qualified health centers and critical access hospitals for BCN Advantage members. Click *RHCs, FQHCs and CAHs* under the Facility Claims heading.

If you have an urgent question and can't find the answer on our website, call Provider Inquiry.

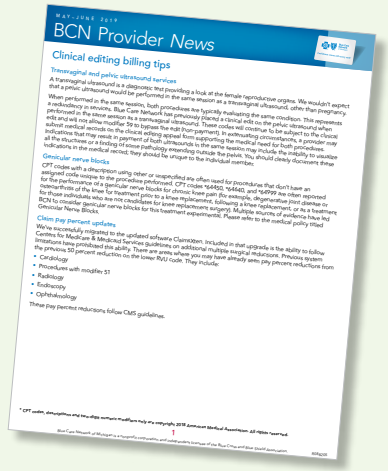
Clinical editing billing tips

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 tip includes:

- Transvaginal and pelvic ultrasound services
- Genicular nerve blocks
- Claim pay percent updates

Clinical editing billing tips


BCN Provider News
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Morbid obesity

Morbid obesity is a serious condition that typically builds slowly over time and leads to symptoms that interfere with basic physical functions, such as breathing, sleeping and walking. Long-term effects include shorter life expectancy and co-morbid conditions such as Type 2 diabetes mellitus, heart disease, high blood pressure and obstructive sleep apnea.

The National Institutes of Health define morbid obesity as:

- BMI of 40 Kg/m2, regardless of comorbid conditions
- More than 100 pounds over ideal body weight
- BMI of 35 or greater and one or more co-morbid conditions that can be linked to obesity

Many providers are reluctant to document obesity as morbid or severe for fear of offending patients, but patients need an accurate understanding of their condition.

It's appropriate to document "obesity" if the patient doesn't meet any of the criteria listed above. On the other hand, if the patient meets one of the criteria for morbid (severe) obesity, it should be documented as such.

In addition, the provider should document any interventions or recommendations made during the visit to help the patient lose weight. This may include diet and exercise counseling, or referral to a dietitian or bariatric surgeon.

Coding tips

- To assign code E66.01, the provider must specifically document either "**morbid obesity**" or "**severe obesity**" in the record and have a documented plan or intervention that addresses the patient's morbid obesity.
- When the provider documents "obesity" or "overweight," this leads to assignment of codes E66.9 or E66.3, respectively. This would be inappropriate in a patient who meets criteria for morbid obesity as it will reflect a lower than accurate severity of illness.
- Documentation of the BMI value allows assignment of a separate set of codes (Z68.XX). Assignment of these codes at least once a year is an essential quality measure.
- If the patient's BMI is higher than normal (greater than 25), the provider must also document a clinical descriptor based on his or her interpretation of the BMI, such as "obese," "morbidly obese" or "overweight." This is especially important for patients with a BMI of 40 or greater as they meet the definition of morbid (severe) obesity.

Billing Q&A

Question:

We are having difficulty with a restriction on a procedure billed using *91040 - Esophageal balloon distension study, diagnostic, with provocation when performed. This procedure is a diagnostic test that has two components. The technical component of the procedure is approved to be performed in the facility setting, but because this is a diagnostic test, the performing physician also needs to interpret the results and issue a report.

We were told that the facility is the only entity that can submit a claim for *91040. However, the physician also needs to submit a claim for the professional services of reading and interpretation and would bill *91040-26 to reflect the professional component. This claim must be submitted by the MD office on a HCFA-1500 since this is a professional claim. According to information I have, the physician is not allowed to bill any service from the MD office. Under this policy, the physician is not able to submit a claim for their professional services.

Can you assist me in a resolution?

Answer:

CPT code *91040 does contain both a professional and technical component. When the service is performed in a setting other than an office, the professional component may be reimbursed if the claim is submitted in accordance with professional billing guidelines as outlined in the *BCN Provider Manual*. Physicians who are not facility based can submit claims electronically or use a paper version of the CMS-1500 claim form. The appropriate place of service and modifier to indicate that only the professional component was performed should be indicated on the claim.

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.

We've made additional changes to the peer-to-peer review process

We've made additional changes to the process of asking for a peer-to-peer review of a denied authorization of a non-behavioral health service for BCN HMO℠ (commercial) or BCN Advantage℠ members.

The request for a peer-to-peer review:

- Must be submitted within the time frame available for filing an appeal for that determination. Once the appeal time frame has expired, the provider can no longer request a peer-to-peer review.
- Can't be submitted if a provider appeal of that denial has already been submitted
- May be submitted only for denials based on medical necessity
- Can't be submitted for a denial of a member's appeal or grievance

We have outlined these requirements — and additional information about them — in Section 1 of the document **How to request a peer-to-peer review with a BCN medical director**.

These requirements apply to authorization requests for both inpatient and outpatient services. They are in addition to the change we communicated in December 2018 telling you to use the **Physician peer-to-peer request form (for non-behavioral health cases)** to submit the peer-to-peer review request.

You can access both documents — the description of the process for submitting a peer-to-peer review request and the form — by completing the following steps:

1. Visit **ereferrals.bcbsm.com**.
2. Click *BCN*.
3. Click ***Authorization Requirements & Criteria***.
4. Look under the "Referral and authorization information" heading.

Clarifying biofeedback and neurofeedback authorization requirements for BCN members

When submitting authorization requests for biofeedback and neurofeedback for BCN HMO℠ (commercial) and BCN Advantage℠ members, there are things you have to do differently for each. Here's what you need to know.

Biofeedback is covered, when authorized, for specific medical diagnoses and not for behavioral health diagnoses.

- When you submit your initial request to authorize biofeedback, you must attach all the required clinical documentation to the case in the e-referral system.
- BCN's Utilization Management staff, not the Behavioral Health staff, make the determination on the request.

In the future, you'll also need to complete a questionnaire for biofeedback in the e-referral system. Look for more information about that in upcoming web-DENIS messages and articles in *BCN Provider News*.

Neurofeedback is covered, when authorized, for specific behavioral health diagnoses only.

- Neurofeedback requires an independent evaluation (psychological or neuropsychological testing) confirming that the member has a diagnosis of attention deficit hyperactivity disorder or attention deficit disorder. This must be completed by someone other than the neurofeedback provider.
- When you submit your initial request to authorize neurofeedback, you must attach the report from the independent evaluation to the case in the e-referral system, along with any additional clinical documentation required.
- BCN's Behavioral Health staff, not the Utilization Management staff, make the determination on the request.
- When you submit requests to authorize additional neurofeedback visits, you must complete the questionnaire that opens in the e-referral system.

Instructions for attaching a document from the member's medical record are outlined in the article **How to attach clinical information to your authorization request in the e-referral system**, in the November-December 2016 *BCN Provider News*, on page 44. These instructions are also in:

- The **e-referral User Guide**. Look in the "Submit Outpatient Authorization" section, under "Create New (communication)."
- The **Behavioral Health e-referral User Guide**. Look in the section titled "Submitting a Neurofeedback Authorization," under "Create New (communication)."

The Care Management and Behavioral Health chapters of the *BCN Provider Manual* will be updated with these clarifications.

Submit BCN authorization requests for all therapy and physical medicine visits to eviCore starting May 27

Starting May 27, 2019, submit all BCN authorization requests for outpatient physical, occupational and speech therapy by therapists and physical medicine services by chiropractors to eviCore healthcare. This includes requests for both initial and follow-up visits, for both BCN HMO℠ (commercial) and BCN Advantage℠ members.

Through May 26, 2019, you'll continue to submit these requests through the e-referral system (for initial visits) and the Landmark Healthcare portal (for follow-up visits).

Sign up for training

To learn about the changes involved in submitting these requests to eviCore, sign up now for the eviCore webinar training sessions in late May and early June.

Refer to the article on **Page 37**, titled "Register for a webinar on submitting BCN authorization requests for therapy and physical medicine to eviCore" to find out what the training will cover and how to register for a webinar.

Among other things, you'll learn how to submit authorization requests directly through the eviCore provider portal. This is the most efficient way to get a determination. You can access the eviCore portal in these ways:

- Visit **www.evicore.com**. Click *Login: Providers* and enter your user ID and password.
- Go to web-DENIS. BCN will provide a link to the eviCore portal from within web-DENIS.

  Important: You'll be able to submit requests directly to the eviCore portal starting May 27 but you won't be able to access the eviCore provider portal through web-DENIS until May 31. We'll let you know how that works in the training.

You can also submit authorization requests to eviCore by phone at 1-855-774-1317 or by fax at 1-855-774-1319.

When calling, follow the prompts to:

- Start a new authorization request
- Ask to speak to a physician (therapist)
- Check the status of an authorization request already submitted
- Request changes to an existing authorization
- Inquire about benefits
- Discuss provider categorizations

Providers who use the 278 electronic standard transaction to submit authorization requests will not be able to use it to submit therapy requests to eviCore. You should submit all therapy requests to eviCore using one of the methods outlined above.

Please see eviCore, continued on Page 36

eviCore, *continued from Page 35*

About the transition

Here are some things you should know as you make the transition to submitting requests to eviCore:

- If you submit a new authorization request to the e-referral system on or after May 27, you'll get a message instructing you to submit it to eviCore.
- Use the eviCore portal to request follow-up visits on a request originally submitted through the e-referral system or to Landmark Healthcare.

Learn more by attending a training webinar and by reviewing the updated document **Outpatient rehabilitation services: Frequently asked questions for rehab providers**.

Additional information

This change applies to requests for BCN HMO℠ (commercial) and BCN Advantage℠ 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℠ 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℠ PPO authorization requests starting Jan. 1, 2018.

What to do when error messages display in e-referral

If you're a provider trying to edit one of your cases in the e-referral system, you may see an error message that says:

"The case is unavailable because it's being reviewed. Please try again later."

Recently, e-referral began displaying this message when a provider tries to edit a case that's locked because our Utilization Management team is working on it.

This error message can appear for any Blue Cross Blue Shield of Michigan or Blue Care Network case in the e-referral system, including commercial and Medicare Advantage cases. If you encounter one of these messages, edit the case later to give our team time to review and exit the case.

If you encounter another type of other error message, contact the Web Support Help Desk at 1-877-258-3932.

Register for a webinar on submitting all BCN authorization requests for therapy and physical medicine to eviCore

To help you make a smooth transition to submitting all Blue Care Network authorization requests for outpatient physical, occupational and speech therapy by therapists and physical medicine services by chiropractors to eviCore starting May 27, 2019, we're offering online training sessions.

Each webinar lasts one hour and covers these topics:

- Overview of eviCore healthcare
- Overview of eviCore's clinical approach
- Review of the authorization process
- How to access the eviCore provider portal through **www.evicore.com** or through web-DENIS
- How to submit authorization requests through the eviCore provider portal
- Overview of eviCore's provider resources

To sign up, follow the steps outlined below.

1. Identify which webinar date works best for you. Choose one date from the table below:

May 2019	June 2019
Thursday, May 16 – 10 to 11 a.m.	Tuesday, June 4 – 10 to 11 a.m.
Tuesday, May 21 – 2 to 3 p.m.	Thursday, June 6 – 2 to 3 p.m.
Thursday, May 23 – 10 to 11 a.m.	
Wednesday, May 29 – 2 to 3 p.m.	

2. Visit **www.evicore.webex.com**.
3. Click *Webex Training* in the left navigation.
4. Click the *Upcoming* tab.
5. Find the date and time of the webinar you wish to attend.
6. Click *Register* in the column to the right of that webinar.
7. Enter your registration information.

After you have registered, you'll receive an email containing the toll-free phone number, meeting number, conference password and link to the web portion of the webinar. Keep the registration email so you'll have the information for your session.

eviCore also provides other training resources at **www.evicore.com**. Click *Providers* at the upper right. On the Providers Area tab that opens, scroll down to view the resources available and click to open the ones you want to see.

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