

BCN Provider News



2019 *BCN Provider News* Archives

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2. Insert the search word in the Find field.
3. Click *Search* or an arrow to move from one location to the other.

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

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In the Results ...

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Providers: Don't issue referrals for BCN Advantage members staying in-network

We ran an article in the November-December 2018 **issue** to let providers know that you don't need to issue referrals for a BCN AdvantageSM member who is seeing a specialist in that plan's provider network.

Beginning in March 2019, if you try to submit a global referral for a BCN Advantage member in the e-referral system you'll receive a message indicating that the global referral cannot be accepted and therefore shouldn't be submitted. Remember though, that authorizations and plan notifications are still required for certain services with any provider and for all services with a provider who's not in the network of the member's health plan.

When you see a BCN Advantage patient, the first step is to always check their eligibility, their health plan and their benefit coverage either through web-DENIS, Provider Inquiry or the 270/271 electronic standard transaction. Section 1 of the **e-referral User Guide** gives instructions on how to do this using web-DENIS. See Helpful tips for checking eligibility in web-DENIS (**Page 3**).

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

Some reminders about Healthy *Blue Living* physical exams and qualification forms

Each Healthy *Blue Living*SM HMO member is required to visit his or her primary care physician for an exam within 90 days of enrollment or renewal. Providers can schedule a physical exam for Healthy *Blue Living* HMO members any time throughout the year. If last year's physical was in March, for example, the member can schedule a physical in January. There are no limits on how many times a member can schedule a physical exam. BCN encourages each member to see his or her PCP well before the deadline and will accept a qualification form from an office visit occurring up to 180 days prior to the member's renewal date.

Please see [Healthy *Blue Living*](#), continued on Page 3

Inside this issue...

5 Blue Cross Blue Shield's and Blue Care Network's provider directories to identify treatment for opioid addiction

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Referrals, continued from Page 1

Check if the member is enrolled in a BCN Advantage health plan with a local network. If the member’s plan has a local network, make sure to recommend a specialist or provider in that local network. BCN Advantage health plans with a local network include:

- BCN AdvantageSM HMO ConnectedCare
- BCN AdvantageSM HMO HealthySaver
- BCN AdvantageSM HMO HealthyValue
- BCN AdvantageSM HMO MyChoice Wellness

More information about these products can be found in the 2019 Blue Care Network products-at-a-glance document. You can view this document by visiting bcbsm.com/providers, logging into Provider Secured Services, clicking *BCN Provider Publications and Resources* on the right side of the Welcome page and then clicking *BCN Products*. Finally, click *Blue Care Network products at a glance for 2019*. Additional information is also in the *BCN Provider Manual*, in the BCN Advantage chapter.

You can also check whether a physician or provider is contracted with a local network through our online provider search. For tips on doing this, see [How to find the BCN networks you’re contracted with](#), on [Page 5](#).

If you’re already in the e-referral tool submitting requests for many patients, you can also check whether the provider is in the plan’s network there. After selecting the patient, look up the servicing provider. The network status of the provider for that health plan will be listed in the far left column of

the provider search results. The same provider may be listed multiple times if they have affiliations with multiple groups. You should always select a provider with a “Pref”, or preferred, network status with a group affiliation (if one is available) rather than a listing not associated with a group. In the e-referral system, the network status column includes:

- **Pref = Preferred.** The provider is in the plan’s network. If the member has a local network, the provider is in the local network. Choose a preferred provider whenever possible.
- **In = In network.** The provider is in the plan’s larger BCN Advantage network but is not in the local network. The member will need an authorization from BCN to see this provider. You cannot issue a global referral to this provider for this member, but you can request an authorization through the e-referral system through the Submit Outpatient Authorization option in the drop-down menu or for inpatient services through the Submit Inpatient Authorization option.
- **Out = Not contracted.** This provider is not affiliated with the health plan or with BCN Advantage. The member will need an authorization from BCN to see this provider. You cannot issue a global referral to this provider for this member, but you can request an authorization in the e-referral system through the Submit Outpatient Authorization option in the drop-down menu or for inpatient services through the Submit Inpatient Authorization option.

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

Editor

Cindy Palese
bcnprovidernews@bcbsm.com

Provider Communications

Catherine Vera-Burgos, Manager
Elizabeth Donoghue Colvin
Jennifer Fry
Tracy Petipren

Market Communications Publications

Cathy Rauckis

Contributors

William Beecroft, M.D.; Terri Brady; Laura Cornish; Pharm. D; Jody Gembariski; Duane DiFranco, M.D.; Sonja Rashed; Kelly Redmond-Anderson

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Helpful tips for checking eligibility in web-DENIS

When you look up a member's eligibility in web-DENIS, the Eligibility/Coverage page will tell you the name of the member's health plan and whether the member has active coverage. Click on the member's name to find specific information for the patient you are serving. If the member is enrolled in a local network, you will see a red provider network disclaimer on the Member Eligibility/Coverage page.

Eligibility/Coverage

BCN Advantage HMO POS

CONTRACT ID: GROUP
 COVERAGE: ALL COVERED
 ENROLLED DATE: 01/01/2018
 SAMPLE MEMBER: Active

Profile Lookup

Billing Status: Active

Next Insurance
 Account Balance / Amount Owed

The plan is BCN Advantage.

The contract is active.

Remember to address open diagnosis or treatment opportunity gaps at a face-to-face visit with your patient. Document the diagnosis codes in the patient's medical record following CPT guidelines and close the gap in Health e-CheckUP.

Additional coverage or members may be available on this contract - click on the Subscriber's name (below), then select BCBSM Coverage.

Member Selection

Click on the member name to locate member eligibility and benefits.

Member	Status	Relationship/Gender	Birth Date	PCP Name	BCN COB	Member/Case/Alert
SAMPLE MEMBER	Active	01 - Subscriber F	10-06-1981	PCP NAME	BCN COB	Member/Case/Alert

Member Eligibility/Coverage

BCN Advantage ConnectedCare HMO

Relation: Subscriber
 PCP Copay: \$ (See Medical Benefits Below)
 Billing Status: Active
 Coverage Dates: 01-01-2018 Paid to 12-31-2018
 Sex: M
 Birth Date: 11-30-1984

Additional coverage or members may be available on this contract - click BCBSM Coverage (below)

BCBSM Coverage Member Selection Next Contract Provider Network

Showing Benefits

Medical Benefits: [Details] [BCN COB] [11-30-2018]

Other Benefits: [Details] [BCN COB]

Select data to view Benefits and Deductibles/Maximums. COB information is only applicable for current coverage.

Provider Network: The BCN Advantage HMO ConnectedCare network primarily consists of physicians affiliated with the Together Health Networks (Triad and Assemblies) in the Southeast and East regions. Care provided outside this network requires a referral from the primary care physician and authorization from BCN. Check participation in the provider network.

If the member has a local network, there will be a special provider network message.

Healthy Blue Living, continued from Page 1

Billing for the exam

Providers should use the appropriate ICD diagnosis as the primary diagnosis when billing for the initial or subsequent examination and for the initial assessment for members participating in the Wellness Rewards Tracking program.

Use ICD-10 code Z00.00 or Z00.01. Additional diagnoses may be reported for specific conditions (for example, high blood pressure). There is no member cost-sharing for the completion of the qualification form when the primary diagnosis reported is Z00.00 or Z00.01. There is no member cost-sharing for the office visit when the primary diagnosis is Z00.00 or if a preventive medical examination is reported.

Billing for the qualification form

Providers must file a claim to be paid for completing the Blue Care Network qualification form for a member covered by Healthy Blue Living or Healthy Blue Living HMO BasicSM for members participating in BCN's Wellness Rewards Tracking program. Claims for completing the form should be billed in the amount of \$40 using the CPT code *99080. Payment will be reflected on the remittance advice.

For detailed billing information for Healthy Blue Living:

- Log into Provider Secured Services at **bcbsm.com/providers**.
- Click *BCN Provider Publications and Resources*.
- Click on *Billing/claims* in the left navigation.
- Click *Healthy Blue Living visits and forms* under the "Professional Claims – Billing Instructions" heading.

*CPT codes, descriptions and two-digit modifiers only are copyright 2018 American Medical Association. All rights reserved.

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Blue Cross Blue Shield's and Blue Care Network's provider directories to identify treatment for opioid addiction



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Practitioners that publicly participate in a medication-assisted treatment program and participate with Blue Cross Blue Shield of Michigan or Blue Care Network will be displayed in our directory identified with “Suboxone Treatment for Opiate Addiction” location service code. This indicates that these practitioners have certification to prescribe buprenorphine medications to patients to assist them with opioid use disorders.

Our members can search by “Area of Focus” and click on “Suboxone Treatment for Opiate Addiction” to see a list of practitioners in their area.

Blue Care Network announced an incentive for providers offering medication-assisted treatment in the **July-August** issue.

An article about MAT also appeared in the **March-April** issue.

If you have questions regarding this article, please contact our Provider Enrollment team at 1-800-822-2761.



How to find the BCN networks you're contracted with

A guide to help providers use the online provider search on **bcbsm.com** to determine which health plans they accept has been posted. The *Finding your products* flyer shows providers how to “find themselves” using the Blue Cross online provider search and confirm which Blue Cross Blue Shield of Michigan and Blue Care Network products they accept.

Providers may want to use this guide to look up their own information or to look up information because they want to refer a patient to another doctor who's part of the patient's health plan network.

This step-by-step guide can be found within Provider Secured Services in the *BCBSM Newsletters and Resources* website under *Products and Networks*, as well as on the *BCN Provider Publications and Resources* website, on the *BCN Products* page.

Products at a glance and ID card brochure are posted on our website

We've posted the *2019 BCN products at a glance document* and the *Blue Care Network ID Card Brochure* on the BCN Provider Publications and Resources website within Provider Secured Services.

The products at a glance document is a general summary of BCN products. It shouldn't be used to determine a member's benefits. BCN recommends that each time a member presents for services the provider check the eligibility and benefits for that member.

The ID card brochure will help you know about the different ID cards you may see in your practice from members who have Blue Care Network coverage.

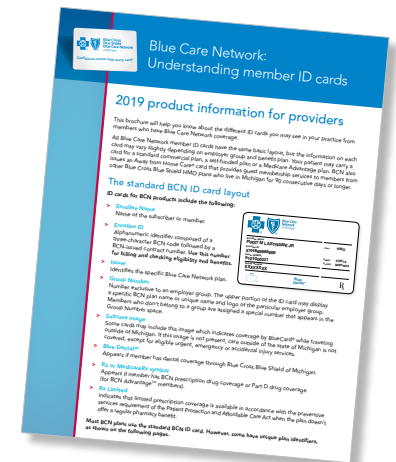
To find the BCN products at a glance document:

- Visit **bcbsm.com/providers**.
- Log in to Provider Secured Services.
- Click *BCN Provider Publications and Resources*.
- Click *BCN Products*.
- Click *Blue Care Network products at a glance for 2019*.



To find the BCN ID card brochure:

1. Visit **ereferrals.bcbsm.com**.
2. Click *Quick Guides*.
3. Click *Blue Care Network Member ID Cards*.





Understanding the difference between ‘home health’ and ‘home infusion’

In practice, you may use the terms “home health” and “home infusion” synonymously. However, when it comes to your patients’ benefits with Blue Cross Blue Shield of Michigan and Blue Care Network, these terms have very different meanings and coverage requirements.

Home health care is a benefit for members who have it as part of their plan and meet specific criteria, including being certified by a doctor as non-ambulatory or homebound. This allows them to receive certain services at home as an alternative to long-term hospital care. These services include skilled nursing, physical therapy, speech therapy, nutritional therapy, occupational therapy and social service guidance.

Some services, including the following, **aren’t** covered under the home health care benefit.

- **Custodial care:** This service is for patients in nursing homes, hospice or other facility settings who don’t need skilled medical or nursing care. It’s provided by individuals who aren’t required to have special training. Services include assistance with daily living activities, such as bathing, dressing, shopping, cleaning, cooking and laundry.
- **Personal care:** This is care given by certified home health aides, Services include bathing, dressing or using the bathroom.

Home infusion, a service that our Site of Care Optimization policy refers to, is an alternative to traveling to a hospital outpatient infusion center or physician’s office to receive certain medications from a health care professional. Home infusion services are included under the Blue Cross and BCN medical benefit. There’s no requirement for your patient to be deemed non-ambulatory or homebound to use a contracted home infusion provider.

Home infusion providers use specially trained nurses that travel to your patients’ homes to administer the medications you’ve prescribed. They’ll also monitor patients throughout the infusion process and for an appropriate amount of time after the infusion has been completed. Home infusion is a safe and convenient way to administer prescription medications.

For more information

- Use web-DENIS to determine whether a member has the home health benefit.
- To learn more about the home health benefit or the Site of Care Optimization policy, review our medical policies by using the **Medical Policy & Pre-Cert/Pre-Auth Router**.
- For information on the medical drugs included in the Site of Care Program, follow these steps:

For Blue Cross

- From the Provider Secured Services landing page, click on *BCBSM Provider Publications and Resources*.
- Click on *Newsletters and Resources*.
- Click on *Forms*.
- Click on *Physician administered medications*

For BCN

- Visit the **Medical Benefit Drugs – Pharmacy** page in the BCN section of **ereferrals.bcbsm.com**.
- Under the heading “For BCN HMO (commercial) members,” click on **Requirements for drugs covered under the medical benefit – BCN HMO**

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BCN to update anesthesia conversion factor

Blue Care Network will update the anesthesia conversion factor, effective with dates of service on or after Jan. 1, 2019. This change applies to services provided to Blue Care Network HMO commercial members.

In alignment with Blue Cross Blue Shield of Michigan, the conversion factor used to calculate anesthesia base units for anesthesia procedures will increase to \$59.82 from \$58.65 throughout Michigan.

This updates an article that ran in the **July-August issue**, Page 4.

Redesigned *Blues Brief* available electronically starting January

Our one-page provider and facility newsletter, *Blues Brief*, will have a new look starting in January. *Blues Brief* contains brief Blue Cross Blue Shield of Michigan and Blue Care Network articles and is distributed by provider consultants to physicians, specialists and their office staff. Provider offices receive it monthly; facilities receive it quarterly.

The refreshed look will feature a new header, color scheme and icons to identify which articles pertain to individual lines of business. Specialty-specific versions will be created periodically for chiropractic, behavioral health and physical, occupational and speech therapy offices.

Besides the new look, providers can subscribe to *Blues Brief* to receive it electronically. Choose from the monthly physician office version, quarterly hospitals and facilities version or the specialty-specific versions. To 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.

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Providers rely on printed materials, electronic resources and online learning

Providers responding to a survey about training and education needs said they rely on publications to get key network information. Here are our key takeaways from the survey we conducted in July 2018. We received 120 responses.

- Printed materials and publications continue to be an important resource. Basic training on how to find materials is helpful.
- Electronic resources (*The Record*, *BCN Provider News*, and web-DENIS) are key ways providers and their staff get information. Respondents told us to continue using these methods to share changes and updates.
- Online learning and webinars are convenient ways for providers and their staff to learn. You told us to do more of these.

Providers also shared the topics they'd like to learn more about. Here are the top responses:

- Patient benefits and eligibility
- Billing basics
- Trouble-shooting claim issues
- Navigating web-DENIS
- Provider manuals
- Medical authorizations
- BlueCard® claims and appeals



In addition, providers told us they prefer these training methods:

- Self-guided online e-learning (19%)
- Printed materials (19%)
- Live webinars (17%)

We appreciate your feedback as we work to improve our online resource and training.

Specialists: Confirm referrals through BCN's e-referral system

Specialists cannot require that the member present a written copy of the referral and cannot expect that the primary care physician or BCN's Utilization Management department fax the referral. Referrals should be confirmed by viewing them in the e-referral system or by calling Provider Inquiry. This information is included in the *BCN Provider Manual*.





BCN Advantage will start notifying providers on the CMS preclusion list in January

The Centers for Medicare & Medicaid Services adopted a rule in April 2018 that stipulates providers can't be on a preclusion list and receive payment from a Medicare plan. CMS will make the preclusion list available to Part D sponsors and Medicare Advantage plans, like BCN Advantage, beginning Jan. 1, 2019.

Once Blue Cross Blue Shield of Michigan and Blue Care Network receive the preclusion list on the first of each month, our provider enrollment and data management department will send a letter — within 30 days — to any contracted Medicare Advantage PPO provider or BCN Advantage provider who is on the list. The letter will include the effective date of the provider's preclusion, which will be 90 days from the date of the published preclusion list.

We're required to remove any contracted provider who is included on the preclusion list from our networks. We're also required to notify enrollees who have received care in the last 12 months from a contracted provider or a prescription from a provider who is on the preclusion list.

In addition, effective April 1, 2019:

- Part D sponsors will be required to reject a pharmacy claim (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the preclusion list.
- Medicare Advantage plans will be required to deny payment for a health care item or service furnished by an individual or entity on the preclusion list.

What is the preclusion list?

The preclusion list is a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. The list was created to replace the Medicare Advantage and prescriber enrollment requirements and to ensure patient protections and to protect the trust funds from prescribers and providers identified as bad actors.

More information is available at the [CMS website](#).

Medicare Advantage non-compliance audits began Oct. 1, 2018

Blue Cross Blue Shield of Michigan and Blue Care Network have changed the audit policy on pursuing the submission of Additional Documentation Requests (also known as ADRs). As of Oct. 1, 2018, we've implemented existing Medicare policy to ensure program compliance for letters requesting medical records. Previously, we did not pursue remedies on non-responses to these letters.

For providers who do not respond to the request in the allotted time frame or by the extension time frame, we may deny their entire claim or service as not reasonable or necessary. Blue Care Network will notify providers that we've issued a non-compliance denial for a claim or service and the claim will be recovered from future payments.

If we receive the requested ADR after a denial has been issued, but within 30 calendar days after the last denial date, we'll re-open the claim and make a medical record determination.



Medicare Part B medical specialty drug prior authorization lists changing in 2019

Some updates are coming for the Part B medical specialty medical prior authorization drug list for Medicare Plus BlueSM PPO and BCN AdvantageSM members. These changes include additions and removals from the prior authorization program as follows.

Medicare Plus Blue PPO

Removals — for dates of service starting Jan. 1, 2019:	
J0202	Lemtrada [®]
J2323	Tysabri [®]
J2350	Ocrevus [®]
Additions — for dates of service starting Feb. 1, 2019:	
J1746	Trogarzo [™]
J2840	Kanuma [®]
J2860	Sylvant [®]
J3357	Stelara [®] SQ
J3358	Stelara [®] IV
J3490/C9036	Onpattro [™]
J9022	Tecentriq [®]
J9023	Bavencio [®]
J9042	Adcetris [®]
J9176	Empliciti [®]
J9308	Cyramza [®]
J9352	Yondelis [®]

For Medicare Plus Blue, we require prior authorization for these medications when you bill them on a professional CMS-1500 claim form or by electronic submission through an 837P transaction, for the following sites of care:

- Physician office (Place of Service Code 11)
- Outpatient facility (Place of Service Code 19, 22 or 24)

We do not require authorization for these medications when you bill them on a facility claim form (such as a UB04) or electronically through an 837I transaction.

Important reminder

You must get authorization **before** administering these medications. Use the Novologix[®] online web tool to quickly submit your requests.

BCN Advantage

Removals — for dates of service starting Jan. 1, 2019:	
J0897	Xgeva [®]
J9032	Beleodaq [®]
J9310	Rituxan [®]
Additions — for dates of service starting Feb. 1, 2019:	
J1746	Trogarzo [™]
J2860	Sylvant [®]
J3357	Stelara [®] SQ
J3358	Stelara [®] IV
J3490/C9036	Onpattro [™]
J9022	Tecentriq [®]
J9023	Bavencio [®]
J9042	Adcetris [®]
J9176	Empliciti [®]
J9352	Yondelis [®]

For BCN Advantage, we require prior authorization for these medications when you bill them on a professional CMS-1500 claim form (or submit them electronically through an 837P transaction) or on a facility claim form such as a UB04 (or submit them electronically through an 837I transaction), for the following sites of care:

- Physician office (Place of Service Code 11)
- Outpatient facility (Place of Service Code 19, 22 or 24)
- Home (Place of Service Code 12)



Online health services will be available to Blue Cross, BCN Medicare Advantage members, beginning Jan. 1

As a reminder, BCN AdvantageSM and Medicare Plus BlueSM PPO plans will offer Blue Cross Online VisitsSM beginning Jan. 1, 2019.

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

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

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

For more details on this service, see the **article** titled *BCN Advantage members get added support with online visits* on Page 14 in the November-December 2018 issue of *BCN Provider News*.

Billing changes for home infusion services for URMBT members with BCN Advantage effective Jan. 1

URMBT members with BCN AdvantageSM currently have a home infusion benefit that allows most Part D drugs to be administered at home with no cost share for the member. Effective Jan. 1, 2019, this benefit is appropriately covered under the member's Part D *benefit*.

URMBT members may still have these medications infused at home starting in January but the drug will need to be billed under the member's Part D benefit which is administered by ESI. This means the member will have some out-of-pocket expenses for the home infusion therapy drug *if they or their prescriber choose to have the drug administered at home*.

Physicians shouldn't need to do anything different than in the past if they desire home infusion therapy for their patient. They should continue to send home infusion prescription orders to contracted home infusion providers.

The *home infusion provider* will need to bill Part D drugs to ESI and collect the appropriate copay from the member. Drugs covered under Part B should continue to be billed to BCN Advantage. If the drug is administered in the physician's office or other outpatient facility, the drug would continue to be covered under Part B.

Certain medications will continue to be covered under Part B with no member cost share if infused at home, for example:

- IVIG therapy used for treating a primary immunodeficiency condition
- Drugs that require a DME device (for example, infusion pump)

For all BCN Advantage plans that have Part D benefits with BCN (groups and individuals), the home infusion benefit will remain unchanged. All home infusion drugs should be billed to BCN for these members with no change in cost share.

As a reminder, providers should always check eligibility and benefits through web-DENIS.

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A look at Blue Cross' efforts to address the opioid epidemic

By Duane J. DiFranco, M.D.



More than **2,600 Michigan residents** died in 2017 from drug overdoses, exceeding the number of traffic and firearm fatalities reported that year. As the opioid epidemic continues to capture the attention of public health officials and decision-makers across the country, Blue Cross Blue Shield of Michigan and Blue Care Network are continuing efforts to address the issue through public awareness, collaboration and improvements to clinical care delivery.

A multifaceted approach

Prevention, treatment, advocacy and collaboration have been the foundation of Blue Cross' efforts addressing the opioid epidemic. What began as an internal, cross-functional task force among company representatives has extended to working with physician groups, forging partnerships with other insurers and supporting community groups across the state.

A few of our key focuses have been:

- **Raising awareness:** Educating the health care community and general public about opioid and prescription drug misuse has been critical. Whether it's sharing information

about safe disposal or sharing ways to identify or treat substance use disorder, Blue Cross' goal is to advocate for prevention and awareness around all aspects of the opioid epidemic.

- **Removing barriers to treatment:** Blue Cross and Blue Care Network have removed barriers to addiction treatment by providing access to **medication-assisted treatment**, which reduces cravings and keeps those in recovery stable. Prior authorizations are not necessary for most buprenorphine-based treatment regimens like Suboxone®, Vivitrol® or methadone. By using real-time hospital discharge data, our pharmacy team works with our behavioral health experts to engage members in treatment following an opioid or heroin overdose.
- **Supporting community coalitions:** Earlier this year, the **Blue Cross Blue Shield of Michigan Foundation** joined forces with the Michigan Health Endowment Fund and the Community Foundation for Southeast Michigan to award more than \$500,000 in grants to nine community coalitions across the state working to fight opioid abuse. The funding is helping communities start sustainable, evidence-based practices that include education, law enforcement and clinical interventions addressing opioid and prescription drug abuse in Michigan.

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Treating chronic pain

As the conversation around pain management evolves, Blue Cross remains focused on working directly with doctors to coordinate care and reduce opioid and prescription drug misuse. A proper balance needs to be struck. Opioids have a legitimate place and “overshooting the mark” must be avoided. People with, or at risk of, opioid use disorder need assistance and so do people with significant pain syndromes. Some of the strategic approaches we’ve taken to encourage balanced and appropriate opioid prescribing practices, include:

- Enforcing policy change:** As of Feb. 1, 2018, we’ve been working with physicians to limit the quantity and day supply of addictive substances. This common-sense step helps members get the pain management medication doctors believe is needed, while taking positive steps to address a growing epidemic of addiction and overdose deaths. An initial fill of a prescription for one of these medications is limited to a five-day supply; Additional fills are limited to no more than a 30-day supply, but do not apply to members with a cancer diagnosis or who are terminally ill. Blue Cross also uses system edits, such as refill-too-soon logic, to limit early refills and to help prevent stock piling of controlled substances.
- Forging partnerships:** Blue Cross and the Michigan Opioid Prescribing Engagement Network work with our physician groups to improve statewide prescribing practices and utilization. Michigan OPEN works with doctors and hospitals to decrease new opioid prescriptions to surgical patients and raise awareness of the danger of opioids. Blue Cross is also a member of America’s Health Insurance Plans’ and the Blue Cross and Blue Shield Association’s opioid prevention and abuse workgroups. These groups are focused on developing recommendations on how health insurers can work with others in the health care community to ensure safe opioid prescribing.

- Identifying at-risk members:** Blue Cross has worked to monitor who’s obtaining controlled substances from multiple prescribers and analyze claims for larger-than-average amounts. In addition to this, our Controlled Substance Workgroup of doctors, behavioral health specialists, case managers, pharmacists and corporate investigators review claims of members with behavior reflecting opioid misuse or abuse to then coordinate treatment referrals and ongoing case management.
- Providing resources on appropriate treatment of pain:** Blue Cross has worked with the State of Michigan and with our providers to develop clinical care guidelines for the prescription of opioid medication in primary care. We’ve also sponsored, in collaboration with provider-partners, continuing medical education across the state to better equip providers to treat those with significant pain.

Promising results

While there’s still work to do to address the opioid epidemic, Blue Cross has seen notable results from our efforts. Within six months of working with doctors, there has been a 51 percent reduction in Blue Cross members taking both opioid and benzodiazepine drugs. In three years, numbers of members receiving the dangerous “triple threat” drug (a combination of opioids, benzodiazepines and Soma®) have decreased by 84 percent. By incentivizing physician groups through Value Partnership programs, Blue Cross has also been able to increase electronic prescribing of controlled substances more than 27 percent. Opioid prescriptions have gone down 32 percent and more than 608,000 fewer opioid pills have been dispensed through our Doctor Shopper initiative.

For more information, visit Blue Cross’ [opioids 101 online resource page at www.mibluesperspectives.com/opioids101](http://www.mibluesperspectives.com/opioids101). See what we’ve done, what we plan to do, and how you can help.

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Helping patients who don't want opioids for pain management



We understand that many people would prefer not to rely on opioids to manage their pain. Here are some non-opioid alternatives you may want to consider when treating patients with pain:

Comprehensive evaluations: Primary care providers can work in tandem with psychologists who have special training to provide comprehensive evaluations of a patient's pain. It's one of the best, most effective ways to determine a safe, long-term way to treat chronic pain.

Physical therapy and functional rehabilitation: In certain cases, physical therapy can be a great way of relieving pain over time through the natural strengthening of the body. Functional rehabilitation also has a psychological care component beneficial to all patients.

Other drug combinations: Ibuprofen and Tylenol taken together may be as effective as opioids, but with fewer side effects and a lower risk of addiction. Also, some conditions, such as fibromyalgia, may actually get worse with opioid use.

Injections: Where appropriate, you may want to prescribe injections of non-opioid drug combinations that are less addictive than opioids.

Lifestyle modifications: Weight loss, exercise, proper sleeping habits, a healthy diet and a number of other factors can all play into chronic pain. Helping patients manage these aspects of their lives can result in less pain and a healthier path going forward.

More research is needed for us to determine whether some alternative forms of pain treatment, such as massage therapy and acupuncture, can effectively treat pain. However, the options listed above are both comprehensive and effective. Blue Cross will continue to explore and evaluate the efficacy of alternative treatments for chronic pain going forward as part of our multi-pronged effort to help people struggling with pain.

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February focus is on heart health

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

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

Risk factors that can't be controlled

- Age (55 or older in men, 65 or older for women)
- Family history of early heart disease

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

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

Factors that determine LDL ("bad") cholesterol level

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

Some highlights from the MQIC guidelines are noted below. For the complete guidelines, visit **MQIC**.



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Lipid screening and management

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

Management of overweight and obesity in adults

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

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

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

Providers can also refer members to the **National Heart, Lung and Blood Institute** website for information about heart disease.

References:

[MQIC.org](http://www.mqic.org)[Lipid Screening and Management](#)[Management of overweight and obesity in adults](#)[National Heart Lung and Blood Institute \(http://www.nhlbi.nih.gov/\)](http://www.nhlbi.nih.gov/)<http://www.cdc.gov/bloodpressure/facts.htm>

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Blue Care Network supports Patient Safety Awareness Week

The National Patient Safety Foundation has designated March 10 through 16, 2019, as National Patient Safety Week. This is designed to increase awareness about patient safety among health professionals and their patients.

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

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

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

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

Learn more about patient communication

Listen to what patients say is important to them. See how doctors balance busy schedules and spend time with patients.

Watch our video at brainshark.com/bcbsm/patientcommunication.

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 profiling for cutaneous melanoma
- Lumbar traction devices for the treatment of low back pain
- Polymerase chain reaction testing in the diagnosis of onychomycosis

Covered services

- Bone marrow transplant — hematopoietic cell transplantation for acute myeloid leukemia
- Coronary computed tomography angiography with selective noninvasive fractional flow reserve (FFR_{CT})FR
- Intensity-modulated radiation therapy: Abdomen and pelvis
- Intensity-modulated radiation therapy of the breast and lung
- Intensity-modulated radiation therapy: Cancer of the head and neck or thyroid
- Intensity-modulated radiation therapy: Central nervous system tumors
- Intensity-modulated radiation therapy of the prostate
- Sleep disorders, diagnosis and medical management



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Blue Cross and BCN’s efforts to increase medication-assisted treatment

MI Blues Perspectives, one of our two Blue Cross blogs, recently posted an article about our efforts to increase medication-assisted treatment rates for opioid addiction. You can read it on our [blog](#).

Trump signs opioids law at White House event

President Donald Trump signed sweeping opioids legislation into law at the White House Oct. 24, [CNN](#) reported. The event marked a year since he declared the opioid crisis a national public health emergency. The bill signed includes provisions aimed at promoting research to find new drugs for pain management that will not be addictive and expands access to treatment for substance use disorders for Medicaid patients.

Drug overdose deaths falling nationwide

The estimated number of deaths from drug overdoses has fallen for each of the last seven months on record nationwide, giving reason for cautious optimism about the state of the country’s substance abuse epidemic, [Time magazine](#) reported Oct. 23. Fatal overdoses rates have risen sharply over the past several decades but preliminary data from the Centers for Disease Control and Prevention suggests a modest downturn.

Michigan opioid overdose deaths reach record high last year

The [Detroit Free Press](#) reported Oct. 4 that overdose deaths from opioids reached a record high in Michigan in 2017, according to a new report released by the Michigan Department of Health and Human Services. The report says that 1,941 of the last year’s 2,729 overdose deaths were opioid related, an increase of 9 percent from 2016. The number represents a slowing of the year-over-year increase in opioid-related deaths. Between 2015 and 2016, opioid overdose deaths jumped 35 percent.

Study: Nearly 30 percent of opioid prescriptions lack clear clinical explanation

A study published in the *Annals of Internal Medicine* found that 28.5 percent of opioid prescriptions written in the U.S. between 2006 and 2015 lacked a documented clinical reason, [USA Today](#) reported. The findings, based on analysis of data from the National Ambulatory Medical Care Survey, showed 66 percent of opioid prescriptions were for noncancer pain while 5 percent were intended to treat cancer-related pain.

GDAHC recognizes Michigan OPEN for health care leadership

The Greater Detroit Area Health Council recognized Michigan Opioid Prescribing and Engagement Network with the Eagle Award for Visionary Leadership. The award recognizes the contributions of an organization in southeast Michigan that has made steady progress in advancing health care quality, access or cost. Michigan OPEN, along with other leaders in health care, was honored Nov. 8 at the 2018 Salute to Healthcare celebration. For information about Michigan OPEN initiatives, visit [Michigan-open.org](#).



Blue Care Network removed deductibles for outpatient mental health services from certain plans

The U.S. Department of Labor clarified how cost-sharing requirements for mental health and substance use disorder benefits should be calculated under the Mental Health Parity and Addiction Act.

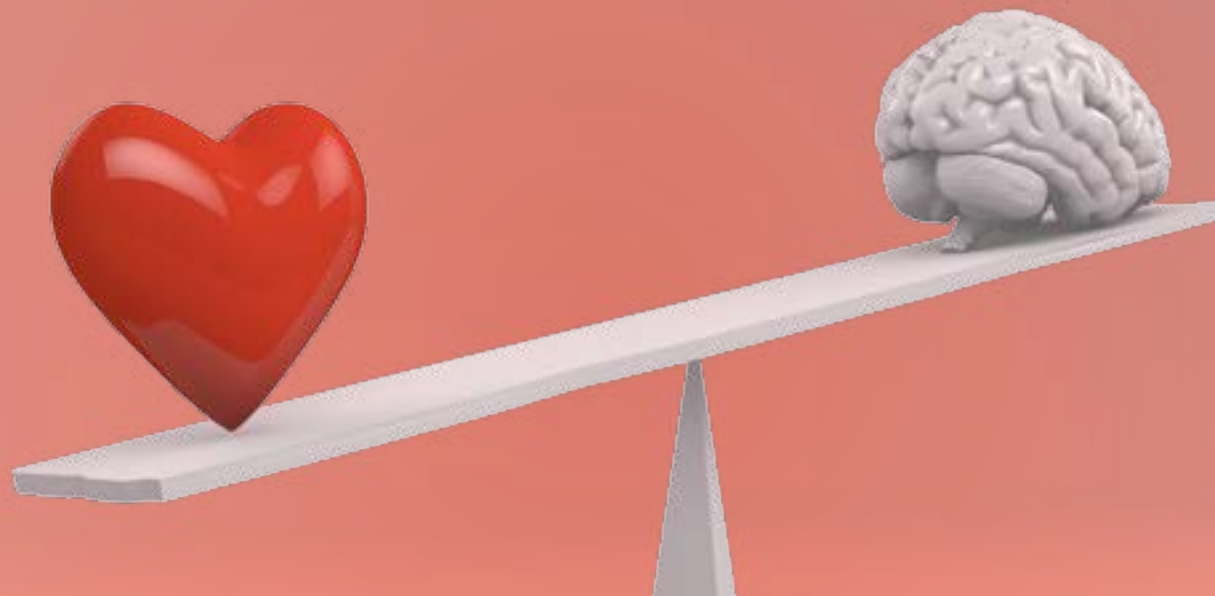
As a result, Blue Care Network analyzed the cost-sharing requirements on its plans based on the clarification. To ensure that we continue to comply with the Mental Health Parity and Addiction Act, effective Jan. 1, 2019, BCN removed the deductible for outpatient mental health and substance use disorder services from certain plans. A fixed copay may still apply depending on the group's benefit plan. The following plans are not affected:

- HSA qualified high deductible health plans
- Blue Elect Plus Self-Referral OptionSM plans
- Routine Care plans
- Plan with WDEDFC (waiver of deductible on services with a fixed dollar copay) and WDRPOV (waiver of deductible on specialist office visits) riders
- Plans that already remove the deductible for outpatient behavioral health services

The changes will automatically take effect on Jan. 1.

We're required to notify members who are affected, and we began mailing notifications in October.

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



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Blue Care Network to continue Behavioral Health Incentive Program in 2019

Our Behavioral Health Incentive Program offers six BCN-assessed measures with a few changes in 2019:

- The “follow-up after hospitalization” incentive will increase to \$200.
- We’ll add “initiation of alcohol and other drug abuse or dependence treatment” and incentivize this measure at \$100.
- We’ll discontinue the “pharmacotherapy adherence for bipolar disorder” measure.

The measures in the chart below 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.

Quality incentive measure	Payment	Intake period	Provider action
Follow-up after mental health hospitalization	\$200	1/1-10/31/2019	None – claims data
Anti-depressant medication management – Acute	\$75	1/1-4/30/2019	None – claims data
Anti-depressant medication management – Continuous	\$100	1/1-4/30/2019	None – claims data
Appropriate glucose monitoring	\$100	1/1-12/31/2019	None – claims data
First-line psychosocial care for children and adolescents on antipsychotics	\$100	1/1-12/31/2019	None – claims data
Initiation of alcohol and other drug abuse or dependence treatment	\$100	1/1-11/1/2019	None – claims data

The BHIP booklet and flyer will be available on web-DENIS starting in January.

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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BCN's Depression Management program offers resources for members

Blue Care Network's Depression Management program provides members diagnosed with depression with education and self management strategies to deal with this potentially disabling condition. The program was developed in conjunction with the Michigan Quality Improvement Consortium guideline for **Management of Adults with Major Depression**.

The goals of the program include:

- Educating members about the basic pathophysiology of depression and current treatment modalities with emphasis on acute and continuation phases of treatment
- Providing members with self management techniques with an emphasis on medication compliance
- Decreasing workplace absenteeism
- Decreasing inappropriate inpatient admissions and emergency room visits
- Addressing comorbid medical conditions
- Helping practitioners track and monitor services for members with depression

The Depression Management program is available to all BCN HMOSM (commercial) members 18 years and older and BCN AdvantageSM members. We identify members through:

- Claims for outpatient, inpatient and emergency room visits for depression
- Pharmacy claims for antidepressants
- Referrals from physicians
- Data collected from members' completed health assessments
- Referrals from BCN's utilization and case management departments
- Member self referral

Our predictive modeling refers members to this program when we see a diagnosis of depression combined with other risk factors. Risk factors can include socioeconomic risks, a co-occurring chronic disorder, a recent inpatient admission or high emergency department utilization. A behavioral health professional reaches out to members, explains the program and offers members support, education and resources. The behavioral health case manager assesses the member using a comprehensive assessment as well as evidence-based screening tools (PHQ9, GAD7, SOCRATES) and creates a plan of care. In the event of a hospitalization, the case manager makes sure that a follow up visit is scheduled within seven days of discharge and monitors for appointment compliance.

We provide education to the member that focuses on explaining the diagnosis and symptoms, ways to improve health through wellness activities, the importance of medication adherence and how to improve self-management of symptoms. We offer physicians support through patient-specific case management reports, clinical guidelines, articles and program assistance from a behavioral health chronic condition management specialist.

To learn more about BCN's depression management program or to refer a member, contact the Engagement Center at 1-800-775-2583 (TTY users call 711), from 8 a.m. to 5 p.m. Monday through Friday.

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Best Practices

Adolescent immunizations

An interview with Dr. Bethany Hall, Brighton

What do you do in your practice to encourage your adolescent patients to keep up with their immunizations?

We have a couple things in place that help us keep our immunization rates high. For every patient visit, we print out an MCIR. We try to catch adolescents when they come in for sick visits. Often, they're not too sick to get a vaccine while they're here.

We also review their records to see when they had a physical. If they haven't had one in the last year, we send out a letter. Or if they're in for a sick visit, my receptionist tries to schedule a physical while they're here.

We also have a 'gaps in care' registry. One of our nurses spends time reviewing registries for patients who haven't had a physical in the last year and she makes phone calls to schedule appointments.

We've been doing these things for several years and are always working to improve our immunization rates. Tracked over time, we have definitely seen improvements.

What are some of the challenges of keeping immunizations up to date for this population?

It's mostly getting them here. Most of these teens have had all their other immunizations when they were younger. It's more of a making sure we take the opportunity when they are here in the office. It's a team effort. We get our whole staff involved.

The biggest challenge is the HPV vaccine, specifically. My approach is to first learn from the parent what their



Dr. Bethany Hall with her medical assistant, Halie Johnson.

concerns are. I tell them the chances of getting cancer from HPV is much higher than getting meningitis and most parents consent to the Menactra vaccine.

Most parents are worried about a severe reaction to the vaccine. They can rationally know it's a good vaccine, but the fear of something horrible happening is strong. You can talk that through.

When the child is due at 11 years, some parents say, "I don't want him or her to have it yet." So you need to listen to the parent and hear their concerns.

I have four children of my own and they've all had the vaccine. Sometimes it's helpful for parents to hear from a provider that they are recommending the very vaccines they give to their own children. I've personally never have had a patient who's had a severe reaction. So my own personal experiences are important and helpful in advising parents.

Is there anything you'd like to add?

Immunizations are so important, and we continue to educate parents and hear their concerns. The best way to immunize adolescents is to get them in the door. You have to keep focused and commit to addressing vaccines at every visit.

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Help patients get annual health screenings

As the new year approaches, Blue Care Network is preparing for annual HEDIS® record reviews. BCN team members will be contacting provider offices from January to May to request medical records. As always, we appreciate your cooperation and partnership in making HEDIS 2019 a success.

As part of our joint effort in making this happen, here’s a checklist to help patients take care of their health.

- ✓ Get an early start with patients in 2019. Take a BMI on every patient. Note that all patients under 20 years old need a BMI percentage, height and weight measure.
- ✓ For children ages 3 to 17, complete counseling for nutrition. Complete checklist verifying nutrition discussion and counseling for physical activity. Recommend patients exercise one hour per day; complete checklist verifying discussion of physical activity.
- ✓ For diabetics complete the following: HbA1c, nephropathy monitoring (urine for protein or on ACE/ARB medications, or renal diagnosis), controlled blood pressure (<139/89), diabetic eye exam. Schedule follow-up visits as results indicate.
- ✓ For patients with hypertension, follow-up on medication regimen; document lifestyle changes and blood pressure to ensure appropriate management. A controlled blood pressure is 139/89 or less.
- ✓ For members discharged from an inpatient setting, complete a medication reconciliation within 30 days of discharge.
- ✓ Review history and order colon cancer screening test, if needed (age 50 to 75, colonoscopy every 10 years). For patients that refuse a colonoscopy, suggest they complete a FOBT.
- ✓ For all females between age 50 and 74, order a mammogram (if they haven’t had one for 24 months) and cervical cancer screening age 21 to 64 (if they haven’t had one in three years or five years.) Patients must be 30 years old on the date of service of the PAP/HPV to meet the five-year interval requirement and the HPV must be a co-test.
- ✓ Talk to every patient about the need for physical exercise – 30 minutes a day.
- ✓ For seniors assess the following: fall risk, safe environment, incontinence management, immunizations.
- ✓ Schedule a depression assessment.
- ✓ Childhood and adolescents immunizations: Check immunization record on MCIR and schedule visits to have complete and timely immunizations.

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

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

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Watch for fraudulent prescription and durable medical equipment schemes

Blue Cross Blue Shield of Michigan and Blue Care Network want to make you aware of the escalating prescription schemes that solicit authorization from prescribers for medications that may not be medically necessary for patients. We've received complaints from members who have received unwanted medication and supplies.

Some telemarketing companies solicit insurance information and primary care physicians' contact information from patients through phone calls, emails, social media and online or mail surveys. These companies will then fax prescriptions to the prescriber's office to obtain his or her authorization. Other times, pharmacies may call requesting authorization from the prescriber to change a medication to a different formulation (for example, ER/CR vs. IR). Once the faxed authorization is received, the member begins receiving mailed deliveries of medications or durable medical equipment supplies. Typically, the members' efforts to contact the pharmacy or DME company to end the shipments aren't successful.



How to avoid the faxed prescription scheme

Blue Cross urges you to be vigilant about prescriptions received through fax from pharmacies indicating that the patient has requested the medication or needs an authorization for refill. Pay attention to fax or phone requests for the following types of prescriptions:

- Topical applications (lidocaine, doxepin, fluocinonide, calcipotriene, diclofenac, triamcinolone)
- Acid reflux or GERD medication (omeprazole-sodium bicarbonate)
- Diabetic supplies, blood glucose meters, alcohol pads, test strips, lancet devices, control solutions and lancets
- Nasal sprays (dihydroergotamine)
- Non-steroidal anti-inflammatory drugs (naproxen CR/ER, mefenamic acid, fenoprofen calcium)

Red flags

- The faxed prescription may already be completed or offer check boxes for the prescriber to fill out.
- Prescriptions will often request three to five medications, sometimes labeled as a "kit."
- Beware of requesting pharmacies/DME suppliers that are located out of state. Many times, the prescription will be associated with a pharmacy/DME supplier you and your patient have not had any previous interaction with.
- The prescription will usually request high quantities of medications. Requests for topical applications usually range between 180 to 1,000 grams. Requests for oral dosage forms will typically be enough for a 90-day supply.

Targeted medications frequently change. Carefully review any prescription that your office did not initiate. If you aren't sure that the patient requested the medication, please do not approve the request. And be especially cautious about requests for topical applications and low/moderate intensity pain relievers.

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We've added drugs to the medical benefit specialty drug prior authorization program

Blue Care Network and Blue Cross Blue Shield of Michigan have added Onpattro, Poteligeo, and Signifor LAR to our medical benefit specialty drug prior authorization program for commercial members.

The prior authorization program for specialty drugs covered under the medical benefit is expanding for BCN HMOSM and Blue Cross' PPO commercial members as follows:

Brand name HCPCS code	Prior authorization requirements for all dates of service on or after:
Onpattro TM J3490	HMO — Nov. 1, 2018 PPO — Dec. 1, 2018
Poteligeo [®] J9999	HMO — Nov. 1, 2018 (only for members starting treatment on or after that date) PPO — None required
Signifor LAR [®] J2502	HMO — Feb. 1, 2019 PPO — Already required

These changes don't apply to BCN AdvantageSM, Medicare Plus BlueSM PPO or Federal Employee Program[®] members.

[How to submit authorization requests](#)

Submit authorization requests prior to the start of services for medical benefit drugs that require authorization using the NovoLogix[®] web tool within Provider Secured Services.

[Always verify benefits](#)

Approval of a prior authorization request isn't a guarantee of payment. You need to verify each member's eligibility and benefits. Members are responsible for the full cost of medications not covered under their medical benefit coverage.

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We're excluding some Custom Select drugs effective Jan. 1, 2019

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

Because there are safe, effective and less-costly alternatives available, we'll no longer cover some brand-name and generic drugs on the *Custom Select Drug List* starting Jan. 1, 2019.

A member whose prescription drug plan uses the *Custom Select Drug List* will be responsible for the full cost if he or she fills a prescription for one of these drugs on or after this date.

For a complete list of covered drugs go to bcbsm.com/pharmacy and click *Drug lists*.

Common use	Drugs to be excluded January 1, 2019	Average cost per unit or package	Covered generic alternatives	Average cost per unit or package
Allergies	Xyzal®	\$1	These drugs are available over the counter without a prescription.	
	Zyrtec® solution	\$3		
Diabetes	Actoplus Met® XR	\$13 - \$25	Actoplus Met®	\$2
	Fortamet®	\$6 - \$11	Glucophage®, Glucophage® XR	<\$1
Heart conditions	Lanoxin® 62.5 and 187.5mcg	\$15	Lanoxin® 125 mcg, 250 mcg	<\$1
HIV	Crixivan®	\$3	Go to bcbsm.com/pharmacy and click <i>Drug lists</i> for a complete list of covered alternatives. Members should discuss their treatment options with their doctor.	
	Rescriptor®	\$3		
	Trizivir®	\$20		
	Videx®	\$27		
	Videx® EC	\$9		
	Viracept®	\$5 - \$12		
Migraines	Migranal® nasal spray	\$551	Cafergot®	\$15
			D.H.E. 45®	\$179
			Generic triptans (such as Imitrex®, Maxalt®, Zomig®)	\$10 – \$20
Mood disorders	Aplenzin®	\$52 - \$156	Wellbutrin®, Wellbutrin® SR, Wellbutrin® XL	<\$1

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Custom Select drugs, continued from Page 26

Common use	Drugs to be excluded January 1, 2019	Average cost per unit or package	Covered generic alternatives	Average cost per unit or package
Muscle relaxants	Lorzone®	\$9 - \$10	Flexeril®	<\$1
			Norflex®	
			Parafon Forte DSC® 500 mg	
			Robaxin®	
			Zanaflex®	
Overactive bladder	Toviaz®	\$13	Detrol®, Detrol® LA	\$2 - \$5
			Ditropan®, Ditropan® XL	
			Sanctura®, Sanctura® XR	
Skin conditions	Bactroban® cream	\$222	Bactroban® ointment	\$6
	Denavir®	\$975	gentamicin cream, ointment	\$50
			Zovirax® ointment	\$297
	Desonate®	\$660	Dermacort®, Hytone® 2.5%	\$7 - \$150
			Desowen®	
			Kenalog® 0.025% cream, lotion	
			Valisone® lotion	
	Florone®, Psorcon®	\$210 - \$932	Aristocort®, Kenalog® 0.5%	\$5 - \$80
			Diprolene® cream, lotion	
			Diprosone® cream, ointment	
			Elocon® ointment	
			Valisone® ointment	
	Pandel®	\$1287	Diprosone® lotion	\$8 - \$100
			Elocon® cream, lotion, solution	
Kenalog® ointment, spray				
Synalar® ointment				
Westcort® ointment				
Zyclara®	\$1485	Aldara®	\$165	
		Efudex®	\$165	

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We'll require a prior authorization for opioid dosages over 90 morphine milligram equivalents per day effective in February

Blue Cross Blue Shield of Michigan and Blue Care Network remain committed to battling our country's opioid crisis through various programs and initiatives. Starting Feb. 1, 2019, Blue Cross and Blue Care Network will require prior authorization the first time a member's opioid dosage exceeds 90 morphine milligram equivalents per day. This change affects commercial members only and doesn't apply to members with an oncology diagnosis or terminal illness, or who are on Medicare.

We'll continue to ensure that our members receive high-quality care for pain, while reducing potential risks that come from such treatments.

Higher opioid dosages have not been shown to reduce long-term pain and are associated with a higher risk of overdose and death. Dosages at or above 100 morphine milligram equivalents per day are associated with a nearly nine-fold increase in overdose risk compared to dosages of 20 morphine milligram equivalents per day or less.

To help reduce the risk of overdose, we encourage providers to review their patients' total daily dose of opioids. This helps to identify patients who may benefit from closer monitoring, reduction or tapering of opioids, a naloxone prescription or other measures.

Here are some free resources available from the Centers for Medicare and Medicaid Services and the Centers for Disease Control and Prevention.

- The **CMS morphine equivalent chart** is available at the CMS website.
- The CDC's new **Opioid Guideline app** includes its Guideline for Prescribing Opioids for Chronic Pain, tools and other resources, including a morphine milligram equivalent calculator.

The following are opioids commonly prescribed at 90 morphine milligram equivalents per day:

- 90 mg of hydrocodone
(Nine tablets of hydrocodone/acetaminophen 10/325 mg)
- 60 mg of oxycodone
(Two tablets of oxycodone extended-release 30 mg)



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Several drugs will have a higher copayment, effective Jan. 1

We're making tier changes to several drugs with lower-cost alternatives to help control costs for Blue Cross Blue Shield of Michigan and Blue Care Network commercial prescription drug plans.

On Jan. 1, indomethacin (Indocin[®]) suppository will become Tier 3 with a nonpreferred brand copayment.

On Jan. 1, the following drugs will become Tier 1B (for BCN members only) with a nonpreferred generic copayment:

- Prednisolone (Millipred[®]) tablet
- Candesartan (Atacand[®])
- Candesartan/HCTZ (Atacand[®] HCT)
- Venlafaxine (Effexor[®]) tablet
- Desipramine (Norpramin[®])
- Naproxen (Naprosyn[®]) suspension

Please see [Higher copay drugs](#) , continued on Page 30

AllianceRx Walgreens Prime specialty pharmacy program starts Jan. 1

We ran an **article** in the November-December 2018 issue announcing that AllianceRx Walgreens Prime is now the exclusive provider of specialty pharmacy services for drugs under the pharmacy benefit. We want to clarify that this is true only for some Blue Cross Blue Shield of Michigan and Blue Care Network **commercial** members and it applies to drugs filled under pharmacy benefits. It does not apply to Medicare Advantage members.

To reiterate, you'll need to write a new prescription for the affected patients **before Jan. 1, 2019**.

For a current list of specialty drugs in this program, go to bcsbm.com/pharmacy and click on *What are specialty drugs*, then *Specialty Drug Program Rx Benefit Member Guide*. This list is updated monthly.

For more information, visit alliancerxwp.com/hcp.



Higher copay drugs, continued from Page 29

The following table includes the drugs that will have a higher copayment along with available generic lower-cost alternatives in the same drug class. Brand names are listed in parentheses for reference. Instead of using a higher-cost drug, members can save money by switching to one of these lower-cost alternatives.

Common uses	Higher-cost drug	Generic lower-cost alternatives in the same drug class
Allergic and inflammatory conditions	Prednisolone (Millipred) <i>tablet</i>	<ul style="list-style-type: none"> dexamethasone methylprednisolone prednisolone (Millipred, Pediapred) <i>solution</i> prednisone
High blood pressure, heart conditions	Candesartan (Atacand)	<ul style="list-style-type: none"> irbesartan (Avapro) losartan (Cozaar) telmisartan (Micardis) valsartan (Diovan)
	Candesartan/HCTZ (Atacand HCT)	<ul style="list-style-type: none"> losartan/HCTZ (Hyzaar) irbesartan/HCTZ (Avalide) telmisartan/HCTZ (Micardis HCT) valsartan/HCTZ (Diovan HCT)
Mood disorders, neuropathic pain	Venlafaxine (Effexor) <i>tablet</i>	<ul style="list-style-type: none"> venlafaxine (Effexor) <i>capsule</i> desvenlafaxine (Pristiq) duloxetine (Cymbalta)
	Desipramine (Norpramin)	<ul style="list-style-type: none"> amitriptyline (Elavil) imipramine (Tofranil) nortriptyline (Pamelor)
Pain	Indomethacin (Indocin) <i>suppository</i>	<ul style="list-style-type: none"> indomethacin (Indocin) <i>capsule</i> diclofenac (Voltaren) immediate-release <i>tablet</i> ibuprofen (Motrin) meloxicam (Mobic) naproxen (Anaprox, Naprosyn) <i>tablet or capsule</i>
	Naproxen (Naprosyn) <i>suspension</i>	<ul style="list-style-type: none"> diclofenac (Voltaren) immediate-release <i>tablet</i> ibuprofen (Motrin) meloxicam (Mobic) naproxen (Anaprox, Naprosyn) <i>tablet or capsule</i>



Information about administering the Shingrix shingles vaccine

Blue Cross Blue Shield of Michigan and Blue Care Network cover Shingrix® with no cost share for most commercial (non-Medicare) members age 50 and older. Shingrix prevents shingles and its complications and is administered as two injections. The second injection should be administered at least 60 days up to six months after the first injection.

The Centers for Disease Control and Prevention released a monitoring report in May 2018 that indicated that providers may be confusing Shingrix with Zostavax®. From October 2017 to February 2018, the Vaccine Adverse Events Reporting System received 155 reports regarding Shingrix. Of these, 13, or 8 percent, were attributed to administration error. These errors include:

- Subcutaneous administration rather than intramuscular administration
- Inappropriate age

- Wrong vaccine information statement
- No instructions to return for the second dose
- Administering the wrong vaccine
- Administering without reconstitution of the vaccine

The CDC recommends that healthy adults age 50 and older get Shingrix even if in the past they:

- Had shingles
- Received Zostavax
- Are not sure if they had chickenpox

Blue Cross and BCN also cover the shingles vaccine Zostavax with no cost sharing for most commercial (non-Medicare) members age 60 and older. Shingrix should not be administered less than two months after Zostavax was administered.

Shingrix versus Zostavax

	Shingrix®	Zostavax®
Manufacturer	GSK	Merck
Type	Recombinant adjuvanted	Live-attenuated virus
Storage	Refrigerator (do <i>NOT</i> freeze)	Freezer
Dosage	0.5 mL IM x 2 doses (2-6 months apart)	0.65 mL SC x 1 dose
Supply and administration	<p>Two components:</p> <ul style="list-style-type: none"> • Vial one: Single-dose vial of adjuvant suspension component (blue-green cap) • Vial two: Single-dose vial of lyophilized gE antigen component (brown cap) <p>Contents in vial one (adjuvant) should be withdrawn and transferred in entirety to vial two (antigen).</p> <p>Gently shake until powder is completely dissolved. Withdraw 0.5 mL from vial two and administer intramuscularly.</p>	Single-dose vial of lyophilized vaccine and a vial of sterile water diluent
ACIP recommendation	Immunocompetent adults aged ≥50 years, including those who previously received Zostavax. Shingrix is preferred over Zostavax.	Immunocompetent adults aged ≥60 years

Read the [CDC report](#) on its website.

Refer to [Shingrix prescribing information](#) for more details.

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We're changing coverage for some vitamin supplements, effective Jan. 1

Blue Cross Blue Shield of Michigan and Blue Care Network will no longer cover certain vitamins or nutritional supplements starting Jan. 1, 2019. The vitamins and nutritional supplements listed below will no longer be covered because these products are not approved by the U.S. Food and Drug Administration.

Many of these vitamins and nutritional supplements have over-the-counter alternatives that are available without a prescription.

A
ACTIVE FE
ANIMI-3
AV-PHOS 250 NEUTRAL
B
BIFERA RX
C
CALCIUM-FOLIC ACID PLUS D
CENTRATEX
CORVITA
CORVITE FE
D
DIALYVITE
DIALYVITE 3000
DIALYVITE 5000
DIALYVITE SUPREME D
E
ESCAVITE
ESCAVITE D
ESCAVITE LQ
F
FEROCON
FERRALET 90
FERRAPLUS 90
FERREX 150 FORTE
FERREX 28
FERROCITE PLUS
FLUORABON
FOLBEE
FOCALGIN DSS
FOLGARD OS
FOLGARD RX
FOLIC ACID-CYANCOBAL-PYRIDOXIN
FOLIVANE-F
FOLIVANE-PLUS
FOLPLEX 2.2
FOLTRATE
FORTAVIT
FUSION PLUS

H
HEMATINIC PLUS
HEMATINIC WITH FOLIC ACID
HEMATOGEN
HEMATOGEN FORTE
HEMATRON-AF
HEMAX
HEMETAB
HEMOCYTE PLUS
HEMOCYTE-F
I
INTEGRA F
INTEGRA PLUS
IROSPAN
K
K-PHOS NEUTRAL
M
MAGNEBIND 400 RX
MULTIGEN FOLIC
MULTIGEN PLUS
MULTIVITAMINES-A,B,C,D,E
MULTIVITAMIN W/FLUORIDE & IRON
MULTIVITAMIN WITH FLUORIDE
MVC-FLUORIDE
MYNEPHROCAPS
MYNEPHRON
N
NEPHPLEX RX
NEPHROCAPS
NEPHROCAPS QT
NEPHRON FA
NEPHRO-VITE RX
NIVA-PLUS
P
PHOSPHA 250 NEUTRAL
PHOSPHOROUS
POLY-IRON 150 FORTE
POLY-VI-FLOR
POLY-VI-FLOR W/IRON

POLY-VITAMIN WITH FLUORIDE
PUREVIT DUALFE PLUS
R
RENAL CAPS
RENA-VITE RX
RENO CAPS
S
SE-TAN PLUS
STROVITE FORTE
STROVITE ONE
T
TANDEM PLUS
TARON FORTE
THRIVITE-19
TL GARD RX
TL-HEM 150
TL ICON
TRICON
TRIGELS-F FORTE
TRIPHROCAPS
TRI-VITAMIN WITH FLUORIDE
V
V-C FORTE
VI-C FORTE
VIRT-GARD
VOL-CARE RX
VOL-NATE
VOL-TAB RX
VIRT-PHOS 250 NEUTRAL
VIRT-VITE
VIRT-VITE PLUS
VIT 3
VITAFOL
VITAL-D RX
VITAMINS A,C,D & FLUORIDE
VOL-PLUS
VP-VITE RX

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Medical Drug Prior Authorization and Site of Care programs expanded

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

Starting on the dates below, Tegsedi™ has been added to the Medical Drug Prior Authorization program for BCN HMOSM and Blue Cross PPO (commercial) lines of business. Tegsedi has also been added to the Site of Care program for BCN HMO (commercial) members, effective Dec. 1, 2018.

Drug Name	HCPCS code	Prior Authorization Program		Site of Care Program	
		PPO	HMO	PPO	HMO
Tegsedi™ (inotersen)	J3490	2/1/2019	12/1/2018	N/A	12/1/2018

Members currently on Tegsedi need a prior authorization for dates of service on or after the dates indicated in the table above.

Providers must submit an authorization request through the NovoLogix electronic system to demonstrate medical necessity. Authorization requests for these drugs should be submitted prior to the start of services. A prior authorization approval isn't a guarantee of payment. Health care practitioners must verify eligibility and benefits for members. Members are responsible for the full cost of medications not covered under their medical benefit coverage.

These new authorization requirements **do not** apply to BCN AdvantageSM, Medicare Plus BlueSM PPO or Federal Employee Program[®] members.

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

To access the list, follow these steps:

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

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

BCN

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

Blue Cross

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

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Clinical editing updates will be in place by January

We've published several articles about the updates we're making to our clinical editing system. A major upgrade, from ClaimCheck to ClaimsXten, should be in place by the beginning of January.

As we noted in the last issue, our edits are based on national coding standards, including AMA CPT and CMS/Medicare guidelines, as well as our health plan policies, such as our medical policies. Codes change, and coding guidelines are updated, which necessitate our ongoing review.

Our primary focus with clinical editing is correct coding. We want to make sure that we reimburse our providers correctly. Ideally, as we make our systems more efficient and keep our guidelines current, you should see an increased number of claims process accurately and more timely on an initial submission.

Some things to look for

New explanation (EX) codes.

You should always look and review the EX code on the claim. As we move forward you'll see multiple new codes due to our system upgrade with enhancements planned in the first quarter.

- Many of 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 is important to review the wording to identify those that are related to clinical edits. You may be already seeing some of these new EX codes. An example is f53, an EX code related to multiple procedure reduction for endoscopy.
- 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; it's an EX code related to an age edit.

The clinical editing form is being updated.

It's important to make sure that you use the most current form. There is now **one form** for BCN HMOSM, Blue Cross PPO and Blue Cross Medicare Advantage PPO clinical editing appeals.

To access the current form:

1. Visit bcbsm.com/providers.
2. Log in to Provider Secured Services.
3. Click *BCN Provider Publications and Resources*.
4. Click *Billing/Claims* in the left navigation.
5. Click *Clinical Editing Appeal form* under Clinical Editing Resources.

Please remember to complete the required fields on the appeal form, including marking that you are appealing an HMO clinical editing appeal.

There are no changes to the clinical editing appeal process.

Some key points about the clinical editing appeal process:

- Submit your appeal within 180 days of the original clinical editing denial.
- 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.
- Remember that there is only one level of appeal, so it's important to ensure that the appeal is complete and submitted on time.

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Clinical editing updates, *continued from Page 34*

Additional information

For additional information on clinical editing and the appeals process, log in to Provider Secured Services and go to BCN Provider Publications and Resources.

From the Billing/Claims link, you can access:

- The Claims chapter of the *BCN Provider Manual*, which contains a section on clinical editing.
- Links to clinical editing resources, including:
 - Information on appropriate modifier usage
 - Information on EX codes
 - An appeal quick guide
 - Links to previous clinical editing articles

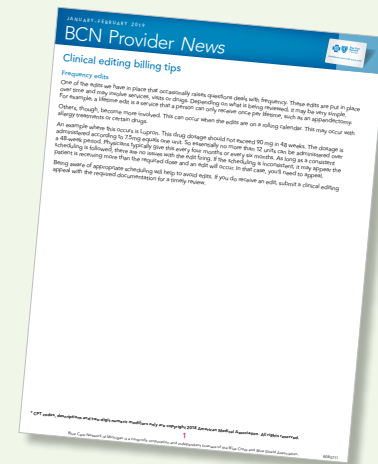
Clinical editing billing tips

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:

- Frequency edits

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



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Question:

For the new e-referral for continued stay reviews, does this include newborn and NICU babies as well? Currently, we fax inpatient clinical reviews for these patients. Are we to start only using the e-referral portal as well?

Answer:

The requests listed below must be submitted by fax:

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

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

Question:

We are a gastroenterology group and we struggle with claims on patients that have not been admitted but are in observation. We're not the attending physician, so we don't bill observation CPT codes. We bill with the appropriate "outpatient" evaluation and management service CPTs and occasionally the patient will need a gastroscopy, colonoscopy or ERCP.

What are the "rules" for other providers involved with the patient in observation? We've received rejections from BCN requiring an authorization for our service.

Answer:

From what you say, it doesn't sound like you are doing anything incorrectly. As you are not the attending, you are not supposed to report the observation E/M codes but rather the standard E/M codes representing the level of care provided with location 22. It appears the facility hasn't reported the observation service at the time your claim has been submitted, so at that point it appears to be a routine outpatient visit.

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.



*CPT codes, descriptions and two-digit modifiers only are copyright 2018 American Medical Association. All rights reserved.

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2019 changes to applied behavior analysis codes for autism

As we recently announced on web-DENIS, there are some coding changes beginning January 1 for applied behavior analysis services for autism.

These changes don't impact Blue Care Network because you shouldn't be using those T codes right now.

If you bill T codes for applied behavior analysis to Blue Cross' PPO, please look in the January 2019 issue of *The Record* for more information.

BCN's ABA providers should continue to request authorizations and submit claims as they do today.

*CPT codes, descriptions and two-digit modifiers only are copyright 2018 American Medical Association. All rights reserved.



Some reminders about Healthy *Blue* Living physical exams and qualification forms

Healthy *Blue* Living HMOSM members are required to visit their primary care physician for an exam within 90 days of enrollment or renewal.

As a reminder, providers should use the appropriate ICD diagnosis as the primary diagnosis when billing for the initial or subsequent examination and for the initial assessment for members participating in the Wellness Rewards Tracking program.

For more information about billing for Healthy *Blue* Living physical exams and qualification forms, see **Page 1**.

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Updated authorization criteria and e-referral questionnaires

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

- Cervical spine surgery with artificial disc replacement
- Cholecystectomy (laparoscopic) for adults
- Deep brain stimulation
- Endometrial ablation
- Endoscopy, upper gastrointestinal for gastroesophageal reflux disease
- Hip replacement surgery procedure, initial
- Hyperbaric oxygen therapy, outpatient
- Knee replacement surgery, nonunicondylar, initial
- Knee replacement surgery, unicondylar, initial
- Lumbar spine surgery for adults
- Shoulder joint replacement surgery
- Transcatheter arterial chemoembolization of hepatic tumors (TACE)
- Varicose vein treatment

The updated questionnaires are in the e-referral system. We use these criteria and questionnaires when making utilization management determinations for the following members:

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

Note: The criteria and questionnaires for cholecystectomy (laparoscopic), endoscopy (upper gastrointestinal for gastroesophageal reflux disease), hyperbaric oxygen therapy, lumbar spine surgery, endometrial ablation, varicose vein treatment and cervical spine surgery with artificial disc replacement apply to BCN HMO and BCN Advantage members only.

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

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

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

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Complete the provider specialty questionnaire in the e-referral system

We've added a questionnaire to the e-referral system that asks you to select the specialty of the provider you're referring a member to. That's the only question you'll need to answer.

You'll see this provider specialty questionnaire only when you're submitting a global referral to a multispecialty group. As a reminder, only BCN HMOSM (commercial) members require a global referral.

If you're making a global referral to a multispecialty group, you'll see a prompt asking you to complete the provider specialty questionnaire. Here's what to do:

1. Click the link to open the questionnaire.
2. Select the specialty of the provider you're referring to from the drop-down menu.
3. Click *Next* to continue submitting your global referral.

Completing the questionnaire will help your referral get to the right provider in the multispecialty group.

The provider specialty questionnaire began opening in the e-referral system on Oct. 28, 2018.

We're updating the **e-referral User Guide** with information on the provider specialty questionnaire.

Care management survey winners

Two doctors have won \$250 gift cards for participating in the 2017 BCN Utilization Management **survey**.

Congratulations to Jacob Kalo, M.D., St. John Physician Hospital Organization, in Warren and James R. Lum, D.O., Genesys Physician Hospital Organization, Burton.

Providers and referral coordinators have until Dec. 31, 2018 to respond to our survey. We use your comments to make improvements to our utilization management processes.

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

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

For more information, see the article in the **November-December 2018** issue, Page 48.

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eviCore to manage two radiopharmaceutical drugs, starting Feb. 1

For dates of services on or after Feb. 1, 2019, the following radiopharmaceutical drugs require authorization through eviCore healthcare:

- Lutathera® (lutetium Lu 177 dotatate, HCPCS code A9513)
- Xofigo® (radium Ra 223 dichloride, HCPCS code A9606)

This applies to members covered by:

- Blue Cross' PPO (commercial) and Blue Cross Medicare Plus BlueSM PPO
Note: eviCore already manages procedures associated with code A9606 for Blue Cross PPO and Medicare Plus Blue members. eviCore will begin managing procedures associated with code C9031 on Feb. 1.
- BCN HMOSM (commercial) and BCN AdvantageSM

Note: Lutathera was previously managed for BCN HMO members under the prior authorization program for drugs covered under the medical benefit. eviCore already manages procedures associated with code C9031 for BCN Advantage members. For BCN HMO members, C codes aren't payable. However, services associated with the administration of an approved treatment plan with Lutathera are payable for BCN HMO members. eviCore will begin managing procedures associated with code A9606 for both BCN HMO and BCN Advantage on Feb. 1.

Submit authorization requests to eviCore online at evicore.com or by telephone at 1-855-774-1317.

We'll update the **Procedures that require authorization by eviCore healthcare** document prior to the effective date of the change.

Note: These changes do not apply to MESSA members.

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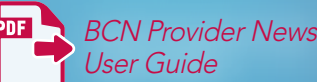
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Depression screening and treatment are important steps to wellness

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.

Editor

Cindy Palese
bcnprovidernews@bcbsm.com

Provider Communications

Catherine Vera-Burgos, Manager
Elizabeth Donoghue Colvin
Jennifer Fry
Tracy Petipren

**Market Communications
Publications**

Cathy Rauckis

Contributors

William Beecroft, M.D.; Terri Brady; Camillya Christian-Smith; Laura Cornish; Pharm. D; Amy Frady;
Jody Gembariski; Duane DiFranco, M.D.; Sonja Rashed; Kelly Redmond-Anderson

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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:

<p>Access to primary care</p>	<ul style="list-style-type: none"> • Regular and routine care – 30 business days • Urgent care – 48 hours • After-hours care – 24/7
<p>Access to behavioral health care</p>	<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
<p>Access to specialty care</p>	<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

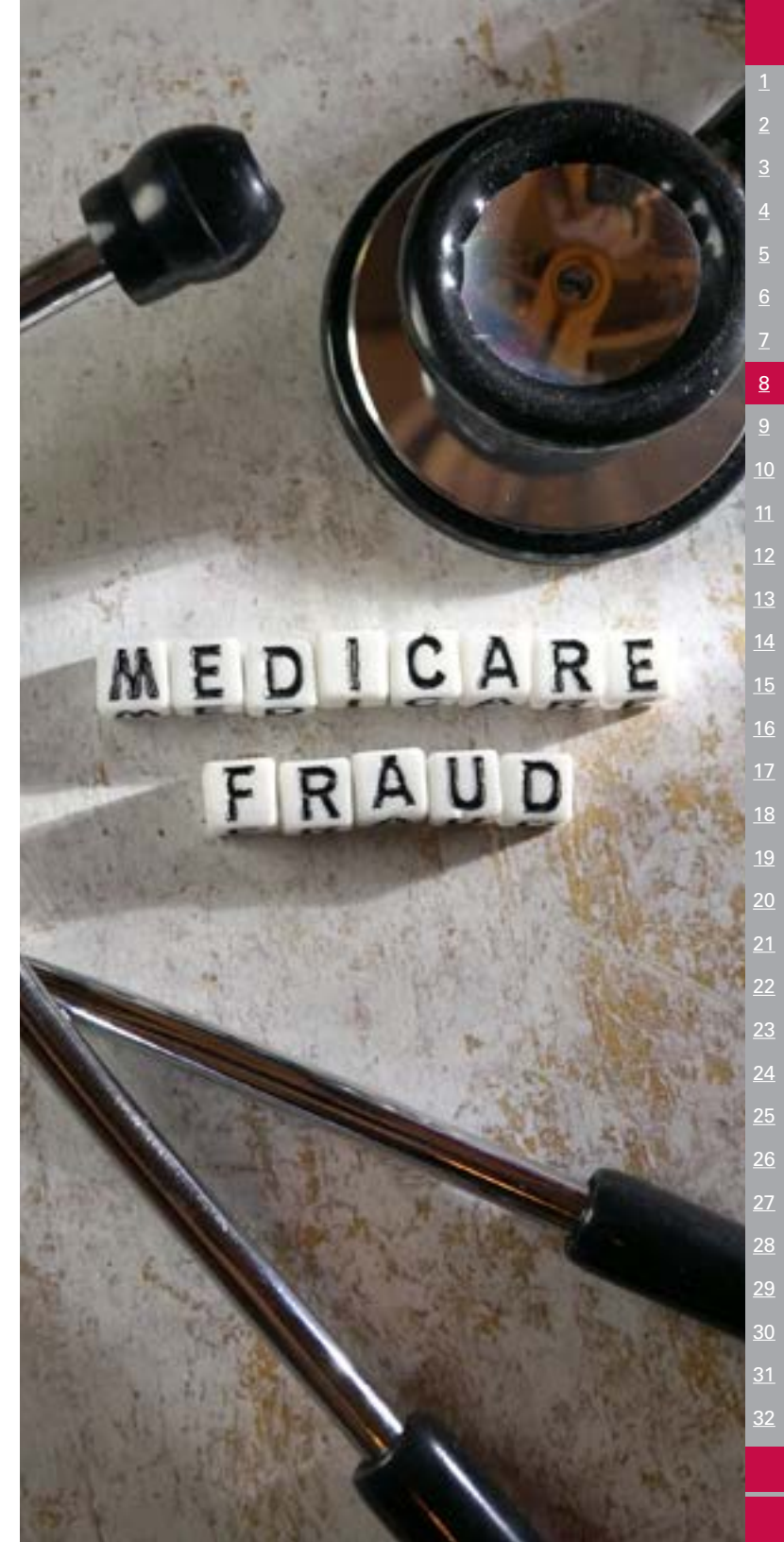
Fraud is intentional deceit or misrepresentation of the truth that results in some extra cost to the health care system. Fraud schemes range from those committed by individuals acting alone to broad-based activities by institutions or groups of individuals. Seldom do these schemes target only one insurer 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.

Please see [Fraud, waste and abuse](#), continued on Page 9



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[Feedback](#)Fraud, waste and abuse, *continued from Page 8*

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.

Please see [Diabetes](#), continued on Page 11





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 URMBT 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.

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



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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](#).

Please see [Opioid epidemic](#), continued on Page 13

**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

*Medical Policy Updates*



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

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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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.

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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

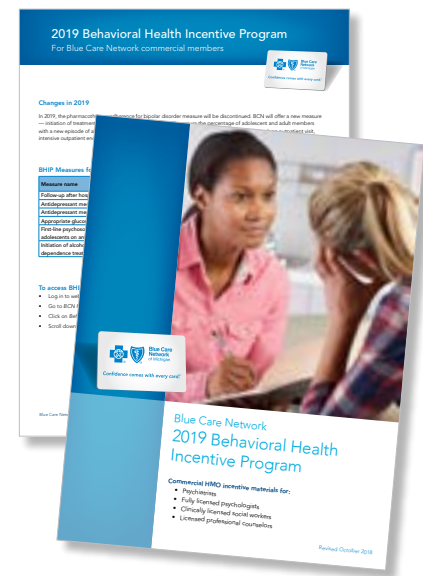
Our Behavioral Health Incentive Program for 2019 offers six BCN-assessed measures.

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**.

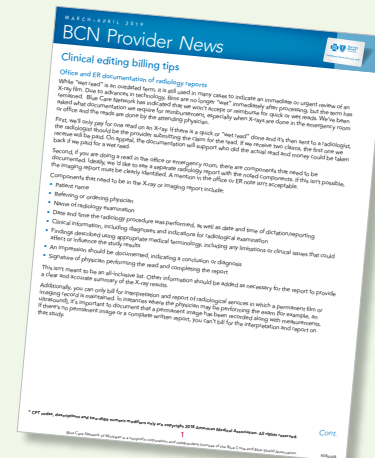
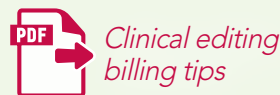
Clinical editing billing tips

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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Dr. Thomas Selznick
with patient,
Tonya Lara Keller

photo by Deepa Elangainathan

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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.

Please see [Best Practices](#), continued on Page 24

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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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.

Editor

Cindy Palese
bcnprovidernews@bcbsm.com

Provider Communications

Catherine Vera-Burgos, Manager
 Elizabeth Donoghue Colvin
 Jennifer Fry
 Tracy Petipren

Market Communications Publications

Cathy Rauckis

Contributors

William Beecroft, M.D.; Terri Brady; Camillya Christian-Smith; Laura Cornish; Pharm. D; Amy Frady; Jody Gembariski; Duane DiFranco, M.D.; Sonja Rashed; Kelly Redmond-Anderson

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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*.



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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.



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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.

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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 HMOSM (commercial) and BCN AdvantageSM members.

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

Acute initial inpatient admissions

Submit these authorization requests through the e referral system, which is available 24 hours a day, seven days a week. 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
- Handling expedited appeals of utilization management decisions

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

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

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

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Medicare Advantage post-acute care training dates set

Authorizations for Medicare Plus BlueSM PPO and BCN AdvantageSM 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.

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Training, continued from Page 6

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

Acute care hospitals	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Monday, May 13, 2 to 4 p.m.
Grand Rapids	<ul style="list-style-type: none"> • Tuesday, May 14, 9 to 11 a.m. • Tuesday, May 14, 1 to 3 p.m.
Saginaw	<ul style="list-style-type: none"> • Wednesday, May 15, 9 to 11 a.m. • Wednesday, May 15, 1 to 3 p.m.
Southfield	<ul style="list-style-type: none"> • Thursday, May 16, 9 to 11 a.m. • Friday, May 17, 9 to 11 a.m.



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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](#).

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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 suggest 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.

Patient
CareMotivational Interviewing – A technique
to facilitate behavior changeBy *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 setbacks. Discuss the importance of support systems.

Please see [From the medical director](#), continued on Page 10

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*Felecia Williams is a medical director
for Blue Care Network.*

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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>



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 Arrhythmia 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.



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[®], PancreaGEN[™], 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



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Opioid news roundup



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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.



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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](#).



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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.

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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.

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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.



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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

1. https://www.harvardpilgrim.org/portal/page?_pageid=253,277266&_dad=portal&_schema=PORTAL
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>

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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.



Spotlight on behavioral health

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

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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.

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

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.

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.

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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-BlueSM.

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.

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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 a 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. They 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 HMOSM commercial members. Effective May 1, 2019, Inflectra will be the preferred infliximab product for adult BCN HMOSM (commercial) members.

Note: This change doesn't apply to:

1. Pediatric BCN HMOSM 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 AdvantageSM 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 HMOSM 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."

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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 **ProviderPortal**SM 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 **ProviderPortal**SM 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: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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.

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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*	CLOI	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.

^aGlucophage/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.

CLOI = 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



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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.

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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*SM 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.

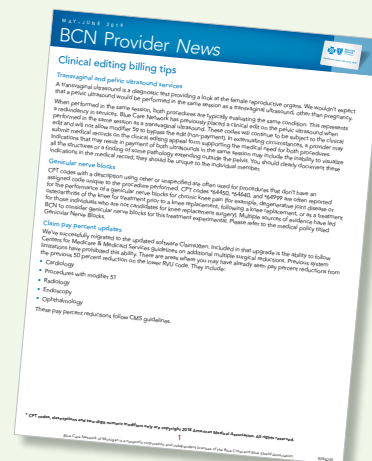
If you have an urgent question and can't find the answer on our website, call Provider Inquiry.

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



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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 Bulletin

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.

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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 HMOSM (commercial) or BCN AdvantageSM 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.



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Clarifying biofeedback and neurofeedback authorization requirements for BCN members

When submitting authorization requests for biofeedback and neurofeedback for BCN HMOSM (commercial) and BCN AdvantageSM 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.



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

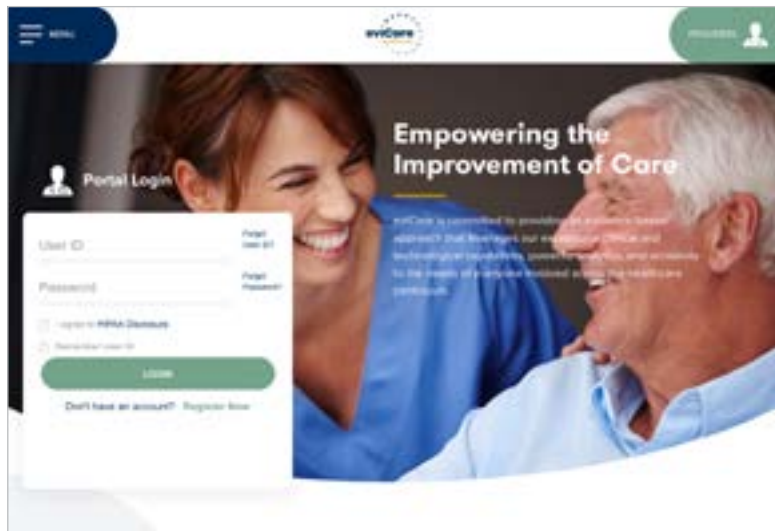
Starting May 27, 2019, submit all BCN authorization requests for outpatient physical, occupational and speech therapy by therapists and physical medicine services by chiropractors to eviCore healthcare. This includes requests for both initial and follow-up visits, for both BCN HMOSM (commercial) and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

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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 HMOSM (commercial) and BCN AdvantageSM members and to the following providers:

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

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

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.

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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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Preliminary results of pilot opioid use disorder treatment program show promise

By William T. Beecroft, M.D.

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

Results of Blue Care Network’s CLIMB program for members with opioid use disorders show that people do better when they take full advantage of the recommended interventions, which include medically-assisted treatment, or MAT. Our relapse rate has decreased from 36% to 14% for members in the program.

CLIMB is an acronym for Community-based, Life-changing, Individual Medically-assisted and evidence-Based program. (The treatment program was extended to include select Blue Cross Blue Shield of Michigan PPO members. It was reported in the January-February 2019 issue of **Physician and Hospital Update**).

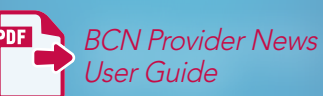
Please see [Opioid Use](#), continued on Page 20

Providers and office staff: Sign up for new training webinars

Do you or your staff have questions about provider enrollment, pharmacy or you just need a refresher on how to work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network? Well, now there’s a webinar to help with those questions.

Provider Experience is developing a more comprehensive schedule of training opportunities for providers and staff. You’ll see a comprehensive calendar of webinar training presented over the next several months. We’ll make recordings available on our website, so you can reference the information at your convenience or make the training available for office staff.

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



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Training, *continued from Page 1*

Here are the webinar offerings for July and August:

Blues 101 – Understanding the Basics

July 16, 2019 from 1 – 2 p.m.

[Click here to register](#)

Blues 201 – Enrollment

July 23, 2019 from 2 – 4 p.m.

[Click here to register](#)

July 25, 2019 from 10 a.m. – noon

[Click here to register](#)

Specialty Topics – Pharmacy Site of Care (Offered twice)

July 17, 10 – 11 a.m.

[Click here to register](#)

July 25, 1:30 – 2:30 p.m.

[Click here to register](#)

Pharmacy Oncology Program through AIM

See the article on [Page 26](#) for dates and registration links.

Stay tuned for details on new webinars in September and October. We'll offer the Blues 101 webinar again and are planning two more Blues 201 trainings about authorizations and referrals and claims appeals.

Editor

Cindy Palese
bcnprovidernews@bcbsm.com

Provider Communications

Catherine Vera-Burgos, Manager
Elizabeth Donoghue Colvin
Jennifer Fry
Tracy Petipren

Market Communications Publications

Autumn Molnar

Contributors

William Beecroft, M.D.; Camillya Christian-Smith; Laura Cornish; Pharm. D; Amy Frady; Jody Gembarski; Duane DiFranco, M.D.; Sonja Rashed; Kelly Redmond-Anderson

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BCN Leadership changes

Blue Care Network has tapped Tiffany Albert, BCN president and CEO, to fill the role of senior vice president, Health Plan Business. Tiffany has provided leadership across Health Plan Business as CEO, as director for the middle and small group segment and as former CEO of our LifeSecure subsidiary. She replaces Kevin Klobucar, who is retiring at the end of the year.



Tiffany Albert

Kathryn Levine has been promoted to president and CEO, Blue Care Network, and will retain responsibilities for corporate marketing and customer experience for BCN and Blue Cross Blue Shield of Michigan. As we continue our efforts to be a best-in-category consumer-centric organization, Levine's new role enables us to combine two areas of strategic strength—BCN and Customer Experience—allowing Health Plan Business to better integrate customer experience enhancements across all business segments.



Kathryn Levine

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How to submit inpatient admission authorization requests on holidays

Blue Care Network corporate offices will close on Thursday, July 4 and Friday, July 5.

During this office closure, BCN's inpatient utilization management area will still accept inpatient authorization requests for BCN HMOSM (commercial) and BCN AdvantageSM members.

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

Acute initial inpatient admissions

Submit these authorization requests as well as concurrent reviews and discharge dates through the e-referral system, which is available 24 hours a day, seven days a week. If the e-referral system is not available, you can fax requests for inpatient admissions and continued stays to BCN HMO (commercial) at 1-866-313-8433 and to BCN Advantage at 1-866-526-1326

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

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.

- For BCN HMO members admitted at any time and for BCN Advantage members admitted through May 31, 2019, Blue Care Network manages the authorizations. Follow the guidelines in the document **Post-acute care admissions: Submitting authorization requests to BCN.**
- For BCN Advantage members admitted on or after June 1, 2019, naviHealth manages the authorizations. Follow the guidelines in the document **Post-acute care services: Frequently asked questions by providers.**



Other authorization requests

The types of 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
- Handling expedited appeals of utilization management decisions

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

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

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We're expanding the use of CAQH ProView

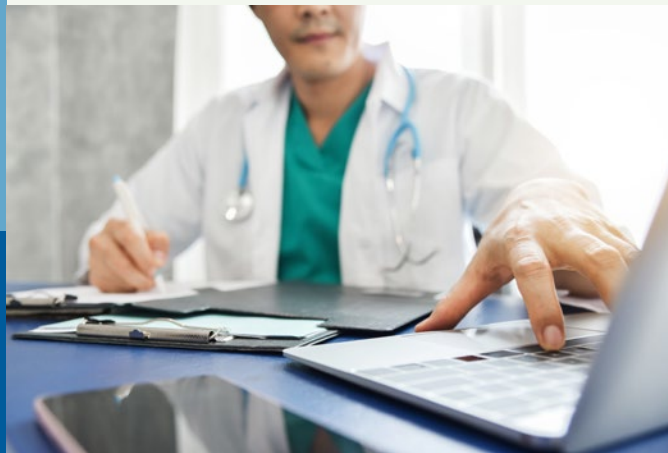
Blue Cross Blue Shield of Michigan Provider Operations and Innovation is expanding the use of the CAQH ProView application to include enrollment demographic and credentialing data for delegated credentialing practitioners.

Through this initiative, we're streamlining the data exchange process between delegated practitioner groups and Blue Cross to improve provider data quality in our online directories.

We'll accept automated data feeds from CAQH ProView 3.0 into our provider data repository to maintain provider data and reduce duplication of data submission for the delegated groups.

We'll begin beta testing this electronic data exchange with the University of Michigan Medical Group and Genesys PHO for initial enrollment and changes during the latter part of 2019, with the exchange of recredentialing data to follow.

Note: We still require signature documents for contracting. Continue to send these documents to the Provider Enrollment and Data Management department.



CAQH Direct Assure rollout continues through 2019

We'll continue rolling out Direct Assure in phases with the goal to have all providers using it by the end of December 2019. Currently, 25% of our practitioners participate. We'll roll out Phase IV at the end of June. Practitioners included in this roll-out are specialists who are likely to be audited by the Centers for Medicare & Medicaid Services:

- Primary care physicians
- Cardiologists
- Oncologists
- Ophthalmologists

Keep your CAQH record updated

To make a smooth transition to CAQH Direct Assure, keep your CAQH record updated with the correct practice location information. You can familiarize yourself with the Direct Assure application by watching the **Update your Practice Locations in CAQH ProView** video tutorial.

This video will walk you through the steps involved in reconciling your location information with Blue Cross Blue Shield of Michigan.

While making updates to practice locations in CAQH, keep the following in mind:

- If, after logging into CAQH, you see a pop-up message that reads *Help Patients Find You*, that means that you are now participating in Direct Assure.
- Once active with Direct Assure, adding, ending or updating a group address in CAQH will now be sent to Blue Cross for processing.
- Don't forget to add the Type 2 (group) National Provider Identifier (NPI 2) for each location.
- When you select, *I see patients here one day per week or I see patients one day per month*, the Practice Affiliation page will display the location in the directory. If a practitioner sees patients but not for appointments, he or she should select *Other* so the record doesn't display in the directory.

If you have questions, call CAQH at 1-888-599-1771, or Provider Enrollment at 1-800-822-2761.

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We're expanding medical coverage for U-M employees who are transgender

Blue Cross Blue Shield of Michigan and Blue Care Network will soon cover additional medical services for University of Michigan employees who are transgender.

The following additional gender affirming services for members transitioning from male to female will be covered, starting July 1, 2019.

- Face and neck hair removal
- Facial feminization surgery
- Chondrolaryngoplasty (Adam's apple reduction)

Currently, Blue Cross and BCN cover genital surgery, mastectomy in female-to-male transition, hormone therapy and counseling when medically necessary to treat gender dysphoria for U-M employees. Gender dysphoria involves a conflict between a person's gender identity and their gender assigned at birth, causing significant distress.

Coverage for the new services will require that members meet benefit criteria. Blue Cross comprehensive major medical members must use Blue Cross participating providers. Blue Cross' PPO and BCN HMO members must use network providers. This benefit has up to a \$30,000 lifetime limit. Michigan Medicine, formerly the University of Michigan Health System, is the only provider in our network that currently performs facial feminization surgical services.

You can request authorizations for members who have a Blue Cross plan, starting June 15, 2019. For members with a BCN plan, authorizations can be requested starting June 12.

The group number for BCN members is 00124316. The group number for Blue Cross members is 007005187. The number will be on the front of their member ID card. As always, be sure to check web-DENIS for benefits and eligibility.

Transgender members may also utilize new coverage for fertility preservation if medical or surgical interventions related to their transition could result in infertility. For more details, see the University of Michigan [fact sheet on coverage for services related to infertility](#).

For more information

For more details, see the University of Michigan [fact sheet on health plan coverage for gender-affirming services](#).

Blue Care Network updates professional fees, effective July 1

Blue Care Network will update fee schedules, effective with dates of service on or after July 1, 2019. This change applies to services provided to Blue Care Network commercial members.

We'll use the 2019 Medicare resource-based relative value scale for most relative value unit-priced procedures.

In alignment with Blue Cross Blue Shield of Michigan, the conversion factor used to calculate anesthesia base units for anesthesia procedures will increase 1.5% to \$60.72 throughout Michigan.

Blue Cross conducts a comprehensive analysis of professional provider performance and current economic indicators annually to calculate practitioner fees, with consideration of corporate and customer cost concerns.

Blue Cross and BCN remain committed to reviewing professional provider performance to determine the need for increases or decreases in our maximum payments.

Only claims submitted with dates of service on or after July 1 will be reimbursed at the new rates.

Note: The Blue Cross Physician Group Incentive Program allocation of professional fees won't change. This component continues to be excluded from BCN professional fees.

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You must use in-network laboratories for your Blue Cross and BCN patients

A regular review of our claims data shows that a number of providers are using noncontracted laboratories for Blue Cross Blue Shield of Michigan and Blue Care Network patients. We've also found some patients are taking their lab scripts to noncontracted labs, not realizing this may result in higher costs.

Going out of network for lab services may cause unnecessary cost-sharing expenses and balance-billing by the labs. We encourage you let your patients know that going to a contracted lab helps ensure they avoid higher copayments and possible other out-of-pocket costs.

Network labs offer a full complement of routine tests, BRCA testing and other specialty testing. In addition, we use contracted labs to obtain data for regulatory reporting and clinical quality review.

According to your participation agreement, you must also use in-network providers when referring patients for non-emergency services. Verify a laboratory's participation in the appropriate network before referring patients for lab samples.

Failure to meet program requirements for utilizing participating laboratory services may lead to corrective action, including potential termination from the Blue Cross network.

Below is a list of labs used for our BCN and Blue Cross members:

Blue Cross PPO (commercial)	Use the Find a Doctor tool on bcbsm.com (except MPSERS, Ford, GM)
Blue Cross® PPO (commercial plans) for MPSERS, Ford, GM salaried employees	Quest Diagnostics™ 1-866-697-8378
Medicare Plus BlueSM PPO	Quest Diagnostics™ - 1-866-697-8378 JVHL – 1-800-445-4979
BCN HMOSM (commercial)	JVHL and JVHL subcontractors 1-800-445-4979
BCN AdvantageSM	JVHL and JVHL subcontractors 1-800-445-4979



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Help members share their Blue Cross ID cards through our mobile app

Do you have patients who forget their member ID cards? Or have questions about their coverage, deductible or copays? When your office needs a copy of the ID card for your records, tell patients to download the **BCBSM mobile app**. It connects members securely to the health plan info on their **bcbsm.com** accounts for Blue Cross Blue Shield of Michigan or Blue Care Network.

Members can download the BCBSM mobile app from the App Store® or Google Play™ onto one of these devices:

- iPhone® or iPad® using iOS 10.0 or better
- smartphone or tablet using Android™ version 5.0 or better

How patients can share their virtual member ID card

Patients can share their member ID card from the mobile app. They'll need to know their login ID and password they created when they downloaded the app. Here's how to help the member share it with you.

Tell them to:

1. Log in to the app
2. Click on ID Card icon.
3. After the card launches, selected the "share" icon at the right side of the screen.
4. Tap the phone's sharing menu icon.
5. A new email message will open with a PDF of their ID card attached.
6. Enter recipient's information and click send.



Use your business email to access provider secured services

We're always looking for ways to protect our members' 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.

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Reminders about preventive screenings mailed to BCN Advantage members

BCN Advantage sent gaps in care letters in June to remind members to talk to their doctors about preventive health screenings. The letters include a service chart that showed both completed and recommended health screenings. BCN also encouraged members to discuss the listed screenings with their doctors.

The service chart listed screenings for breast cancer, colorectal cancer and osteoporosis along with a diabetic A1c test, diabetic retinal eye exam and diabetic kidney function test. They are individualized based on the member.

HEALTH SERVICE	THE SERVICE HELPS YOU...	HOW OFTEN?	YOUR STATUS
Breast cancer screening	Detect breast cancer early when it's easiest to treat.	Mammogram every two years	☑
Colorectal cancer screening	Discover colorectal cancer early when treatment works best.	Ask your doctor how often you get tested. Screening type is best for you.	☐
Diabetic A1c test	Keep track of how well you're managing your diabetes.	Two to four times each year depending on needs.	☑
Diabetic retinal eye exam	Prevent blindness or other eye problems.	Every one to two years as recommended by your doctor.	☑
Diabetic kidney function test	Find kidney disease before it affects health.	Urine protein test every year.	☑
Osteoporosis screening	Identify osteoporosis with a quick painless test.	Bone mass measurement every two years as recommended by your doctor.	☑

Be sure to have your blood pressure checked at every office visit to make sure it's under control.

Your status is based on claims data through May 2019. If you've already completed these services, thank you.

Blue Cross Blue Shield of Michigan and Blue Cross Network are a nonprofit corporation and independent members of the Blue Cross and Blue Shield Association. Y004_1054669y004_C_P0001 08/19

We've included a Customer Service number for BCN Advantage so members can call us with questions.

Gain insights about your patients from CAHPS research on improving the patient experience

The Centers for Medicare & Medicaid Services can help providers better understand their Medicare patients' needs and expectations through information gleaned from the Consumer Assessment of Healthcare Providers and Systems, or CAHPS, survey.

CMS annually compiles survey findings as part of an effort to improve the patient experience and better understand health outcomes. Results from the CAHPS survey, developed by the U.S. Agency for Healthcare Research and Quality, contribute to the CMS star ratings system.

You can learn more about the **CAHPS survey** and how the survey can be used to improve the patient experience. Also, be sure to check out the **CAHPS survey tip sheet** to find out why this annual survey is so important, how it's conducted, what questions are asked and ways you can address care opportunities for patients.



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Medication reconciliation reimbursement increases to \$35 for Medicare Advantage members

When medication reconciliation is conducted within 30 days of a hospital discharge and a claim is submitted for CPT II code *1111F, Blue Cross Blue Shield of Michigan will reimburse providers \$35 for its Medicare Advantage products: Medicare Plus BlueSM and BCN AdvantageSM. Blue Cross commercial continues to reimburse at \$35.

“Medication Reconciliation Post-Discharge” is a HEDIS[®] measure.

To receive reimbursement, follow these steps when patients are discharged after a hospital stay:

- Schedule a medication reconciliation as soon as possible.
- Perform medication reconciliation by comparing the hospital discharge medications against the patient’s current list of medications.
 - Physicians, physician assistants, pharmacists and registered nurses may conduct a medication reconciliation.
 - One example of acceptable documentation in the outpatient medical record is “Current and discharge medications were reconciled.”
- Submit *1111F with the post-discharge office visit claim within 30 days of the discharge. The code description is “Discharge medications reconciled with the current medication list in outpatient medical record.”

About the HEDIS measure

Medication Reconciliation Post-Discharge assesses patients age 18 and older in the measurement year who were discharged from an acute or non-acute inpatient stay between Jan. 1 and Dec. 1 of the measurement year. It looks at patients whose medications were reconciled from the date of discharge through 30 days after discharge (31 days total).

See the PDF to review the [Medication Reconciliation Post-Discharge tip sheet](#).

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

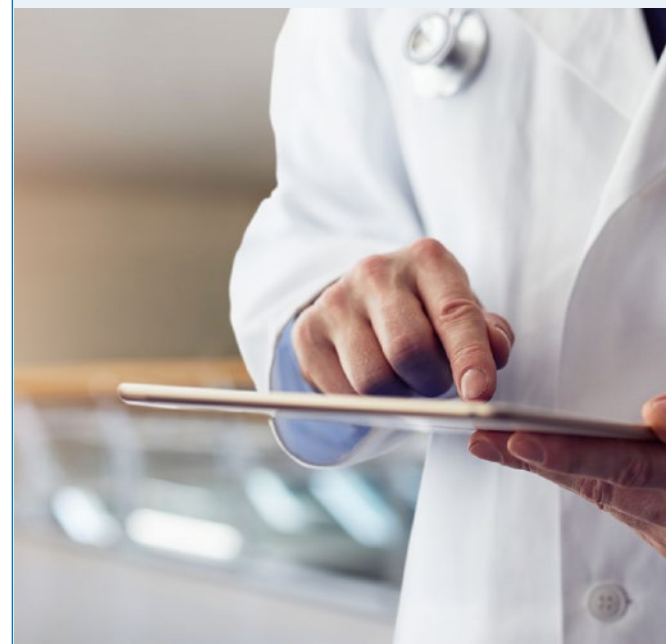
*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2018 American Medical Association. All rights reserved.

Error code changes for BCN Advantage referrals submitted by electronic transaction

If you submit referral requests using the 278 electronic transaction, you will now receive a different error message for referrals submitted for BCN AdvantageSM members. Initially, error code 33 with the description of “Input Errors” was received.

At the end of May, the error changed to “NA.” This means that no action is needed. This is a more appropriate error message as BCN no longer accepts referrals for BCN Advantage members staying in network.

We announced the end of referrals for BCN Advantage members staying in their health plan’s network in our [March-April issue](#) on Page 7.





Update: naviHealth managing authorizations for Medicare Advantage members moving to post-acute care facilities

As you read in the **May-June** issue of *BCN Provider News*, Page 6, naviHealth will be managing authorizations for Medicare Advantage members who are moving into skilled nursing, long-term acute care and inpatient rehabilitation facilities. The transition to naviHealth is effective for authorization requests submitted **for members admitted on or after June 1, 2019**, for both in-state and out-of-state cases.

Here's some additional information to keep in mind:

- Post-acute care facilities should always check to see if an authorization is in place when they're handling an admission for a Medicare Advantage patient. If an authorization wasn't submitted by the acute care facility, the post-acute care facility should submit the authorization request.
- Retrospective authorizations can be submitted electronically up to 90 days post-discharge from an acute care facility. Beyond 90 days, authorizations must be phoned in or faxed.

For more details on how to submit authorization requests, see the *BCN Provider News* article reference above.

Also, we recently updated our **FAQ** on post-acute care services.

If you missed the training, you can view recorded webinars on navihealth.com/BCBSM.

Two Medicare star measures support statin therapy for patients with cardiovascular disease and diabetes

To underscore the importance of statin therapy, the Centers for Medicare & Medicaid Services includes two Medicare star measures aimed at its use for patients with cardiovascular disease and diabetes.

The Centers for Disease Control and Prevention estimates that adults with diabetes are 1.7 times more likely to die from cardiovascular disease than adults without it. Additionally, nearly two out of five people with diabetes who could benefit from statin therapy to lower their risk of heart attack, stroke and related deaths weren't prescribed it, according to the *Journal of the American College of Cardiology*.

We encourage you to consider prescribing statins for your patients diagnosed with atherosclerotic cardiovascular disease and diabetes.

To learn more about the use of statin therapy, view these tip sheets:

- **Statin Therapy for Patients with Cardiovascular Disease**
- **Statin Use in Persons with Diabetes**



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Medicare Part B medical specialty drug prior authorization list changing July 22

We're making changes to the Medicare Plus BlueSM PPO and BCN AdvantageSM Part B specialty prior authorization drug list, as follows:

- For dates of service on or after July 22, 2019, Darzalex[®] (J9145) will require prior authorization.
- Effective immediately, Myozyme[®] (J0220) is removed from the prior authorization list because it is no longer available in the U.S. market.

Here's some additional information you need to know about the change for Darzalex.

Medicare Plus Blue PPO

For Medicare Plus Blue, we require prior authorization for Darzalex when you bill electronically through an 837P transaction or on a professional CMS-1500 claim form, for the following sites of care:

- Physician office (place of service code 11)
- Outpatient facility (place of service code 19, 22 or 24)

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For BCN Advantage, we require prior authorization for Darzalex when you bill it as a professional service or an outpatient facility service electronically through an 837P transaction or on a professional CMS-1500 claim form for:

- Physician office (place of service code 11)
- Outpatient facility (place of service code 19, 22 or 24)
- Home (place of service code 12)

We also require prior authorization when you bill electronically through an 837I transaction or using a UB04 claim form for a hospital outpatient type of bill 013x.

Important reminder

You must get authorization before administering these medications. Use the Novologix[®] online web tool to quickly submit your requests. It offers real-time status checks and immediate approvals for certain medications. Also note:

- For Medicare Plus Blue, you can fax an **Addendum P form** to gain access to the Novologix online web tool.
- For BCN Advantage, if you have access to Provider Secured Services, you already have access to submit authorization requests through Novologix.



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Educate patients about measles vaccine myths

By Dr. Denice Logan



The reoccurrence of measles in the United States, and particularly Michigan, affords providers renewed opportunities to have important conversations with parents who are reluctant to vaccinate their children.

Physicians can address parental concerns, while exploring misconceptions about the vaccine.

For example, getting the vaccine is much safer than getting measles. Measles is a serious disease.

According to the Centers for Disease Control and Prevention, complications can include encephalitis, resulting in deafness, an intellectual disability or death.

Parents also need to understand that serious side effects are very rare. Side effects are generally mild and can include pain and swelling at the injection site. The risk of the vaccine causing serious harm is very small.

There are myths related to measles vaccination that are not supported by sound scientific evidence. Physicians can use the information that follows to facilitate conversations with patients.

Myth: Vaccines contain harmful ingredients, such as thimerosal, formaldehyde and aluminum.

Thimerosal (mercury) is found in milk, seafood and contact lens solution. Formaldehyde is found in a variety of agents, including carpeting, upholstery, cosmetics, paint, felt tip markers, antihistamines, cough drops and mouthwash. We actually make formaldehyde in our bodies in some metabolic processes. Aluminum is found in drinking water, foods and medicines. All these agents are found in such minimal amount than what we are exposed to in our daily lives.

Myth: Vaccines cause autism and SIDS.

A 1998 study that raised this issue was retracted by The Lancet, as it was significantly flawed. The published study only included 12 patients. Eight of the 12 were suing the vaccine producing companies, but this wasn't disclosed. An autism diagnosis can be made at the same time during which a child receives the MMR vaccination. No sound reproducible evidence was even identified to support this 12-participant study.

Myth: Vaccine preventable diseases are just a part of childhood.

It is not better to have the disease than become immune through vaccines. The disease can cause serious complications.



2019 InterQual criteria implemented Aug. 1, 2019, for non-behavioral health determinations

Blue Cross Blue Shield of Michigan and Blue Care Network will implement the 2019 InterQual® criteria starting Aug. 1, 2019, for all levels of care. We'll use these criteria to make utilization management determinations for requests to authorize non-behavioral health services subject to review for the following members:

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

When clinical information is requested for a medical or surgical admission or for other services, we require submission of the specific components of the medical record that validate that the request meets the criteria.

Blue Cross and BCN also use local rules — modifications of InterQual criteria — in making utilization management determinations. The 2019 local rules will also be implemented starting Aug. 1, 2019.

By the end of July, you'll be able to access the updated versions of the modifications (local rules), as applicable, for:

- BCN — on the **Authorization Requirements & Criteria** page in the BCN section of our ereferrals.bcbsm.com website. Look under the "Referral and authorization information" heading.
- Blue Cross — on the **Authorization Requirements & Criteria** page in the Blue Cross section of our ereferrals.bcbsm.com website. You'll see links to the criteria in both the Blue Cross PPO and the Medicare Plus Blue PPO sections of that page.

Refer to the table for more specific information on which criteria are used in making determinations for various types of non-behavioral health authorization requests.

Criteria/Version	Application
InterQual Acute — Adult and Pediatrics	<ul style="list-style-type: none"> • Inpatient admissions • Continued stay discharge readiness
InterQual Level of Care — Subacute and Skilled Nursing Facility	<ul style="list-style-type: none"> • Subacute and skilled nursing facility admissions • Continued stay discharge readiness
InterQual Rehabilitation — Adult and Pediatrics	<ul style="list-style-type: none"> • Inpatient admissions • Continued stay and discharge readiness
InterQual Level of Care — Long Term Acute Care	<ul style="list-style-type: none"> • Long-term acute care facility admissions • Continued stay discharge readiness
InterQual Level of Care — Home Care	<ul style="list-style-type: none"> • Home care requests
InterQual Imaging	<ul style="list-style-type: none"> • Imaging studies and X-rays
InterQual Procedures — Adult and Pediatrics	<ul style="list-style-type: none"> • Surgery and invasive procedures
Medicare Coverage Guidelines (as applicable)	<ul style="list-style-type: none"> • Services that require clinical review for medical necessity and benefit determinations
Blue Cross and BCN medical policies	<ul style="list-style-type: none"> • Services that require clinical review for medical necessity
BCN-developed Local Rules (applies to BCN HMO and BCN Advantage)	<ul style="list-style-type: none"> • Exceptions to the application of InterQual criteria that reflect BCN's accepted practice standards

Note: The information in the table applies to lines of business and members whose authorizations are managed by Blue Cross or BCN directly and not by a vendor.

See the article titled "We're using updated utilization management criteria for behavioral health, starting Aug. 1," on **Page 21** in this newsletter for information on the updated behavioral health criteria we'll use starting Aug 1.





From the medical director, continued from Page 12

Myth: I don't need to vaccinate my child because other children are already immune.

Herd immunity will eventually be less effective if enough people don't continue to receive the vaccine.

Myth: A child can get the disease from the vaccine.

Most vaccines are inactivated. Therefore, it is highly unlikely that this could occur. Oral live polio in the past was associated with cases of polio. It's no longer provided in the United States.

The number of measles cases reported in the United States this year is more than double 2018 data. This makes administration of the vaccine and patient education even more crucial.

Measles vaccine recommendations

The Centers for Disease Control and Prevention recommends that children get two doses of MMR vaccine:

- The first dose at 12 through 15 months of age
- The second dose at 4 through 6 years of age

Teens and adults should also be up to date on MMR vaccinations.

Adults at high risk include international travelers, college and other post-high school students and health care personnel born during or after 1957. Health care personnel born in or after 1957 should get two doses of the MMR vaccine. All other adults born during or after 1957, without presumptive evidence of measles immunity, should be vaccinated with one dose of MMR vaccine.

References:

Advisory Committee on Immunization Practices Recommended Immunization Schedule, www.cdc.gov
 Surveillance Manual /Measles/Vaccine/Preventtable Diseases/CDC
 2019 Michigan Measles Outbreak Information
 Healthy Children.org, www.healthychildren.org

Non-opioid advance directive now available on line

The Michigan Department of Health and Human Services has made the nonopioid directive form available to the public on its website in response to a state law that allows patients to refuse opioid medications by placing a form in their medical file.

The law was signed last year and went into effect in late March.

There are exceptions in the law, including a provision that a prescriber or a nurse under the order of a prescriber may administer an opioid if it is deemed medically necessary for treatment.

Providers can direct patients to Michigan's Opioid Addiction Resources website, at Michigan.gov/opioids. The link can be found under Additional Resources at the bottom of the Find Help page.



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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

- Breast elastography – Ultrasound or magnetic resonance

Covered services

- Closure devices for patent foramen ovale and atrial septal defects
- Gait analysis
- Genetic testing for the diagnosis of inherited peripheral neuropathies
- Genetic testing — Expanded molecular panel testing of cancers to identify targeted therapies
- Drug testing of urine, oral fluids and hair
- Genetic testing for myotonic dystrophy
- Growing rods for scoliosis



Battling the opioid epidemic



A roundup of news and information

CMS develops Medicare Part D opioid mapping tool

The Centers for Medicare & Medicaid Services has developed a Medicare Part D opioid prescribing mapping tool. This interactive tool shows geographic comparisons at the state, county and ZIP-code levels of de-identified Medicare Part D opioid prescriptions filled within the U.S. For more information, go to [CMS.gov](https://www.cms.gov).

Study explores geographic variation in opioid prescribing

How have key opioid prescription measures changed by state between 2006 and 2017 in the U.S.? A new study, published in JAMA, examines this question. To read more, read the [article](#).

Bloomberg gives Michigan \$10 million to fight opioid crisis

Former New York Mayor Michael Bloomberg traveled to Michigan in March to announce a \$10 million contribution to the state’s efforts to fight the opioid crisis, the *Detroit Free Press* reported. The money will come from Bloomberg Philanthropies, which will partner with up to 10 states over the next three years and invest \$50 million to support state programs to develop treatment and prevention programs. To read more, see the [article](#) in the *Detroit Free Press*.

In a related item in *The Detroit News*, Bloomberg and Michigan Gov. Gretchen Whitmer wrote an [opinion piece](#) on what state governments have been doing and Michigan’s fight to combat the opioid crisis.

Michigan schools stocking first aid kits with Narcan®

A number of Detroit-area schools are stocking their facilities with Narcan, the overdose-reversing drug, and training school staff to use it, the *Detroit Free Press* [reported](#) March 14.



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:

For the Acute Coronary Syndrome subset, NSTEMI or Unstable Angina criteria, the requirements for treatment include an anticoagulant being administered or contraindicated. If a patient was on an oral anticoagulant such as Eliquis® or Coumadin® prior to their arrival at the hospital and the treating physician ordered continuation of this anticoagulant, does that satisfy the InterQual requirement?

Answer:

The medications (anticoagulant) don't need to have been newly initiated to apply the criteria. The note attached to the criteria point helps to define the intent:

"Anticoagulant therapy includes unfractionated heparin, enoxaparin, bivalirudin and fondaparinux. Bivalirudin is only recommended for invasive strategies. Fondaparinux should not be used as the only anticoagulant if a percutaneous coronary intervention is performed."

However, since the overriding rule throughout InterQual is that oral medications are excluded unless specifically stated, medications such as Eliquis or Coumadin would not satisfy the criteria requirement.

Question:

For the Acute Coronary Syndrome subset, NSTEMI or Unstable Angina criteria, the requirements for treatment include an antiplatelet medication being administered or contraindicated. Can aspirin, which is classified as an antiplatelet medication, be used to satisfy the InterQual requirement?

Answer:

Aspirin cannot be used to meet more than one criterion (for example, both aspirin and an antiplatelet). To meet the intermediate or critical levels of care, aspirin, an antiplatelet and an anticoagulant must all be given or contraindicated.

Question:

For the Acute Coronary Syndrome subset, criteria note #25 states: "Guideline recommends treatment for patients admitted with acute coronary syndrome include the following unless contraindicated: beta blocker, aspirin, statin, angiotensin-converting enzyme inhibitor or angiotensin receptor blocker, antiplatelet, anticoagulant and continuous cardiac monitoring."

Why is a statin not included in the InterQual criteria requirements for an NSTEMI or Unstable Angina?

Answer:

From Page 30 of the 2018 Review Process:

"The criteria reflect the minimum standard of care that all patients should receive and do not prevent the performance of other tests or procedures that may be clinically appropriate. For example, PCI is not listed as a standard of care in the ACS subset but is often performed on patients who present with acute coronary syndrome (STEMI)."

The treatments required in the criteria are the minimum standard for the level of care and drive the level of care. The note is informational. A statin may also be ordered, but the treatments included in the criteria reflect the minimum standard necessary for the episode day.

Question:

Regarding InterQual criteria point Adult/Geriatric Psychiatry - Inpatient - Episode Day 2-13 - Unable or refusal to eat or drink, if there is an adult member who is eating only snacks but refusing all meals and has lost weight over the course of their admission, versus a geriatric member with severe dementia who is refusing all oral intake and is at significant medical risk as a result, could we apply this criteria to both instances? In short, is this an 'either/or' criteria vs. one with a little room for interpretation?

Answer:

"Unable or refusal to eat or drink" may be applied for both scenarios, including for someone who's just eating snacks because if they're losing weight, they're at risk for losing more if they are discharged.



COPD diagnosis should include spirometry

Caring for patients with chronic obstructive pulmonary disease begins with diagnosing the condition through spirometry. It's necessary to periodically assess the disease, manage exacerbations and provide smoking cessation support. Pharmacologic therapy is pivotal as it provides important options for improvement of symptoms and treatment of exacerbations.

COPD remains underdiagnosed. Consider testing for COPD in smokers with symptoms or with a history of exposure to other COPD risk factors. This includes smokers older than 60 presenting with a chronic cough, or smokers with diagnosis and treatment for respiratory tract infections or asthma.

A written COPD management plan can facilitate COPD care in your office and helps patients manage their symptoms. Blue Care Network asks physicians to complete the management plan during office visits and provide a copy to the member.

To obtain a copy of BCN's COPD management plan:

- Log in to web-DENIS.
- Go to *BCN Provider Publications and Resources*.
- Click on *Forms* under Other Resources.
- Click on *COPD Action Plan* in the Chronic Condition Management section.

Spirometry

Spirometry is necessary to establish a diagnosis of COPD, according to BCN's clinical practice guidelines for the diagnosis and management of COPD. Spirometry also provides a useful diagnostic tool for those patients with symptoms suggestive of COPD. (See table.) A post bronchodilator FEV1/FVC less than 70 percent confirms the presence of airflow limitation.

BCN's *Guidelines for the Diagnosis and Management of Chronic Obstructive Pulmonary Disease* recommend that you consider COPD in any patient 18 years of age or older with respiratory symptoms and those with a history of exposure (for example, occupational exposure) to risk factors for the disease, especially smoking. Characteristic symptoms include cough, sputum production that can be variable from day to day and chronic or progressive dyspnea.

I: Mild COPD	II: Moderate COPD	III: Severe COPD	IV: Very Severe COPD
FEV1/FVC <0.70	FEV1/FVC <0.70	FEV1/FVC <0.70	FEV1/FVC <0.70
FEV1 ≥ 80% predicted	FEV1 50% ≤ and < 80% predicted	FEV1 30% ≤ and < 50% predicted	FEV1 < 30% predicted or FEV1 < 50% with deoxygenating

The 2017 Healthcare Effectiveness Data Information Set measures the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis. CPT codes used to identify spirometry testing for this measure include **94010, **94014-94016, **94060, **94070, **94375 and **94620.



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**** CPT codes, descriptions and two-digit numeric modifiers only are copyright 2018 American Medical Association. All rights reserved.**

Source:

BCN Guidelines for the Diagnosis and Management of Chronic Obstructive Pulmonary Disease (COPD) QM 2071

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Providers can refer patients to adult intensive services for acute behavioral health needs

Blue Care Network offers adult intensive services, or AIS, for health plan members who have been non-adherent or non-responsive to traditional behavioral health services or are at risk for decompensation. (See article in the **March-April 2018** issue of *BCN Provider News*). These members will likely need more specialized crisis services and interventions to remain stable in the least restrictive environment.

Adult intensive services targets providers with skills and systems available to intervene within 24 hours. AIS employs a systems model approach which includes a multidisciplinary team. The goal is to get members into the right care at the right time, rather than cycling through hospitalizations and rapid readmits.

Through AIS, interventions continue until the patient's situation is stable. Long-acting injectables may be effective for some patients.

Members may continue to work with their outpatient providers to coordinate care while in this program.

Data pulled for members with high acuity, high risk for behavioral health and comorbid medical conditions pointed most directly to those with mood disorders (bipolar and MDD), co-occurring substance use, and those with persistent mental illness or psychotic disorders.

As an overarching guideline, the factors that should drive referrals to this program should include consideration for:

- Ongoing, persistent illness with high risk for relapse
- Multiple medication trials or use of ECT
- Non-adherence to treatment or medication regimen
- Non-responsive to traditional treatment strategies (outpatient, intensive outpatient, partial hospitalization, inpatient services)
- Rapid or multiple readmits
- Members on or in need of a treatment order
- High risk for hospitalization or re-hospitalization
- Lack of psychosocial supports in combination with at least one of the above

Preliminary findings

As we continue to gather information about the program, we can share preliminary findings:

1. The following diagnostic categories participating in the program:
 - Bipolar disorders – 41%
 - Major depressive disorders – 32%
 - Schizophrenia/schizoaffective disorders – 15%
 - Polysubstance/opioid disorders – 3%
 - Post-traumatic stress disorder – 3%
2. There appears to be a correlation between high acuity/high risk behavioral health cases, high medical comorbidities and pharmacy utilization.
3. We're seeing a potential decrease in the number of admissions to the highest levels of behavioral health and medical care. We're still gathering information to analyze and to validate this as an outcome trend.

Our goal is to compare member outcomes and whether they are more stable in AIS compared with prior year services. We'll also compare members who engaged in the AIS vs. those referred but never engaged. Further analysis will include whether there is a noted increase or reduction in behavioral, medical, pharmacy, and use of emergency department services.

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



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HEDIS measure calls for routine blood sugar and cholesterol monitoring for children and adolescents on antipsychotic medications

The American Academy of Child and Adolescent Psychiatry recommends that children who take antipsychotic medications get routine blood monitoring, including blood sugar and cholesterol levels. This is important to manage potential side effects and identify risks for heart disease and diabetes.

The Healthcare Effectiveness Data and Information Set, or HEDIS®, metabolic monitoring of antipsychotic medications measures the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions filled and whether they have had both of the following tests in the measurement year:

- At least one test for blood glucose: a blood glucose or HBA1c test
- At least one LCL-C or cholesterol test

Blue Care Network mails letters to members identifying the medication that is prescribed and reminds them of the importance of having these tests completed. We also fax reminders to the prescribing provider.

We ask providers to:

- Have blood drawn annually on children and adolescents on an antipsychotic medication to check blood glucose and cholesterol levels
- Follow up with patient’s parents to discuss and educate on lab results
- Coordinate care with the patient’s behavioral health specialists

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



[AIS](#), continued from Page 18

Referrals to AIS

Behavioral health providers have opportunities to discuss the program and placement:

- When discussing cases with BCN Utilization Management
- As a placement option during physician to physician reviews with BCN
- As a step down from inpatient or residential care for a member who continues to need close monitoring
- As a step-up from outpatient for a member who needs close monitoring as risk factors and decompensation increases

We offer adult intensive services with four BCN providers in the following counties: Oakland, Macomb, Wayne, Monroe, Livingston, Washtenaw, Genesee and Saginaw.

If you need referral assistance or have questions about the program, call BCN Behavioral Health at 1-800-482-5982.

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Opioid Use, *continued from Page 1*

Other initial observations from our pilot, which began in May 2018, include the following:

- Our MAT rate increased 23%; at discharge the rate was 62.5%.
- Five members participated in detoxification only and left the program early against medical advice. Those members eventually used MAT and stopped relapsing.
- Some patients refused medication-assisted treatment and others were unable to be treated with medications for other medical reasons.
- We observed patients having difficulty getting access to medication-assisted treatment after discharge so we're actively recruiting providers who can use this service on an ongoing basis.

To make it easier for members to get medication-assisted treatment, Blue Care Network has also contracted with home health care agencies that make home visits to administer injections included in MAT. Injections are administered monthly and have no copayment once the patient reaches his or her deductible.

CLIMB program background

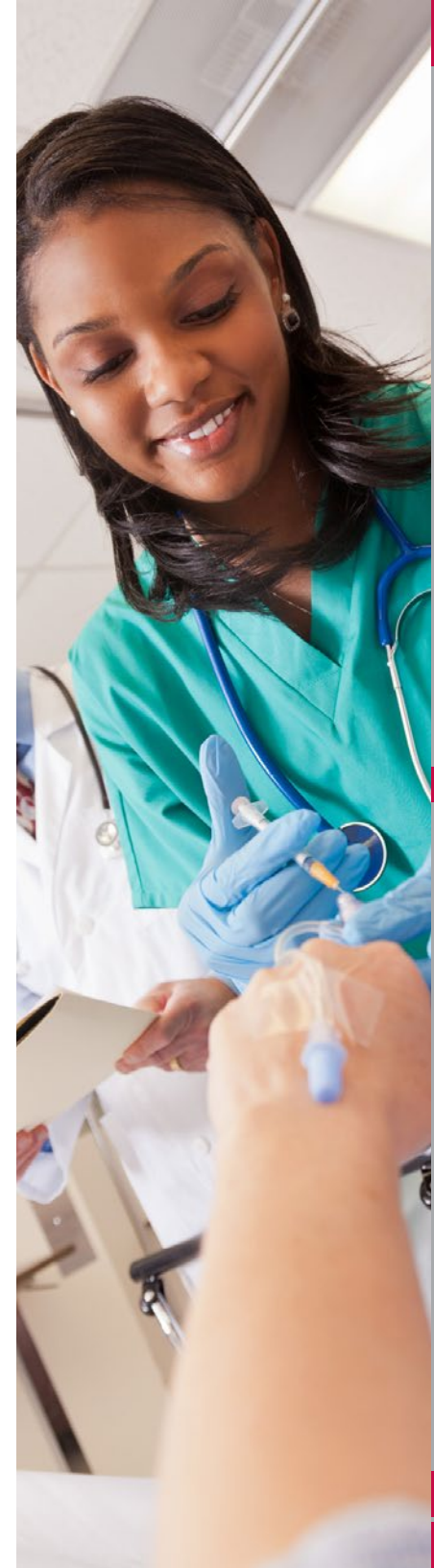
Blue Care Network started authorizing members to use the CLIMB program in May 2018 with two partner facilities. We described the program in detail in the May-June issue of **BCN Provider News**, Page 23.

The CLIMB treatment program is based on current literature and seeks to improve the outcomes of members with an opioid use disorder. The program includes detoxification, supervised residential level of care, use of medication-assisted treatment and intensive outpatient care along with family support, and the use of smartphone technology. Through the CLIMB program, we've attempted to show that treating this disease as any other chronic illness, such as diabetes or hypertension, is in the member's best interest and provides the most long-lasting outcomes. The practices employed in the program have been gaining additional credence because they work and have the greatest success of reestablishing a drug-free lifestyle.

We're very excited about the program and the potential for it to become the new standard of care for opioid use disorder treatment. We'll gather additional data for the next six months, so we can continue to encourage this treatment to our Blue Care Network and Blue Cross Blue Shield of Michigan members.

For further reading on medication-assisted treatment see previous articles in BCN Provider News.

- Making the case for medication-assisted treatment, **March-April 2018**, Page 17
- BCN offers incentive for primary care physicians to offer medication-assisted treatment, **July-August 2018** issue, Page 23



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We're using updated utilization management criteria for behavioral health, starting Aug. 1

Medicare Plus BlueSM PPO, Blue Cross Blue Shield of Michigan's Medicare Advantage plan, and Blue Care Network's commercial and Medicare Advantage plans (BCN HMOSM and BCN AdvantageSM) will begin using the 2019 InterQual[®] criteria for behavioral health utilization management determinations on Aug. 1.

We recently communicated about this in a web-DENIS message and a news item at ereferrals.bcbsm.com.

In addition, certain types of determinations will be based on modifications to InterQual criteria or on local rules or medical policies, as shown in the table below:

Line of business	Modified 2019 InterQual criteria for:	Local rules or medical policies for:
BCN HMO (commercial) and BCN Advantage	<ul style="list-style-type: none"> Substance use disorders: partial hospital program and intensive outpatient program Residential mental health treatment (adult/geriatric and child/adolescent) 	<ul style="list-style-type: none"> Autism spectrum disorder/ applied behavior analysis (for BCN HMO only) Neurofeedback for attention deficit disorder/ attention deficit hyperactivity disorder Transcranial magnetic stimulation Telemedicine (telepsychiatry/teletherapy)
Medicare Plus Blue PPO	<ul style="list-style-type: none"> Substance use disorders: partial hospital program and intensive outpatient program 	None

Note: Determinations on Blue Cross PPO (commercial) behavioral health services are handled by New Directions, an independent company that provides behavioral health services for some Blue Cross members.

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

Also, see the article titled "2019 InterQual criteria implemented Aug. 1, 2019, for non-behavioral health determinations," on [Page 13](#) for information on the updated non-behavioral health criteria we'll use starting Aug. 1, 2019.



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BCN and Blue Cross now accepting applied behavior analysis claims with 2019 procedure codes

Blue Care Network and Blue Cross Blue Shield of Michigan began accepting claims for behavior analysis services billed with the following codes, for dates of service on or after June 1:

- *97151
- *97152
- *97153
- *97154
- *97155
- *97156
- *97157
- *97158
- *0362T
- *0373T

Claims billed with the following codes will still be honored:

- H0031
- H0032
- H2019
- H2014
- S5108
- S5111

This applies to BCN HMOSM and Blue Cross' PPO members. All services continue to require authorization.

Billing guidelines

We've updating the ABA billing guidelines to reflect the 2019 codes. Look for the updated guidelines on the Autism pages within Provider Secured Services. To find them, visit bcbsm.com/providers and log in to Provider Secured Services. Then:

- To access the BCN Autism page:
 1. Click *BCN Provider Publications and Resources* (on the right).
 2. Click *Autism* (in the left navigation).
 3. Click *Applied Behavior Analysis Billing Guidelines and Procedure Codes* under the "Autism provider resource materials" heading.
- To access the Blue Cross Autism page:
 4. Click *BCBSM Provider Publications and Resources* (on the right).
 5. Click *Clinical Criteria & Resources* (in the left navigation).
 6. Scroll down and click *Autism* (in the Resources section).
 7. Click *Applied Behavior Analysis Billing Guidelines and Procedure Codes* under the "Autism provider resource materials" heading.

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2018 American Medical Association. All rights reserved.



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Best Practices

Colorectal cancer screening

An interview with Dr. Robert Carlson, Hastings, MI

How do you make sure your eligible patients get screened for colorectal cancer? Do you have a system in place to follow up?

It starts with our team understanding the importance of all preventive measures, including colorectal cancer screening. I have always been excited about this measure as it gives us a chance to significantly impact cancer in our community.

We recognize that all patients over 50 need an annual preventive exam. We measure ourselves on how many patients get the exam completed. More than 95% of patients come in for this exam, which sets the stage for a discussion on their colorectal cancer screening. Before the age of 50, we're setting the expectation that they will get a colonoscopy or other screening for colon cancer.

We have an electronic medical record that allows us to track discrete pieces of information. Our process is a very conscientious effort to make sure all patients are screened in a timely way.

What kind of patient education do you provide on colorectal cancer screening?

I share information with patients on websites, such as WebMD or Choosing Wisely or invite them to seek out different sites about colon cancer and colonoscopy. When we empower patients to learn about things themselves, they usually make the right decision.

I also explain that some tests have false positives and if they opt for the ColoGuard™ or fecal immunochemical test, they may still have to have a colonoscopy.



Dr. Carlson with patient, Gerald Bachelder

What are some challenges to getting patients to comply and how do you overcome them?

We give patients three choices – the preferred choice of colonoscopy, the ColoGuard test for those concerned about the procedure or preparation, or a fecal immunochemical test. If someone is pushing back, I dig in and ask why they're afraid. Two of the options for colorectal cancer screening are easy to do.

Fear is a huge driver. We need to be respectful of their choices. Whether it's immunizations or colonoscopy, ask them in a caring way why they're reluctant.

When transportation is a challenge, our care managers have driven patients to their colonoscopy procedures.

The challenge is to first stay true to do what you know is right. Get patients in for their annual exam and be ready to have strategies around the barriers to getting the screening done. Be patient, persistent and consistent. Personalize the screening measure when applicable to the patient's life and relationships. Patients value their kids and grandkids, especially if there might be something that can impact generations.

And use the relationship you have established with the patient to get the screening completed.

Please see [Colorectal cancer](#), continued on Page 24

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MQIC offers guidance on managing acute low back pain in adults

Many adults will experience low back pain at some point in their life. More than 25% of adults say they've experienced back pain in the past three months, according to the National Institute of Neurological Disorders and Stroke. Most of the time, low back pain is easily treated or will resolve on its own.

Imaging for acute low back pain isn't recommended within the first six weeks, unless certain "red flags," such as infection, spinal fracture and other medical conditions, are present. A conservative approach is generally considered preferable.

In 2018, the Michigan Quality Improvement Consortium published a **guideline** for adults with low back pain or back-related leg symptoms for more than six weeks. Following are some of the focus areas recommended by the consortium when treating patients with low back pain:

- Offer reassurance.
- Perform a physical exam.
- Encourage patients to stay activity within the limits permitted by pain.
- Refer to non-invasive therapy if the patient experiences persistent disability at two weeks.
- Prescribe medication on a time-contingent basis, not a pain-contingent basis.

New HEDIS blood pressure measure specifications eliminate need for medical record reviews

The controlling high blood pressure HEDIS® measure has been updated to assess patients ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90) during the last reading of the year.

Previous CBP HEDIS, or Healthcare Effectiveness Data and Information Set, specifications required medical record reviews to determine if a patient's blood pressure was under control. Now, Blood Pressure CPT Category II results codes will determine compliance.

When you add the correct CPT Category II and ICD-10 codes to your claims, you won't need to include medical records for confirmation. This optimizes time and reduces record-keeping for providers.

To learn more about claims coding to reduce medical record reviews and other measure changes, **view the CBP tip sheet**. Questions about HEDIS compliance? Go to bcbsm.com/providers for additional resources.

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

Colorectal cancer, *continued from Page 24*

Do you have anything else to add?

We have some strategic relationships with GI specialists. If a patient hasn't scheduled the appointment, we call the patient. If we have a collaborative relationship with a particular specialist, he or she calls us to let us know if the patient has scheduled the appointment. We're in a constant feedback loop.

There are certain things I'm less intense about but, in my humble opinion, there's no reason not to do this screening. Every person in our office understands that we don't take no for answer.

We get beyond the no for those who don't want to do it. My goal for everything we're being measured on is 100 percent. You hit what you aim for. That's what our patients pay for and that's what we want to deliver.

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We've added the asthma medication management measure to the Performance Recognition Program

The Healthcare Effectiveness Data and Information Set, or HEDIS®, uses the Medication Management for People with Asthma measure to evaluate adherence to asthma controller medications. The MMA measure is used to determine the adherence rate for each Blue Care Network commercial member ages 5 to 85 who is identified as having persistent asthma and fills an asthma controller medication during the measurement year. This is reported as the proportion of days covered, or PDC, with an adherence threshold of 75%.

Currently, only about half of BCN members identified as having persistent asthma through the MMA measure achieve a PDC of 75% or greater. Recognizing the impact of improving member adherence to their controller asthma medications, we've added the MMA measure to the 2019 BCN Performance Recognition Program. For every commercial member reaching at least 75% adherence to their asthma controller medications during the entire year the member's primary care physician will receive a \$50 payout as part of the Performance Recognition Program. Table 1 provides a list of asthma controller medications used to calculate adherence for the MMA measure.

Table 1: Asthma controller medications used to calculate adherence in MMA measure

Description	Prescriptions	
Antibody inhibitors	<ul style="list-style-type: none"> Xolair® (Omalizumab) 	
Anti-interleukin-5	<ul style="list-style-type: none"> Nucala® (Mepolizumab) 	<ul style="list-style-type: none"> Cinqair® Reslizumab
Inhaled steroid combinations	<ul style="list-style-type: none"> Symbicort® (Budesonide-Formoterol) Advair® (Fluticasone-Salmeterol) 	<ul style="list-style-type: none"> Breo Ellipta® (Fluticasone-Vilanterol) Dulera® (Mometasone)
Inhaled corticosteroids	<ul style="list-style-type: none"> QVAR® RediHaler (beclomethasone) Arnuity® Ellipta®; Flovent® Diskus®; Flovent® HFA (Fluticasone) 	<ul style="list-style-type: none"> Pulmicort Flexhaler®; Pulmicort solution (Budesonide) Asmanex® (Mometasone)
Leukotriene modifiers	<ul style="list-style-type: none"> Singulair® (Montelukast) 	<ul style="list-style-type: none"> Accolate® (Zafirlukast) Zyflo (Zileuton)
Methylxanthines	<ul style="list-style-type: none"> Theo-24 (Theophylline) 	

Patient education is an important factor in increasing compliance and helping patients manage their asthma. Michigan has a significantly higher prevalence of current asthma at 10.9% compared with the national prevalence of 9.3%, according to the 2016 Michigan Behavioral Risk Factor Survey.

Evidence-based guidelines recommend inhaled corticosteroids, or ICS, the preferred first-line therapy for patients with persistent asthma. Leukotriene antagonists, or LTRAs, are recommended as an alternate or add-on medication. Using a combination of ICS and long-acting beta agonists is recommended if asthma is uncontrolled with ICS and LTRAs, separately or in combination. Despite the availability of effective controller therapy, underuse of controller medication in asthma is common and contributes to exacerbations and hospitalizations.

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BCN oncology management program begins August 1

As announced in the previous issue of **BCN Provider News** on Page 26, AIM Specialty Health® will manage medical oncology and supportive care drugs for BCN HMOSM (commercial) members beginning Aug. 1, 2019. These medications must receive authorization from AIM.

Providers can obtain authorization by going to the **AIM ProviderPortalSM** or by calling AIM at 1-800-728-8008, beginning July 15, 2019, for services on or after Aug. 1, 2019.

This new oncology management program recognizes the value of AIM Cancer Treatment Pathways, which cover more than 80 clinical scenarios. Using these clinical pathways, when appropriate, can improve patient-centered, evidence-based cancer care.

Ordering physicians can earn enhanced reimbursement

When AIM Pathways are prescribed, the ordering physician can earn enhanced reimbursement by billing specific S-codes to BCN. AIM's authorization will include information about the S-codes for those eligible for reimbursement. The reimbursement rate is included in the BCN professional fee schedule. To obtain a copy of the fee schedule, contact your **provider consultant**.

- S0353 — Can be billed once at the onset of treatment
- S0354 — Can be billed no more than monthly for up to five months for an established patient

Patients currently being treated are grandfathered

BCN commercial members who are currently receiving medical oncology treatment prior to Aug. 1, 2019, won't need to obtain an authorization from AIM for six months. We're doing this to ensure that these members don't have an interruption in their care. If a patient's treatment changes during the six months, or if treatment continues beyond January 31, 2020, an authorization will be required.

Attend a webinar to learn more

Learn about the new medical oncology program and how to use the AIM ProviderPortal by attending a webinar intended for non-clinical provider staff.

To attend, simply 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.)

Webinars:

Thursday, July 11, 12 to 1 p.m.

Tuesday, July 30, 9 to 10 a.m.

Thursday, Aug. 22, 12 to 1 p.m.

Tuesday, Sept. 10, 9 to 10 a.m.

Resources

Here are some resources to help you learn more.

- The **ereferrals.bcbsm.com BCN AIM Managed Procedures webpage** includes **a list of medications managed by AIM (PDF)** and a **frequently asked questions** document.
- The **Blue Cross Oncology Management Program webpage** on the AIM website includes Cancer Treatment Pathways worksheets, including clinical details.
- Clinicians are encouraged to learn more at **aimspecialtyhealth.com/oncology** and to view a short video that describes the need for clinical pathways and how these were developed. Click on the link to the video and use AIMONCOLOGY as the password to view the video – **Clinician Overview – Medical Oncology Program video**, running time 11 minutes, 47 seconds.

The new BCN oncology management program is similar to the program implemented by Blue Cross for the UAW Retiree Medical Benefits Trust, or URMBT, non-Medicare members on Jan. 1, 2019. However, the list of medications requiring authorization is different between the two programs. Information about the URMBT program is available on the **Blue Cross AIM Managed Procedures webpage**.

Questions about the oncology management program can be directed to AIM's practice engagement team at **aimmedoncpe@aimspecialtyhealth.com**.

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Enhanced documents now available for Blue Cross and BCN commercial utilization management requirements for medical and pharmacy benefit drugs

To make sure you have the most up-to-date information on utilization management requirements for drugs covered under the medical and pharmacy benefits, we have developed comprehensive lists of requirements for medical specialty drugs and pharmacy benefit drugs for Blue Cross Blue Shield of Michigan's PPO and BCN HMOSM commercial members. These lists are typically updated monthly.

Medical benefit drugs

This list identifies medical drugs targeted in the prior authorization and site of care programs and includes the following information about them:

- Medical necessity criteria
- Quantity limits
- Step therapy requirements

The medical specialty drug list is available to both providers and members, and can be found on the web in the following locations:

For providers:

- On the **Blue Cross Medical Benefit Drugs – Pharmacy** page within the ereferrals.bcbsm.com website. Look under the "For Blue Cross commercial members" heading.
- On the **BCN Medical Benefit Drugs – Pharmacy** page on the ereferrals.bcbsm.com website. Look under the "Authorization and medical necessity criteria resources" heading.
- Within Provider Secured Services. Log in, click *BCBSM Provider Publications and Resources* (on the right), and then click *Newsletters and Resources*. Click *Forms* and then click *Physician administered medications*. Finally, click *Requirements for drugs covered under the medical benefit – BCN HMO and Blue Cross PPO*.
- In the **medical policy, precertification and preauthorization router**. In the Keyword/Phrase field, enter "quantity limit" and click Search.

For members: At bcbsm.com, on the **pharmacy web page**, under the "Medical Coverage Drugs" heading.

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

Pharmacy benefit drugs

To improve efficiencies, we have developed a combined document of prior authorization and step therapy for pharmacy benefit drugs for Blue Cross PPO and BCN HMO commercial members. Previously, the lists of requirements were separate for Blue Cross PPO and BCN HMO.

This list is available to both providers and members, and can be found on the web in the following locations:

For providers:

At bcbsm.com, under Providers, click *Help* and then *Plan Documents and Forms*. Scroll down and click *More Pharmacy Services Forms*. Click *Prior authorization/Step therapy* under **Blue Cross Blue Shield of Michigan** or **Blue Care Network**. Open the **Prior Authorization and Step Therapy Guidelines PDF**.

For members: At bcbsm.com, on the pharmacy web page, under the "Pharmacy Coverage Drugs" heading

Please note that the utilization management requirements listed in these documents apply only to groups that are currently participating in the standard commercial prior authorization program for drugs administered under the medical benefit or pharmacy benefit. These changes **don't** apply to BCN AdvantageSM, Medicare Plus BlueSM PPO or Federal Employee Program[®] members.

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Medicare Part B medical specialty drug prior authorization list changing July 22

We're making changes to the Part B specialty prior authorization drug list for Medicare Plus BlueSM PPO and BCN AdvantageSM as follows:

- For dates of service on or after July 22, 2019, Darzalex[®] (J9145) will require prior authorization.
- Effective immediately, Myozyme[®] (J0220) is removed from the prior authorization list because it is no longer available in the U.S. market.

Please see the full article on [Page 11](#).

We've added Spravato to the prior authorization program for commercial members

Effective June 1, 2019, Spravato[™] (esketamine, HCPCS code J3490) was added to the Medical Drug Prior Authorization Program for BCN HMO and Blue Cross Blue Shield of Michigan's PPO commercial members. This applies to any members starting therapy on or after June 1.

The authorization requirement only applies to groups that are currently participating in the commercial Medical Drug Prior Authorization program for drugs administered under the medical benefit. These changes don't apply to BCN AdvantageSM, Medicare Plus BlueSM PPO or Federal Employee Program[®] members.

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

For a list of requirements related to drugs covered under the medical benefit, 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 Blue Cross (commercial) members".

Asthma, *continued from Page 25*

For tips on how to improve medication adherence:

- Log in to Provider Secured Services.
- Go to *BCN Provider Publications and Resources*.
- Click on *Clinical Quality Corner* under Resources.
- Click on *Medication Adherence Summary* under Pharmacy.

If you'd like to receive a list of your patients in the MMA measure that may benefit from additional adherence counseling, or if you have questions, e-mail us at RxQualityinbox@bcbsm.com.

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Adderall, Kenalog spray and oral inhalers will have new quantity limits starting Sept. 1

Blue Care Network will implement new quantity limits for Adderall®, Kenalog spray and oral inhalers, effective Sept. 1, 2019. See the full list of oral inhalers with quantity limits in the table below. This change only affects our commercial (non-Medicare) members who have BCN pharmacy benefits.

Our goal is to provide our members with safe, high-quality prescription drugs. We'll send letters in July to notify members who may be affected by these quantity limit changes. The letters encourage members to discuss treatment options with their physicians.

If necessary, you can request an override of the quantity limits for your patients. The request should include documentation stating that the amount prescribed is medically necessary.

To get a form for a quantity limit override, log in to Provider Secured Services at bcbsm.com or call the *Pharmacy Services Clinical Help Desk* at 1-800-437-3803.

Quantity limits for oral inhalers starting September 1, 2019

Drug name (generic name)	Strength	Quantity covered
Atrovent® HFA (ipratropium bromide)	All strengths	2 inhalers per 30 days
Incruse® Ellipta® (umeclidinium)	All strengths	1 inhaler per 30 days
Spiriva® Handihaler® (tiotropium bromide)	All strengths	1 inhaler per 30 days
Spriva® Respimat® (tiotropium)	All strengths	1 inhaler per 30 days
Combivent® (ipratropium bromide + albuterol sulfate)	All strengths	2 inhalers per 30 days
Brovana® (arformoterol)	All strengths	60 vials per 30 days
Perforomist® (formoterol)	All strengths	60 vials per 30 days
ProAir®/Ventolin® HFA (albuterol sulfate)	All strengths	4 inhalers per 30 days
ProAir Resplick® (albuterol sulfate)	All strengths	4 inhalers per 30 days
Proventil® HFA (albuterol sulfate)	All strengths	4 inhalers per 30 days
Serevent® (salmeterol xinafoate)	All strengths	1 inhaler per 30 days
Xopenex HFA® (levalbuterol)	All strengths	2 inhalers per 30 days
Levalbuterol Tartrate HFA (levalbuterol)	All strengths	2 inhalers per 30 days
Advair Diskus® (fluticasone propionate + salmeterol)	All strengths	1 inhaler per 30 days
Advair® HFA (fluticasone propionate + salmeterol)	All strengths	1 inhaler per 30 days
Symbicort® (budesonide + formoterol)	All strengths	1 inhaler per 30 days
Aerospan® (flunisolide)	All strengths	2 inhalers per 30 days
Arnuity® Ellipta® (fluticasone furoate)	All strengths	1 inhaler per 30 days
Asmanex® HFA (mometasone furoate)	All strengths	1 inhaler per 30 days
Asmanex® Twisthaler (mometasone furoate)	All strengths	1 inhaler per 30 days
Flovent® Diskus (fluticasone propionate)	All strengths	2 inhalers per 30 days
Flovent® HFA (fluticasone propionate)	All strengths	2 inhalers per 30 days
Pulmicort® Flexhaler™ (budesonide)	All strengths	2 inhalers per 30 days
Qvar™ RediHaler™ (beclomethasone dipropionate)	All strengths	2 inhalers per 30 days

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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 into 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*SM 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.

Colonoscopy billing

We continue to get questions about appropriate billing for colonoscopies, especially when the screening becomes diagnostic.

For most BCN commercial members, screening colonoscopies and the associated services should be covered without cost sharing. This is one of the preventive services that was mandated for full coverage under the Affordable Care Act.

If a screening colonoscopy is performed and no other treatment is required, such as biopsy or polyp removal, then you should report the appropriate screening colonoscopy procedure code. There are two codes, G0105 and G0121. One is for a patient at normal risk and the other is for a patient at high risk, but both indicate a screening colonoscopy. While there is not a specific diagnostic requirement, it should be reported with the screening diagnosis code as well. Further, any ancillary services, such as anesthesia, should be reported with the screening diagnosis code to indicate the purpose of those services.

If the patient requires other services and the screening colonoscopy becomes diagnostic, it requires a procedure code and diagnosis code combination to waive cost sharing. In this situation, you would report the appropriate procedure code to indicate the type of colonoscopy, such as a colonoscopy with a biopsy. In that case, the diagnosis would include as a primary diagnosis, such as Z12.11 or Z12.12, which indicates the diagnosis is screening for a malignant neoplasm of the colon.

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More than a million people in the United States have congestive heart failure. It's the most common diagnosis in hospitalized patients over the age of 65. One in nine deaths has heart failure as a contributing cause.

Once CHF is diagnosed, it's considered a chronic condition and should be evaluated and documented on a yearly basis. When patients with CHF are treated appropriately, however, they may experience minimal or no symptoms. In rare circumstances where it's due to reversible causes, such as infection, arrhythmia or thyrotoxicosis, CHF may resolve after the underlying cause is treated.

Heart failure is often documented as compensated, decompensated or acute exacerbation. These terms can be confusing to coders, so please refer to these definitions for clarification:

- Compensated CHF indicates that because of ongoing treatment, the patient's symptoms are controlled and they have no overt features of CHF, such as shortness of breath, lower extremity edema, fluid retention or pulmonary edema. They still, however, carry the diagnosis of CHF.
- Decompensated CHF or acute exacerbation of CHF indicates an acute flare-up of CHF symptoms. This requires intensification of treatment, often in an inpatient setting. When heart failure is documented as decompensated or exacerbated, it should be coded as acute.

Documentation tips

Document congestive heart failure to the highest level of specificity, using all applicable descriptors. The descriptors include:

- Acuity — acute, chronic or acute on chronic
- Type —
 - Systolic — heart failure with reduced ejection fraction HFrEF
 - Diastolic — heart failure with preserved ejection fraction HFpEF
 - Combined systolic and diastolic
- Cause — if known, using terms that clearly show cause and effect, such as "associated with," "due to," "secondary to," or "hypertensive"
- Status — stable, worsening, improved, compensated, exacerbated, decompensated

Don't use history of to describe CHF in patients who are asymptomatic. As explained above, except in rare circumstances, CHF is a lifelong diagnosis, while history of implies that the condition has resolved.

Documentation of congestive heart failure should also include:

Clinical signs and symptoms

- Lower extremity edema
- Shortness of breath
- Fatigue

Diagnostic findings

- Echocardiogram showing abnormal ventricular function
- Elevated B-type natriuretic peptide, or BNP
- Chest X-ray or CT scan showing pulmonary vascular congestion or pulmonary edema

Treatment

- Lifestyle modification such as low salt diet, fluid restriction or weight loss as indicated
- Medications such as diuretics, beta blockers, ACE inhibitors or ARBs

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We'll continue to update clinical edits to comply with current coding guidelines

Blue Care Network continues to review and modify clinical edits. With these updates, you may notice that claims may receive different edits than they have in the past. And others that previously received edits may not receive any. We take pride in staying up-to-date on current coding standards and national coding guidelines in addition to recommendations from professional societies.

You may notice new edits related to those that review procedure codes to the reported diagnoses. Diagnosis codes should be coded appropriately and to the highest level of specificity to support the service performed. If you do not agree with the clinical edit, please follow our clinical editing appeal process.

- Visit bcbsm.com/providers.
- Log in to Provider Secured Services.
- Click *BCN Provider Publications and Resources* on the right.
- Click *Billing/Claims* in the left navigation.
- Click *Appealing a BCN clinical editing denial*, under the Clinical Editing Resources heading.

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:

- Hospital and observation evaluation and management services
- Behavioral health evaluation and management codes



Coding Corner, *continued from Page 31*

Coding tips

Heart failure classifies to ICD-10 code category I50.XX. The fourth character specifies the type of heart failure, and the fifth character specifies the acuity of heart failure.

Examples of heart failure coding are shown in the chart below:

Condition	ICD-10 code
Left ventricular failure, unspecified	I50.1
Unspecified, systolic congestive heart failure	I50.20
Acute systolic congestive heart failure	I50.21
Chronic systolic congestive heart failure	I50.22
Acute on chronic systolic congestive heart failure	I50.23
Unspecified, diastolic congestive heart failure	I50.30
Chronic combined systolic and diastolic congestive heart failure	I50.42
Acute on chronic combined systolic and diastolic congestive heart failure	I50.43
Heart failure, unspecified	I50.9

Sources:

- webmd.com
- 2018 ICD-10-CM Professional for Physicians

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More BCN questionnaires open in e-referral for certain procedures

Questionnaires now open in the e-referral system for BCN authorization requests for the procedures listed below, which already require authorization. The questionnaires open for both BCN HMOSM (commercial) and BCN AdvantageSM requests unless otherwise noted. This was effective June 23.

Service	Age	Procedure codes
Artificial heart, total	Adult and pediatric	*0051T, *0052T, *0053T, *33927, *33928, *33929, *33992 and *33993
Bariatric surgery (for BCN Advantage)	Adult	*43644, *43645, *43659, *43770, *43771, *43772, *43773, *43774, *43775, *43842, *43843, *43845, *43846, *43847, *43848, *43886, *43887, *43888 and *44130
Biofeedback, non-behavioral health (for BCN Advantage)	Adult	*90901 and *90911 (for select diagnoses)
Biofeedback, non-behavioral health (for BCN HMO)	Adult and pediatric	*90901 and *90911 (for select diagnoses)
Breast implant management	Adult	*19325, *19328 and *19330
Breast reconstruction	Adult	*11920, *11921, *11922, *19316, *19324, *19340, *19342, *19350, *19355, *19357, *19361, *19364, *19366, *19367, *19368, *19369, *19370, *19380, *19396, S2066, S2067 and S2068
Breast reduction, adolescent	Pediatric	*19318
Breast reduction, adult	Adult	*19318
Chemical peels	Adult and pediatric	*15788, *15789, *15792 and *17362
Cosmetic or reconstructive surgery	Adult and pediatric	*0479T, *0480T, *0491T, *0492T, *11950, *11951, *11952, *11954, *15775, 15776, *15780, *15781, *15782, *15783, *15786, *15787, *15820, *15821, *15824, *15825, *15826, *15828, *15829, *15876, *15877, *15878, *15879, *17340, *17380, *21083, *21087, *21172, *21275, *21280, *21282, *30620, *36468, *36469, *54660, *56620, *67909, *67911, G0429, Q2026, Q4100 and S0800
Dental anesthesia or repair of trauma to natural teeth	Adult and pediatric	*00170 and *41899
Enteral nutrition	Adult and pediatric	B4034, B4035, B4036, B4081, B4082, B4083, B4087, B4088, B4102, B4103, B4104, B4105, B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162, B9002, B9998, S9341, S9342 and S9343
Excess skin removal	Adult	*15832, *15833, *15834, *15835, *15836, *15837, *15838 and *15839
Mastectomy for gynecomastia	Adult	*19300
Oral surgery	Adult and pediatric	*40525, *40527, *40700, *40701, *40702, *40720, *40761, *40808, *40810, *40812, *40816, *40818, *40840, *40842, *40843, *40844, *40845, *40899, *41800, *41805, *41806, *41820, *41821, *41822, *41823, *41825, *41826, *41827, *41828, *41830, *41850, *41870, *41872, *41874, *42200, *42210, *42215, *42220 and *42225

Please see [BCN Questionnaires](#), continued on Page 34

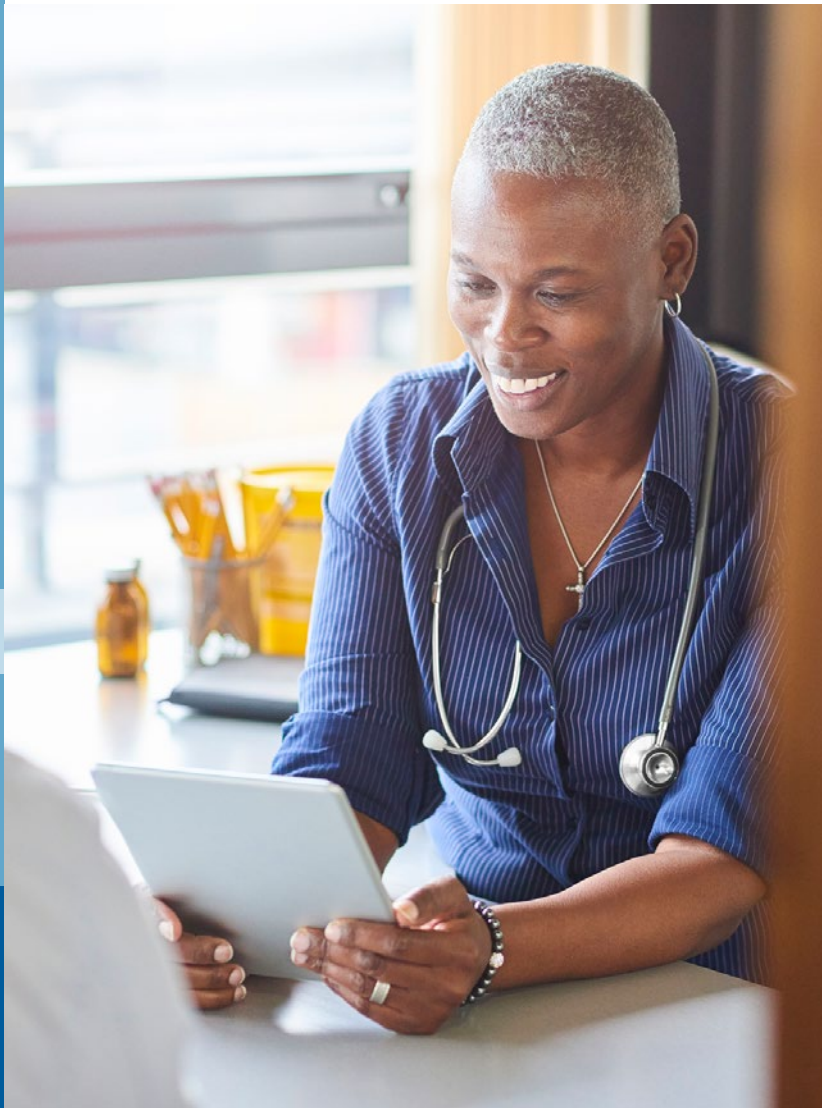
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Orthognathic surgery	Adult and pediatric	*21085, *21120, *21121, *21122, *21123, *21125, *21127, *21141, *21142, *21143, *21144, *21145, *21146, *21147, *21150, *21151, *21154, *21155, *21159, *21160, *21188, *21193, *21194, *21195, *21196, *21198, *21199, *21206, *21208, *21209, *21210, *21215, *21230, *21235, *21244, *21245, *21246, *21247, *21255, *21270, *21295 and *21296
Prostatic urethral lift	Adult	*52441 and *52442
Spine surgery, minimally invasive	Adult	G0276
Temporomandibular joint surgery	Adult and pediatric	*20605, *20606, *21010, *21050, *21060, *21070, *21240, *21242, *21243, *21490 and *29804

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Preview questionnaires will be available online

We'll make preview questionnaires available at ereferrals. bcbsm.com before June 23. To find them, click BCN, then click **Authorization Requirements & Criteria**. Next, look in the "Authorization criteria and preview questionnaires" section.

The preview questionnaires will show what questions you'll need to answer in the e-referral system so you can prepare your answers ahead of time.

Medical policies will be available online

We'll also post links to the medical policies related to these procedures on the Authorization Requirements & Criteria page.

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



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Updated authorization criteria and e-referral questionnaire for ethmoidectomy

We've made updates to the ethmoidectomy authorization criteria and questionnaire in the e-referral system.

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

- BCN HMOSM
- BCN AdvantageSM
- Medicare Plus BlueSM PPO

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

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

The preview questionnaire will show what questions you'll need to answer in the e-referral system so you can prepare your answers ahead of time.

Reminder: Submit BCN authorization requests for all therapy and physical medicine visits to eviCore

Remember to 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 HMOSM (commercial) and BCN AdvantageSM members.

Refer to the article in the **May-June issue** for additional details.

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We made some changes in response to our provider survey

We've identified areas for improvement and made some changes in 2019 related to our utilization review processes in response to recent survey results.

We conducted an online provider satisfaction survey in 2018 to obtain provider feedback related to utilization review. The survey consisted of a series of questions designed to provide information about physician and office staff knowledge, experience, use and satisfaction with utilization management processes. This information assisted us in determining necessary service improvements.

To gather insight into awareness and perception of the programs relating to provider satisfaction, the health plan analyzed the data and, while the results were favorable, the findings identified opportunities in some areas.

Please see [Provider survey](#), continued on Page 3

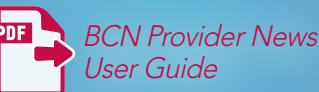
We're making some changes to increase security on our Provider Secured Services, effective Sept. 12

Your online security is important to us. So we're making changes to our Provider Secured Services to help make your information and transactions more secure.

Here are some changes effective Sept. 12.

- Your user ID will be deactivated after 90 days of inactivity.
- We'll maintain a password history of six passwords. When you change your password, it must be different from your previous six passwords.
- Password length is changing to a minimum of eight characters.

Please see [Provider Secured Services](#), continued on Page 2



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Provider Secured Services, *continued from Page 1*

- New passwords must contain at least one:
 - » Number
 - » Upper case letter
 - » Lower case letter
 - » Special character
- Your password cannot be the same as your user ID.
- You'll need to change your password every 60 days. The system will prompt you when it's time to do so.

Signing in after Sept. 12

Users will be able to sign on with their current passwords after we make our security changes.

How to restore access if your user ID has been disabled

Your user ID will be disabled if you enter your password incorrectly three times. To re-enable your ID, you must answer your security questions accurately. If you answer them wrong three times, the account will be locked and you'll need to call the Web Support Help Desk to unlock your ID.

You can reach the Web Support Help Desk at 1-877-258-3932, Monday-Friday between 8 a.m. and 8 p.m. Eastern time.

If your account has been deactivated

We'll have a new process for restoring access to an account that's been deactivated.

Complete and fax the **Provider Secured Services ID Reassignment** form to us. Directions for faxing are on the form.

Questions?

If you have questions or have trouble logging in, call the Web Support Help Desk at the above number.

Editor

Cindy Palese
bcnprovidernews@bcbsm.com

Provider Communications

Catherine Vera-Burgos, Manager
 Elizabeth Donoghue Colvin
 Jennifer Fry
 Tracy Petipren

Market Communications Publications

Colleen McIver

Contributors

William Beecroft, M.D.; Camillya Christian-Smith; Laura Cornish; Pharm. D; Amy Frady; Jody Gembarski; Clare Horvath; Joshua McCullough; Jacquelyn Redding

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Providers: List top locations when updating your information with CAQH

Blue Cross Blue Shield of Michigan and Blue Care Network have updated our systems in collaboration with CAQH that allows providers to list the active locations where you see members.

Follow these guidelines when updating your information in CAQH:

- Make sure you list accurate locations where you're seeing members on a regular basis.
- Indicate the frequency of your practice servicing location to show how many days you practice at each location (for example, weekly, if you practice there at least once a week.)

Limiting your addresses to three active locations for directory publications purposes won't affect claims processing since Blue Cross and BCN services aren't address-specific. Doing so will help direct members to the appropriate locations when seeking services.

As your location patterns change you'll still be able to change the initial addresses.

If you have any questions about this change, contact Provider Enrollment Customer Service at 1-800-822-2761.

Provider survey, *continued from Page 1*

Of the overall satisfaction results, there were four top scores:

- Satisfaction with BCN's online e-referral process
- Finding BCN medical policies online
- BCN's medical director explained remaining appeal options following a denied peer-to-peer discussion
- Timeliness of inpatient admission decisions according to the physician

The bottom two scores were:

- Timeliness of admission review decisions
- Ease of understanding the appeal instructions in the denial notification letter and in BCN's provider manual for inpatient admission appeals

To improve the identified opportunities, we performed the following activities in 2019:

- Conducted on-site training with various facilities on how to use e-referral and manage authorizations efficiently

- Decreased turnaround times for more clinical reviews and explored opportunities to auto-approve certain diagnosis codes for acute admissions
- Educated providers on how to attach clinical information on e-referral submissions. We are now looking at ways to create more questionnaires to obtain clinical information during the submission process
- Reviewed terms associated with authorizations and referrals
- Reviewed the peer-to-peer process for opportunities to improve the experience
- Explored options with the system vendor for better indicators to show notifications to providers when the plan communicates to them through e-referral

Your feedback has provided valuable information about your experience with us and guides us in our efforts to improve our services.

About the survey

The Physician Satisfaction survey was available electronically on our website from September through December 2018. A total of 750 providers responded to the online survey. Two participants were selected from the total participants to receive \$250 gift cards. Your responses help us evaluate our efforts and determine other improvements to enhance our care management processes. The survey questions were designed to gather information about how you use care management services and to measure your satisfaction with each of the functional units within Care Management.

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We're changing the categorization process for physical therapy

We're changing the categorization process for physical therapy. Beginning January 2020, we'll use the same categories for Blue Care Network and BCN AdvantageSM as we do for Blue Cross Blue Shield of Michigan and Medicare Plus BlueSM.

Physical therapists will continue to be assigned to one of three tiers, or categories: A, B or C. The categories are based on physical therapy claims for all four networks. We hope that having one assigned category covering all Blue Cross and BCN networks will make it easier for you to manage therapy requests.

eviCore healthcare, an independent company that manages authorizations for us, will complete the analysis of the categorization process. They'll also generate the Provider Performance Summaries, or profile reports, based on paid claims.

Due to the upcoming changes in the categorization process, you won't receive profile reports that were originally scheduled for July 2019 for Blue Cross and for November 2019 for BCN. You'll maintain your current provider categories and current program requirements until you receive the new combined categories.

eviCore plans to send the new combined categorizations to providers in February 2020. You'll still have 15 days from receipt of your categorization report to request reconsideration. Going forward, the combined profile reports will be available in February and August, with notifications from eviCore going out to providers in late January and July.

We'll include additional information about the categorization merger in the upcoming months.

How can we improve our online tools?

Blue Cross Blue Shield of Michigan and Blue Care Network want to know what we can do to improve our online tools to make them easier and more useful for you – our partner providers. We specifically want to know about your experience using online provider tools and services, including the tools available when you log in to our secure provider website at bcbsm.com. Can you spare eight minutes to share your thoughts? Your input will help us focus future improvements where they can be most helpful to you.

Take survey now.

This survey will be available through the end of September 2019. Thank you for sharing your opinions. Your responses will be confidential.

Sign up for additional training webinars

Provider Experience is continuing its series of training webinars for health care providers and staff. The webinars are designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

Here's how to register for upcoming training webinars:

Webinar name	Date and time	Registration
Blues 201 – AIM Specialty Health®	Tuesday, Sept. 24, 10 to 11 a.m.	Click here to register
Blues 201 – AIM Specialty Health®	Thursday, Sept. 26, 1:30 to 2:30 p.m.	Click here to register

The October sessions focus on the claims and appeals process for Blue Cross Blue Shield of Michigan, Blue Care Network, Medicare Plus Blue and BCN Advantage facility and professional claims.

Webinar name	Date and time	Registration
Blues 201 – Claims Appeal Overview	Tuesday, October 15, 9:30 to 11:30 a.m.	Click here to register
Blues 201 – Claims Appeal Overview	Tuesday, October 15, 1:30 to 3:30 p.m.	Click here to register
Blues 201 – Claims Appeal Overview	Tuesday, October 22, 9:30 to 11:30 a.m.	Click here to register
Blues 201 – Claims Appeal Overview	Tuesday, October 22, 1 to 2 p.m.	Click here to register

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Reminder: Update your *Provider Authorization* form when you have changes

Blue Cross Blue Shield of Michigan is dedicated to safeguarding the protected health information of our members. These safeguards include the completion of a *Trading Partner Agreement and Provider Authorization* form as part of the electronic data interchange setup process. All EDI trading partners must complete a *TPA and Provider Authorization* form before exchanging any PHI with Blue Cross.

Terms of the TPA require you to notify Blue Cross of any changes in your trading partner information. If you switch service bureaus (clearinghouses), software vendors, billing services or the recipient for your 835 files, you must update your Provider Authorization form. Updating the form ensures information is routed to the appropriate destination. No update is needed when your submitter and trading partner IDs don't change.

You should review your provider authorization information if you've:

- Joined a new group practice
- Left a group practice and now bill using your own NPI
- Hired a new billing service
- Started submitting claims through a clearinghouse or you've changed clearinghouses
- Decided you no longer want to receive 835 remittance files
- Selected a new destination for your 835s

You must update your *Provider Authorization* form if you'll be sending claims using a different submitter ID or routing your 835s to a different unique receiver or trading partner ID. To make changes to your EDI setup, visit bcbsm.com/providers and follow these steps:

- Click on *Quick Links*.
- Click on *Electronic Connectivity (EDI)*.
- Click on *How to use EDI to exchange information with us electronically*.
- Click on *Update your Provider Authorization Form* under EDI Agreements.

If you have any questions about EDI enrollment, contact the EDI Help Desk at 1-800-542-0945. For assistance with *TPA and Provider Authorization* form, select the *TPA* option.

How to submit authorization request for transgender services for University of Michigan employees

In the last issue of *BCN Provider News* we told you we've expanded BCN medical coverage for transgender employees of the University of Michigan, effective July 1. This applies to members covered by U-M Premier Care and GradCare plans.

You can identify BCN members who are eligible for these services by their group number, which is 00124316. The number is on the front of their University of Michigan-branded ID cards. As always, be sure to check web-DENIS for benefits and eligibility.

Submitting authorization requests

These new services require authorization. Use the e-referral system to submit authorization requests.

One of the following questionnaires will open in the e-referral system when you submit these authorization requests:

- Face and neck hair removal
- Facial feminization surgery/chondrolaryngoplasty

Preview questionnaires are available on the ereferrals.bcbsm.com website, on BCN's **Authorization Requirements & Criteria** page. We encourage you to use these preview questionnaires to prepare your answers in advance.

For more details, see the University of Michigan **fact sheet on health plan coverage for gender-affirming services**.

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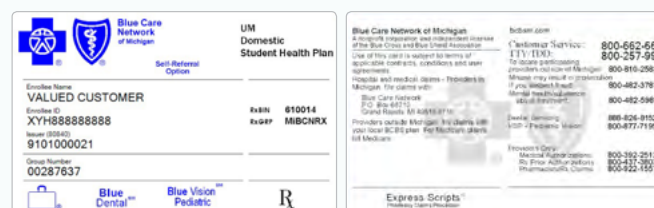
Blue Care Network offers new University of Michigan student health plan

Blue Care Network is offering two new plans for University of Michigan students and their eligible dependents. The U-M Student Health Plan for domestic students was effective Aug. 24. The plan for international students is effective Sept. 1. Both use the self-referral option where members can seek care in or out of network without a referral.

We assign a University Health Service primary care physician to domestic students on the Ann Arbor campus. We assign all other students to a primary care physician based on proximity to their ZIP code. Any medical care received using an out-of-network provider will result in a higher cost share for the student.

These plans also include a unique pharmacy benefit that has minimal authorization requirements for most covered drugs (international plan only), adult dental coverage and vision-exam-only coverage. Vision exam coverage is administered through the medical benefit and not a stand-alone vision product.

Students with this plan will receive a BCN member ID card shown here. You can check the member's eligibility on web-DENIS, by calling Provider Inquiry or through an electronic 270/271 transaction.



Order Blue Cross mobile app supplies for your office

Our Blue Cross mobile app kit helps you spread the word to patients about the conveniences of using the Blue Cross mobile app.

What's in the kit

The kit includes postcards you can hand out to patients, an acrylic stand for the postcards and a poster to display in your lobby or exam rooms. If you already have a kit and need to reorder posters or postcards separately, you can do that, too.

What's great about the app

The app easily connects Blue Cross Blue Shield of Michigan and Blue Care Network members securely to their personal online account. Right there in your office, they can:

- Access their virtual ID card and share it with you
- Check copayment amounts
- Help your medical assistants or nursing staff verify current prescriptions (if they have pharmacy coverage)

The app also gives patients the tools they need — instead of calling you — when they need to:

- Find network doctors or specialists
- Verify the status of referrals and authorizations
- Check what's covered
- Review their claims before paying your bill

Order your supplies today and start spreading the word.

See related article, "Help members share their Blue Cross ID cards through our mobile app," about the mobile app in the **July-August issue**, Page 7.



Mobile app supplies



We're waiving cost share for certain drugs for BCN Advantage Prestige members

BCN AdvantageSM is waiving the member cost share for certain drugs classes for BCN Advantage HMO-POS Prestige members diagnosed with coronary artery disease and congestive heart failure. This will be effective Jan. 1, 2020.

This initiative is a continuation of a pilot with the Centers for Medicare & Medicaid Services that we began in 2019 as part of the CMS' value-based insurance design efforts. The waiver of cost share for drugs associated with congestive heart failure is a new initiative.

We'll identify members for the program based on diagnosis and mail a letter informing members that we've enrolled them in a care management program. Members can opt out of care management, but they'll still receive their eligible prescriptions with no cost share.

For coronary artery disease, we're waiving the cost share for four drug classes: antiplatelet drugs, statins, ACE/ARBs and beta-blockers for members diagnosed under one of 59 ICD-10 codes.

For congestive heart failure, we're waiving the cost share for these drug classes: ACE/ARBs, beta-blockers, diuretics, vasodilators and some other drugs for members diagnosed under one of 24 ICD-10 codes.

About the VBID program

Through the Value-Based Insurance Design model, CMS is testing a broad array of complementary Medicare Advantage health plan innovations designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, and improve the coordination and efficiency of health care service delivery.

We're offering incentives to BCN Advantage Prestige members to participate in advance care planning

We're also piloting a program to promote advance care planning through the VBID program. As part of the medical record documentation, physicians must document whether a member has an advance directive. BCN AdvantageSM Prestige members who have an advance directive and complete an online program about end of life choices will receive a \$25 gift card.

We're working with WelvieSM, a vendor involved with some of our other health and wellness programs, to administer this program.

New advanced illness and frailty exclusions for HEDIS star measures

The National Committee for Quality Assurance now allows patients to be excluded from select HEDIS[®] star quality measures due to advanced illness and frailty. They acknowledge that measured services most likely would not benefit patients who are in declining health.

You can now submit claims with advanced illness and frailty codes to exclude patients who meet the criteria from select measures. Using these codes also reduces medical record requests for HEDIS data collection purposes.

For a description of the criteria and a convenient list with some of the appropriate HEDIS-approved billing codes, see the PDF below to view the *2019 HEDIS[®] Advanced Illness and Frailty Exclusions Guide*.

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



Advanced illness and frailty exclusions

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Process changes for the NOMNC and DENC forms affect skilled nursing facilities

We have changed the processes for completing the Notice of Medicare Non-Coverage form, known as the NOMNC, and the Detailed Explanation of Non-Coverage form, known as the DENC. Both forms are required by the Centers for Medicare & Medicaid Services for Medicare Advantage members.

Here's what's changing:

- naviHealth will now complete the NOMNC form and provide it to the skilled nursing facility prior to each member's termination of services. The skilled nursing facility will continue to be responsible for delivering the form to the member.
- When the member appeals the termination of services decision, naviHealth will complete the DENC form and provide it to the skilled nursing facility. The facility will continue to be responsible for delivering the form to the member. naviHealth will also obtain the medical records and the valid signed NOMNC from the skilled nursing facility and send these documents, along with the DENC to the Quality Improvement Organization.

We hope these changes will help you comply with these government regulations.

Additional information you need to know

It is crucial for skilled nursing facilities to deliver the NOMNC and DENC forms in a timely manner. Failure of the facility to deliver the NOMNC to the member may result in the provider being held financially liable for the continued services until two days after the member receives a valid notice, or until the effective date of the valid notice, whichever is later, per **CMS 100-04 Chapter 30 §260.3.6**. Providers may not balance bill the member for these services.

Background information

Skilled nursing facilities must notify Medicare beneficiaries about their right to appeal a termination of services decision by complying with the requirements for providing the NOMNC form, including the time frames for delivery.

A valid DENC must be provided to the Quality Improvement Organization when the QIO notifies the facility about an appeal of a termination of the skilled nursing facility services. The DENC must be issued to the member and returned to the QIO, along with the requested supporting documentation, within the established time frame set forth by the QIO in the notification to the provider of the appeal.

Copies of the NOMNC and DENC forms and instructions are available at the **CMS website**.

We're adding medications to the BCN Advantage and Medicare Plus Blue PPO Part B specialty prior authorization drug list

See article on **Page 29**.

We're discontinuing the Provider Distinction Awards program

Blue Cross Blue Shield of Michigan and BCN have administered the Provider Distinction Awards program since 2014. This program recognized providers for their contributions to our Medicare Advantage star quality ratings by placing plaques in provider practices honoring those practices achieving 80% or above on the Centers for Medicare & Medicaid Services' star quality measures.

Senior Health Services has decided to discontinue the Provider Distinction Awards program. This difficult decision was based on the amount of effort and costs associated with administering the program, particularly in light of the continuing growth in the number of program recipients and increasing complexity of data analysis.

Although we'll no longer distribute plaques to high-performing offices, we remain appreciative of the high-quality care that our physician practices deliver to our members, helping us achieve our annual star ratings.

Livanta LLC Replaces KEPRO as BFCC-QIO For Medicare regions 2, 3, 5, 7 and 9

Livanta LLC replaced KEPRO as BFCC-QIO (Beneficiary and Family Centered Care-Quality Improvement Organization) serving Medicare Regions 2, 3, 5, 7 and 9, effective June 8, 2019. Livanta’s contact information is listed below.

Note: All related Medicare Beneficiary Notices should be updated to include the phone number and the address listed below:

Livanta LLC
 9000 Junction Drive, Suite 10 1-888-524-9900
 Annapolis Junction, MD 20701 Fax: 1-833-868-4059

Please note that although Livanta now services the regions listed above, some regions will continue to be serviced by KEPRO. KEPRO will continue to retain beneficiary appeals and quality-of-care reviews on a regional basis for Medicare Regions 1, 4, 6,8 and 10. Information for Medicare regions is listed below.

Region	Address	Contact
1 (CT, ME, MA, NH, RI, VT)	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	1-888-319-8452 1-833-868-4055 (fax)
2 (NJ, NY, PR, VI)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	1-866-815-5440 1-833-868-4056 (fax)
3 (DE, DC, MD, PA, VA, WV)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	1-888-396-4646 1-833-868-4057 (fax)
4 (AL, FL, GA, KY, MS, NC, SC, TN)	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	1-888-317-0751 1-833-868-4058 (fax)
5 (IL, IN, MI, MN, OH, WI)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	1-888-524-9900 1-833-868-4059 (fax)
6 (AR, LA, NM, OK, TX)	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	1-888-315-0636 1-833-868-4060 (fax)
7 (IA, KS, MO, NE)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	1-888-755-5580 1-833-868-4061 (fax)
8 (CO, MT, ND, SD, UT, WY)	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	1-888-317-0891 1-833-868-4062 (fax)
9 (AZ, CA, HI, NV, Pacific Islands)	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	1-877-588-1123 1-833-868-4063 (fax)
10 (AK, ID, OR, WA)	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	1-888-305-6759 1-833-868-4064 (fax)

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Oncology management program effective for Medicare Advantage plans in January

A new utilization management program for medical oncology drugs for Medicare Plus BlueSM PPO and BCN AdvantageSM members will begin in January 2020. Providers will need to obtain authorizations from AIM Specialty Health[®] for some medical oncology and supportive care medications.

This program became effective for BCN HMOSM (commercial) members in August 2019. It includes the following benefits:

- Synchronization with Blue Cross Blue Shield of Michigan and Blue Care Network’s medical policies
- 24/7 access to the AIM *ProviderPortal*SM 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 — Receive enhanced reimbursement by choosing an AIM Cancer Treatment Pathway regimen, when clinically appropriate (to be billed using designated S-codes)

Providers can view a list of medications managed by AIM on our ereferrals.bcbsm.com website.

Join a webinar to learn more

Learn about the new medical oncology program and how to use the AIM *ProviderPortal*SM 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*. (The times below are all Eastern time. If the link opens for you in Pacific time, just save it to your calendar and it should automatically change to Eastern time.)

- | | | |
|---|--|--|
| Thursday, Oct. 24, 9 to 10 a.m. | Thursday, Dec. 12, 9 to 10 a.m. | Thursday, Jan. 9, 2020, 9 to 10 a.m. |
| Wednesday, Nov. 6, noon to 1 p.m. | Wednesday, Dec. 18, noon to 1 p.m. | Wednesday, Jan. 22, 2020, noon to 1 p.m. |
| Thursday, Nov. 21, 9 to 10 a.m. | | |

Clinicians are encouraged to learn more at aimspecialtyhealth.com/oncology and to view a short video that describes the need for clinical pathways and how these were developed. Click on the link to the video and use AIMONCOLOGY as the password to view the video – **Clinician Overview – Medical Oncology Program video**, running time 11 minutes, 47 seconds.

We’ll be providing additional information as we approach the effective date.

AIM Specialty Health[®] has started managing medical oncology and supportive care drugs for BCN HMOSM (commercial) members starting Aug. 1, 2019. If you missed the webinars, there’s one left on Tues., Sept. 10, from 9 to 10 a.m. Click [here](#) to register.



Important information about Medicare Advantage SNF post-payment audit and recovery process

For skilled nursing facilities, the post-payment audit and recovery process for Medicare Plus BlueSM PPO and BCN AdvantageSM members is changing. Here’s some information you need to know.

- HMS[®] will no longer perform post-payment SNF audits for dates of service on or after June 1, 2019, for Medicare Plus Blue claims.

Note: BCN Advantage SNF claims haven’t been subject to post-payment audits.

- As we communicated on April 5, 2019, naviHealth will authorize Resource Utilization Group, or RUG, levels during the patient’s stay (from preservice through discharge) for SNF admissions with dates of service **through Sept. 30, 2019**, for Medicare Plus Blue and BCN Advantage members. naviHealth will work with SNFs to ensure that the biller submits the appropriate RUG level for reimbursement.
- To align with Centers for Medicare & Medicaid Services payment methodology, naviHealth will authorize Patient-Driven Payment Model, or PDPM, levels during the patient’s stay (from preservice through discharge) for SNF admissions with service dates **on or after Oct. 1, 2019**, for Medicare Plus Blue and BCN Advantage members. naviHealth will work with SNFs to ensure the biller submits the appropriate PDPM level for reimbursement.
- On a quarterly basis, Blue Cross and BCN will review paid SNF claims to ensure that RUG or PDPM levels in the claims match the RUG or PDPM levels on the authorizations. If we find overpayments because RUG or PDPM levels on the claims don’t match RUG or PDPM levels on the authorizations, we will pursue payment recoveries as necessary.
- You won’t need to submit medical records during the quarterly post-payment review process.

Providers should work closely with naviHealth

To ensure that SNF claims reflect the authorized RUG or PDPM level, you should work closely with naviHealth throughout the patient’s stay.

- Prior to discharge, a naviHealth care coordinator will work with your biller to verify that the authorized RUG or PDPM levels are submitted for reimbursement.
- If you have questions about the RUG or PDPM level that naviHealth authorized, contact naviHealth during the patient’s stay.
- When you submit SNF Medicare Advantage claims, make sure the RUG or PDPM levels on the claims match the RUG or PDPM levels on the authorization connected to the stay.

Additional information

As a reminder, naviHealth started managing authorization requests for Medicare Plus Blue and BCN Advantage members admitted to post-acute care on or after June 1, 2019.

For details, see the **Post-acute care services: Frequently asked questions by providers** document.

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[Feedback](#)

We're offering in home bone density testing for BCN Advantage members

We're offering in-home bone density testing for BCN AdvantageSM members who meet certain criteria. This initiative is intended to help meet the Healthcare Effectiveness Data and Information Set, or HEDIS[®], measure, "Osteoporosis Management in Women Who Had a Fracture." Our member outreach does not include those within the MPSERS or URMBS groups.

We're using a vendor, MedXM, to attempt to schedule eligible members for an in-home bone mineral density test. If the member doesn't schedule the test through the vendor, we contact the primary care physician to complete the test. If the member or physician doesn't respond to MedXM's attempts to contact them, we reach out directly to the member to encourage them to complete the testing in their home with a Blue Cross Blue Shield of Michigan nurse or technician. (There are geographic limitations with in-home testing.)

If a MedXM technician or a Blue Cross nurse completes the bone mineral density screening, we'll send a copy of the results to both the member and her primary care physician.

Members who are covered under the HEDIS measure are women ages 67 to 85 who have recently had a fracture and have not had an osteoporosis medication prescribed or a bone mineral density screening within six months of the fracture date.

The 2019 Quality Rewards Program includes the Osteoporosis Management in Women Who Had a Fracture measure. The payout includes \$100 per service completed for each eligible member after the provider reaches an overall 78% quality score in this measure. The provider will earn the payout regardless of who completes the bone mineral density test, or if the member fills an approved osteoporosis prescription from her doctor.

For more information on osteoporosis, see the article titled, "Talk with your patients about osteoporosis," on **Page 13** of this issue.

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

We're calling select Medicare Part D members to discuss their medications

Blue Cross Blue Shield of Michigan pharmacists have been calling select Medicare Part D members through August to educate members about the importance of taking their medications as prescribed.

We've been contacting members who aren't taking their medications, based on claims data that shows their prescriptions haven't been filled.

Pharmacists will review medications related to the following star measures:

- Statin Therapy for Patients with Cardiovascular Disease
- Diabetes Care — Kidney Disease Monitoring
- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension (RAS antagonists)
- Medication Adherence for Cholesterol (Statins)
- Statin Use in Persons with Diabetes

This campaign is being conducted to support our pharmacy measures within the Centers for Medicare & Medicaid Services' star ratings system.

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Talk with your patients about osteoporosis

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

Starting the conversation

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

Checking on osteoporosis care

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

- HEDIS measures:
 - The Osteoporosis Management in Women Who Had a Fracture Measure. This measure assesses the percentage of women age 67 and older who had a bone mineral density test or treatment for osteoporosis within six months of a fracture.

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

For more information

The U.S. Preventive Services Task Force [webpage on osteoporosis](#) indicates that doctors should screen all women age 65 and older for osteoporosis.

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

You can also check out the Centers for Disease Control and Prevention's [Older Adult Falls](#) webpage.

See the article titled "We're offering in-home bone density testing for BCN Advantage members," on [Page 12](#).

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



Physicians should recommend physical activity to older patients

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

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

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

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

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

The following list includes some groups you can recommend to older patients looking for information about physical activity:

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

For more information contact:

National Institute on Aging Information Center
1-800-222-2225 (toll-free)
1-800-222-4225 (TTY/toll-free)

www.nia.nih.gov
www.nia.nih.gov/Go4Life





Save the date: You're invited to a Stars Premiere event near you

This year, Blue Cross Blue Shield of Michigan's Quality and Provider Education team and the Customer Experience team are inviting you to a special production called the Stars Premiere.

Don't miss this opportunity to join us to hear about and experience the latest and greatest ideas for providing exceptional patient experiences. The event will include information about the Medicare Star Rating System, HEDIS® measures, the Health Outcomes Survey and much more.

The Stars Premiere will be held in theaters around the state. When you attend, you can earn Continuing Education Unit credits and participate in a highly engaging 90 minutes of conversation and activities. We'll also include important information about closing gaps in care immediately following the event. Plus, you'll be able to take away tools and tips designed to help your office improve patient satisfaction.

What to expect

You'll be able to choose from either the 8 a.m. or 11 a.m. session, depending on your area of interest. There will be morning refreshments and movie popcorn. The schedule of events is:

- **8 a.m. session**
 - 8 to 9:30 a.m.: Patient experience and satisfaction session for physicians, office managers and other patient experience leaders
 - 9:30 to 10:45 a.m.: HEDIS, HOS, CAHPS and Stars update session for physicians, office managers and other staff who work to close gaps in care
 - **Note:** Arrive at 7:45 a.m. for refreshments.
- **11 a.m. session**
 - 11 a.m. to noon: ICD-10 for coders, billers and others interested in coding
 - **Note:** Arrive at 10:45 a.m. for refreshments.

Locations and registration

Tentative dates and locations (subject to change) are below. To register, click on the links. **Note:** You won't be able to register until Aug. 1. Each person must register.

- Tuesday, Sept. 17: Lansing, Celebration! Cinema Lansing & IMAX ; 200 E Edgewood Blvd
 - **8 a.m. session**
 - **11 a.m. session**
- Wednesday, Sept. 18: Grand Rapids, Celebration! Cinema Grand Rapids North and IMAX; 2121 Celebration Dr NE
 - **8 a.m. session**
 - **11 a.m. session**
- Thursday, Sept. 19: Traverse City, AMC Cherry Blossom 14; 3825 Marketplace Cir
 - **8 a.m. session**
 - **11 a.m. session**
- Tuesday, Sept. 24: Sterling Heights, AMC Forum 30; 44681 Mound Rd.
 - **8 a.m. session**
 - **11 a.m. session**
- Wednesday, Sept. 25: Saginaw (Frankenmuth) Address available upon registration
 - **8 a.m. session**
 - **11 a.m. session**
- Thursday, Sept. 26: Ann Arbor, GQT Quality 16; Quality 16, 3686 Jackson Rd.
 - **8 a.m. session**
 - **11 a.m. session**

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Blue Cross Coordinated Care to launch in 2020

Blue Cross Blue Shield of Michigan and Blue Care Network will launch a new approach to care management next year, called Blue Cross Coordinated Care.

The program takes a holistic, member-centric approach to help ensure the greatest effect on our members' overall health and the cost of care. It will be deployed across all lines of business, including Blue Cross PPO, BCN HMOSM, group and individual customers and Medicare Advantage members.

The program's goal is to support health care providers in their efforts to provide the best possible care for patients. It's not intended to replace the doctor-patient relationship in any way. Keep in mind that the **Provider-Delivered Care Management** program, which is part of Value Partnerships, will continue.

Specially designated nurse care managers will lead multidisciplinary teams to:

- Help patients understand their treatment plan and options
- Answer any questions they may have regarding their chronic conditions
- Help coordinate their care with you and other health care providers, including pharmacists, behavioral health clinicians and social workers
- Assist in getting additional resources they may need for their specific health care needs, such as transportation
- Provide co-management assistance for members in provider-delivered care management, if necessary

For more details, see the **column** by Drs. Aaron Friedkin and Duane DiFranco and Ann Baker in the May-June 2019 issue of *Hospital and Physician Update*.

Opioid refusal form available for members on Blue Cross website

In the **July-August issue**, we told you about a form that patients can sign if they don't want their doctors to prescribe opioids to them.

The law that went into effect in late March allows patients to refuse opioids by placing a letter in their medical file.

There are exceptions in the law, including a provision that a prescriber or a nurse under the order of a prescriber may administer an opioid if it's medically necessary for treatment.

Blue Cross has made the form available on our website so members can print, sign and give to their doctors for their permanent medical records.

- Tell patients to log in to the member portal of **bcbsm.com**. Then click on *Forms*.
- The nonopioid directive form is under Managing My Account.





CMS to approve grants for substance use disorder treatment funding

The Centers for Medicare & Medicaid Services recently released a notice of funding opportunity for state agencies to apply for planning grants that will aid treatment and substance use disorders. At least 10 states will be approved for this grant; awards totaling \$55 million will be used over the span of the 18-month program. After the completion of the initial program, five states will be selected to carry out the program further to a 36-month demonstration.

Planning grants will focus on:

- Increasing the capacity of Medicaid providers
- Improving reimbursements and expanding the number or treatment capacity of Medicaid providers
- Recruitment, training, and technical assistance for recovery services

The grant builds upon CMS’s approach to combat the opioid crisis (see the **CMS Roadmap**) which includes:

1. Prevention
 - a. Identify and stop the over-prescribing of opioids.
 - b. Enhance the diagnosis of opioid use disorder to get support for people who need it.
 - c. Promote effective, non-opioid pain treatments.
2. Treatment
 - a. Ensure access to treatment across CMS programs and geography.
 - b. Give patients options for a broader range of treatments.
 - c. Support innovation through new models and best practices.
3. Data
 - a. Understand opioid use patterns across populations.
 - b. Promote sharing of actionable data.
 - c. Monitor trends to assess impact of prevention and treatment efforts.





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

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Statewide partners commit \$5 million for programs to treat opioid addiction

Gov. Gretchen Whitmer and the Michigan Opioid Partnership announced in June that a combination of public and private funds totaling \$5 million in grants will support programs for people with opioid use disorder. Grants will fund the planning, training and coordination of treatment for opioid use disorder, including the use of medication-assisted treatment.

Two hospital systems across the state will receive grants to pilot projects designed to help change the culture in hospitals to better combat the opioid epidemic: Beaumont Hospital and Munson Medical Center. The hospitals will receive grants of more than \$1.3 million for projects that utilize medication-assisted treatment in partnership with outpatient treatment providers. Additional hospital grants are expected to be announced in the coming months.

For complete details, see the [MI Blues Perspectives blog](#).

2019 Opioid Progress Report released

The American Medical Association has released its **2019 Opioid Progress Report** — the third year that the AMA has reported on actions that physicians have taken to help end the nation's opioid epidemic. The report shows significant decreases in opioid prescribing as well as increases in the use of prescription drug monitoring programs and naloxone prescriptions. Here are some key findings:

- Opioid prescriptions decreased 33% between 2013 through 2018 from 251.8 million to 168.8 million.
- Health care professionals made more than 462 million prescription drug monitoring programs queries in 2018, up from 61.4 million in 2014.
- More than 66,000 physicians and other health care professionals have a federal waiver to prescribe buprenorphine in the office for the treatment of opioid use disorder — an increase of more than 28,000 since 2016.

In addition to the national data, the AMA also released state-level data for opioid prescribing and **PDMP use**.

Follow MQIC blood lead testing guidelines

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

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

For more information on this program, visit the [Michigan Department of Health and Human Services](#) website.

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

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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

- Radiofrequency ablation of peripheral nerves to treat pain including Coolief™ Cooled radiofrequency
- Genetic testing for FMR1 and FMR2 Variants (Including Fragile X and Fragile XE Syndromes)
- Genotype-guided warfarin dosing

Covered services

- Artificial pancreas device systems
- Genetic testing — Assays of genetic expression in tumor tissue as a technique to determine prognosis in patients with breast cancer
- Drug testing of urine, oral fluids and hair
- Genetic testing — Expanded molecular panel testing of cancers to identify targeted therapies
- Genetic testing for hereditary hemochromatosis
- Reconstructive breast surgery / management of implants
- Reduction mammoplasty
- Genetic testing for FLT3, NPM1, CEBPA, IDH1 and IDH2 variants in acute myeloid leukemia
- Genetic testing — Molecular markers in fine needle aspirates (FNA) of the thyroid



Medical Policy Updates

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:

For the General Medical – Respiratory criteria on episode day one in the Acute level of care, would a pigtail catheter satisfy the criteria requirement of a chest tube?

Answer:

Chest tube criteria can be applied for a pigtail drain when it is used to treat an acute issue and all rules and requirements for a criteria point can be met. Chest tube criteria should not be applied for a chest tube or fluid drainage system that is not being used for an acute issue. Chest tubes placed for long term use would not meet the intent of this criteria.

Question:

Within multiple subsets of the Acute Adult InterQual criteria, interventions or treatments require the administration of a volume expander. Would the administration of blood products with the intention of supporting the circulatory system meet this requirement?

Answer:

The note attached to the Volume Expander criteria helps to clarify its intent:

“Volume expanders are fluids administered intravenously to increase circulatory volume. Studies have demonstrated that a balanced crystalloid solution (for example, lactated ringers) is preferable to colloid in restoration of intravascular volume. However, the type of fluid selected for administration should be based on patient specific factors. In order to apply criteria for volume expanders, there should be documentation of a volume deficit supported by clinical findings. The volume of infusion is patient specific and varies based on the cause of volume depletion, comorbid condition, and patient response. Criteria for volume expander should not be applied for maintenance intravenous fluids or electrolyte replacement.”

When applying criteria for volume expanders, the documentation must support that the fluids are being given for the purpose of volume expansion.

Please see [Criteria corner](#), continued on Page 20

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Criteria corner, continued from Page 19

Question:

For criteria point 'Adult and Geriatric Psychiatry' - Inpatient - Ep. Day 2-13 and 14-X - ... - Acute Onset of Disorientation: Is the acuity of onset only after the member has been admitted, or could it be for the treatment episode?

For example, let's say that a member has been admitted to an inpatient psychiatric unit for a psychotic episode, and the symptoms include delusional thought content, auditory hallucinations and general disorientation to person/place/time. The member's baseline is absent disorientation and hallucinations. If we were to review the case on day four, would the acute onset of disorientation count as this is an acute episode, or would it not apply because the disorientation occurred before the 24 hours preceding the review?

Answer:

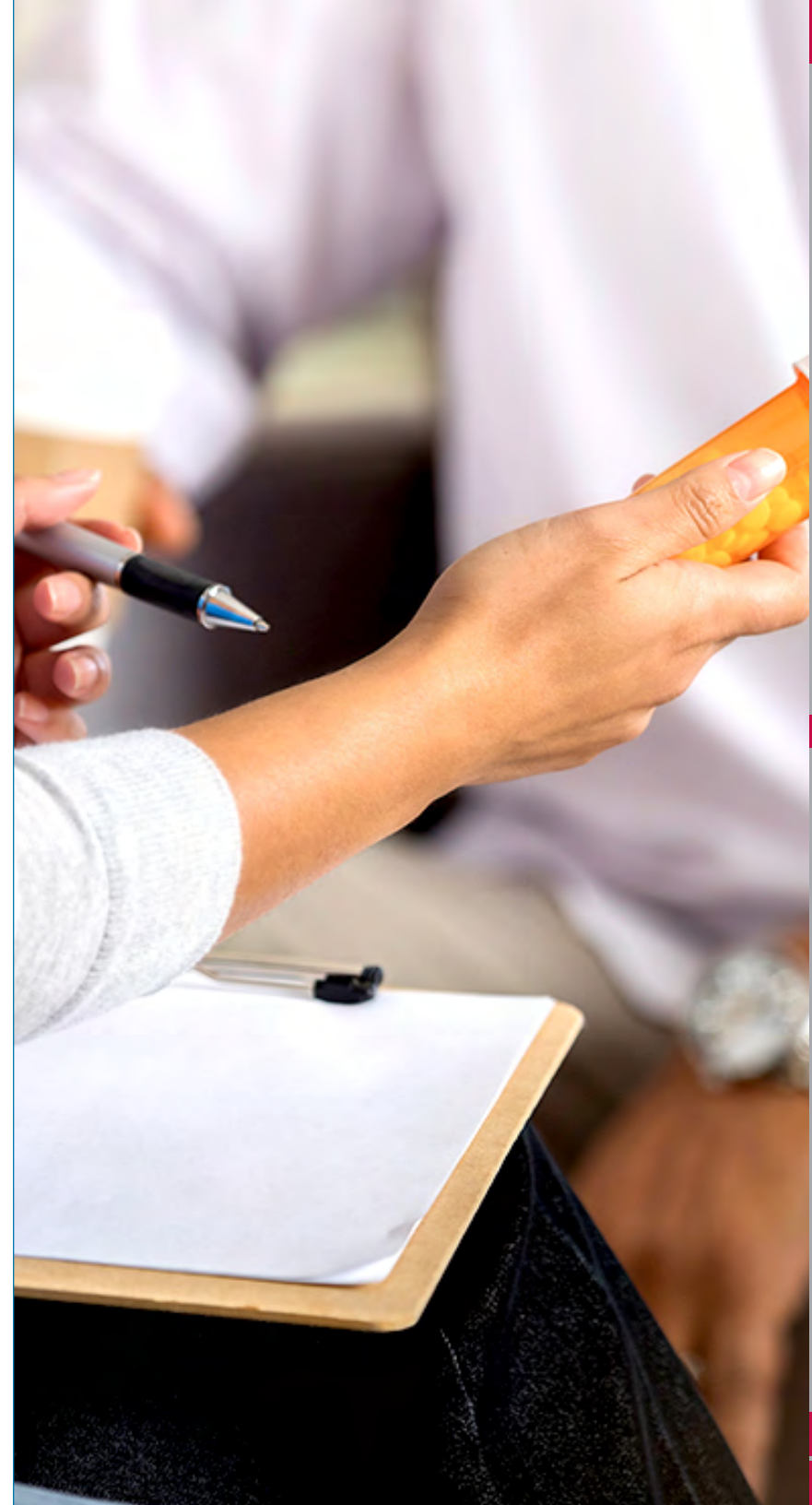
The patient's disorientation must be present within the last 24 hours, requiring continued stay.

Question:

If a medication is ordered by an attending psychiatrist, but the patient refuses to take it, would you say that it does or does not count for any of the 'Adult/Geriatric' or 'Child/Adolescent Psychiatry' - Inpatient - Ep. Day 2-13 or 14-Psychiatric Medication Evaluation criteria, either 'Medication Adjustment' or 'Medication Initiated'?

Answer:

The patient must receive the ordered interventions to meet criteria.



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Primary care physicians can help prevent suicide

By Kristyn Stewart, M.D.



Suicide rates have steadily risen since 2000, making suicide the tenth leading cause of death in the United States, claiming more than double the lives each year as homicides. Suicide was the second leading cause of death among individuals between the ages of 10 and 34, and the fourth leading cause of death among individuals between the ages of 35 and 54 in 2017, according to the National

Institute of Mental Health.

In addition to the emotional loss associated with suicide, there is also an economic loss as the burden falls most heavily on adults of working age. This leads to lost income, lost productivity and increased medical costs in the workforce. According to the Suicide Prevention Resource Center, the average cost of one suicide is \$1,329,553, and 97% of this cost is due to lost productivity.

The rates of suicide were highest for American Indian and Alaska Native males and females, followed by white males and females. While males are four times more likely to die by suicide, females are three times more likely to attempt suicide. The risk is further elevated in those with substance use disorders; they are six times more likely to complete suicide than those without substance use disorders.

In 2017, firearms were the most common method of death by suicide, accounting for a little more than half (50.57%) of all suicide deaths followed by suffocation (including hangings) at 27.72% and poisoning at 13.89%, according to the American Foundation for Suicide Prevention. Additional risk factors include mood disorders, past history of attempts and family history of suicide.

Suicide prevention in the primary care setting is essential given that up to 45% of individuals who die by suicide have seen their primary care physician within a month of their death and up to 67% of those who attempt suicide receive medical attention after an attempt, according to Substance Abuse and Mental Health Services Administration.

Primary care physicians have the potential to prevent suicides as well as connect patients to specialty care through collaboration or in partnership with behavioral health providers. Primary care physicians are increasingly asked to screen for a variety of health conditions, but often lack the capacity to take these screenings on.

However, there are brief screening tools for suicide risk and other mental health issues, such as depression, that can be completed by patients while in waiting areas. Providers can then review these self-reports to identify in advance those who may be at risk and need additional time at their office visit.

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From the medical director, *continued from Page 21*

These screening tools are easily implemented in an office setting. The burden needn't fall directly on the shoulders of physicians, as other health professionals can take on the task of screening individuals for depression, suicide and mental and substance use disorders.

Education regarding risk factors and warning signs can assist prevention. The following list of warning signs can help identify a person who may be at acute risk of taking his or her own life.

- Threatening to hurt or kill oneself, or talking of wanting to hurt or kill oneself
- Seeking access to firearms, available pills or other means
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary

The best way to prevent suicide is to use a comprehensive approach that includes these key components¹:

- Establish protocols for screening, assessment, intervention and referral.
- Train all staff in suicide care practices and protocols, including safety planning and lethal means counseling.
- Create agreements with specific behavioral health practices that will take referrals.
- Ensure continuity of care by transmitting patient health information to emergency and behavioral health care providers to create seamless care transitions.
- Follow up with at-risk patients by phone between visits and provide information about the National Suicide Prevention Lifeline crisis line and services.

Resources

There are multiple free toolkits available to primary care physicians to assist in this implementation and they contain educational materials, screens such as the PHQ-9 and additional resources. Several are listed below:

Suicide Prevention Resource Center toolkit:

<http://www.sprc.org/settings/primary-care/toolkit>

Zero Suicide

<http://zerosuicide.sprc.org/>

Each Mind Matters Resource Center

<https://emmresourcecenter.org/resources/training-resource-guide-suicide-prevention-primary-care-settings>

National Suicide Prevention Lifeline

<http://www.suicidepreventionlifeline.org>

1-800-273-TALK (8255), available 24 hours a day, seven days a week. The service is available to anyone. Calls are confidential.

¹Suicide Prevention Resource Center: <https://www.sprc.org/settings/primary-care>

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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% 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 only brochures.

The image shows a 'Depression Tools Order Form' with the following sections:

- Header:** 'Depression Tools Order Form' with a logo.
- Introductory text:** 'As part of our efforts to address the depression screening and treatment, we are offering resources for your office. Our depression toolkit includes:'
- Toolkit items:** Three small images representing different tools: 'Step therapy, patient education, and more depression', 'A checklist for your office', and 'Social media brochures for patients and providers'.
- Ordering instructions:** 'You can order up to five toolkits at a time for your office. Member brochures can also be ordered separately for your waiting room. Quantities are limited to 50 per order.'
- Ordering options:**
 - Complete toolkit (12/19)
 - Member brochures (12/19)
- Form fields:** 'Possible name: _____', 'Address: _____', 'City: _____ State: _____ ZIP code: _____'.



[Depression tools order form](#)

Michigan board-certified behavior analysts must be licensed starting Jan. 7, 2020, to be reimbursed by BCN and Blue Cross

Starting Jan. 7, 2020, board-certified behavior analysts practicing in Michigan must have a current license from the State of Michigan to be eligible for reimbursement from Blue Cross and Blue Care Network. BCBA's who are not licensed are not eligible for reimbursement for services provided on or after Jan. 1, 2020.

For information on the licensing process, refer to the [Behavior Analysts webpage](#) of the Michigan Department of Licensing and Regulatory Affairs website.



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Providers should discuss childhood immunizations with parents

Approximately 300 children in the United States die each year from vaccine-preventable diseases, according to the National Committee for Quality Assurance.

Childhood vaccines are crucial to help protect children from serious and potentially life-threatening diseases. It’s important for providers to continue to have conversations with parents about the importance of vaccines.

Below are the HEDIS® specifications for childhood immunizations.

- One Tdap (tetanus, diphtheria toxoids and acellular pertussis) vaccination between 10 and 13 years of age
- One meningococcal (serogroup A, C, W, or Y) vaccination between 11 and 13 years of age
- Two or three human papillomavirus (HPV) vaccinations between 9 and 13 years of age ; Either
 - Two HPV vaccinations (must be 146 days apart)
 - Three HPV vaccinations
- Four DTaP (diphtheria, tetanus, and acellular pertussis) vaccinations between 42 days old and 2 years of age
- Three IPV (inactivated polio vaccine) vaccinations between 42 days old and 2 years of age
- One MMR (measles, mumps, and rubella) vaccination between 1 and 2 years of age
- Three HiB (haemophilus influenza type B) vaccinations between 42 days old and 2 years of age
- Three hepatitis B vaccinations by 2 years of age.
- One VZV (varicella zoster) vaccination between 1 and 2 years of age
- Four pneumococcal conjugate vaccinations between 42 days old and 2 years of age
- One hepatitis A vaccination between 1 and 2 years of age
- Two or three rotavirus vaccinations between 42 days old and 2 years of age
 - Two doses of the two-dose rotavirus vaccine or
 - Three doses of the three-dose rotavirus vaccine
- Two Influenza vaccinations between 6 months and 2 years of age

References

<https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases?topicid=23>

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

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Preventive cancer screenings

The National Committee for Quality Assurance HEDIS® measures include several cancer screening guidelines. They're listed below.

- Cervical cancer screening — Every three years for women age 21 to 64 or a cervical cancer screening and human papillomavirus (HPV) co-test every five years for women age 30 to 64
- Breast cancer screening — Every two years for women 50 to 74
- Colorectal cancer screening — Men and women 50 to 75
All the following qualify:
 - Fecal occult blood test — Annually
 - Colonoscopy — Every 10 years
 - Flexible sigmoidoscopy — Every five years
 - CT colonography — Every five years
 - FIT (fecal immunochemical test) DNA — Every three years

For information on HEDIS measures and technical resources go to the [NCQA website](#).

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

We're sending letters to members to remind them about preventive screenings and immunizations

Blue Care Network is sending gaps in care letters to members in October to encourage them to get recommended screenings and immunizations. The letters also include recommended immunizations for children and adolescents. This mailing doesn't include BCN AdvantageSM members.

Members will receive one of the following screening letters based on their status. We send letters regardless of whether the member has a primary care physician on file with us.

- Screenings for adult members
- Immunizations for adolescents
- Immunizations for 0-to 2-year-olds

These gaps in care letters encourage members to be proactive about their health. They also help fulfill our responsibility to improve quality scores and encourage members to stay healthy and visit their doctors.





We've added more vaccines to the pharmacy benefit

Eligible Blue Care Network and Blue Cross Blue Shield of Michigan commercial (non-Medicare) members now have coverage for additional vaccines under their pharmacy benefits, effective Aug. 1. This allows participating pharmacies to bill through the pharmacy claims processing system.

We've added the following vaccines to the pharmacy benefit:

- Tetanus, diphtheria
- Polio
- Measles, mumps, rubella
- Meningococcal B
- Varicella (chickenpox)

The program covers the same vaccines that are offered under the Vaccine Affiliation program, which are currently billed under the medical benefit. Listed here are the vaccines and age requirements covered under the pharmacy benefit.



Vaccine	Common name	Age requirements
Influenza virus	Flu	None
Havrix®	Hepatitis A	None
Vaqta®	Hepatitis A	None
Twinrix®	Hepatitis A & B	None
Gardasil®9	HPV	9 to 27 years old
Cervarix®	HPV	9 to 27 years old
Gardasil®	HPV	9 to 27 years old
M-M-R® II	Measles, mumps, rubella	None
Menveo®	Meningitis	None
Menactra®	Meningitis	None
Menomune®	Meningitis	None
Trumenba®	Meningococcal B	None
Bexsero®	Meningococcal B	None
Ipol®	Polio	None
Pneumovax 23	Pneumonia	None
Pneumococcal (PCV7)	Pneumonia	None
Prevnar 13®	Pneumonia	65 and older
Shingrix®	Shingles	50 and older
Zostavax®	Shingles	60 and older
Boostrix®	Tetanus, diphtheria and whooping cough	None
Adacel®	Tetanus, diphtheria and whooping cough	None
Tenivac®	Tetanus, Diphtheria	None
Varivax®	Varicella (chickenpox)	None

BCN and Blue Cross members' vaccines can be processed under both pharmacy benefits and medical plans but only one plan can be billed per claim. Both plans require a qualified administrator at a Blue Cross-participating pharmacy or medical office to give the vaccine.

- Qualified pharmacists giving the vaccine can bill one of the following:
 - The member's pharmacy plan
 - The member's medical plan when the pharmacy participates in the medical Vaccine Affiliation program
- Participating medical offices giving the vaccine should bill the member's medical plan.

Most BCN and Blue Cross commercial (non-Medicare) members with prescription drug coverage are eligible. Most of the vaccines will be covered with no out-of-pocket cost to members if their benefits meet the coverage criteria.

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Vaccines, *continued from Page 26*

Grandfathered and retiree opt-out groups won't be part of this program. These groups will maintain their current vaccine coverage under their medical benefit.

Most Blue Care Network and Blue Cross members can search for a participating retail pharmacy by logging in to their member account at bcbsm.com.

Here's what members need to do:

- After logging in, hover the mouse over *My Coverage* in the blue bar at the top of the page.
- Select *Prescription Drugs* from the drop-down menu.
- Scroll down to *Where to go for care*; then click on *Locate a retail pharmacy*. The link will take the member directly to Express Scripts®. They won't have to log in again.

Members can also **look up pharmacies** in our network. But they'll get the most up-to-date information by searching online through Express Scripts.

Additional medical benefit specialty drugs have authorization and site-of-care requirements for BCN HMO members, effective Oct. 1

Effective Oct. 1, 2019, additional medical benefit specialty drugs have authorization and site-of-care requirements for BCN HMOSM (commercial) members. These changes **don't** apply to BCN AdvantageSM members.

Prior authorization requirements

For members initiating therapy on or after Oct. 1, 2019, you must request authorization for these drugs:

- Lemtrada® (alemtuzumab, HCPCS code J0202)
- Ocrevus® (ocrelizumab, HCPCS code J2350)
- Tysabri® (natalizumab, HCPCS code J2323)

Members who currently receive these drugs in one of the following locations are authorized to continue treatment through Sept. 30, 2020:

- Doctor's or other health care provider's office
- The member's home, from a home infusion therapy provider
- Ambulatory infusion center
- Hospital outpatient facility (Lemtrada and Tysabri **only**)

However, you'll need to request authorization for these members for therapy that begins on or after Oct. 1, 2020, for these services to be eligible for reimbursement.

Site of care requirement for Ocrevus

Ocrevus will also be added to the Site of Care program, effective Oct. 1, 2019. If your patient currently receives Ocrevus infusions at an outpatient hospital facility, you may need to discuss other infusion options.

As part of our shared commitment to keeping health care affordable, we hope you'll join us in supporting our members as they move to new therapy locations.

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Specialty drugs, *continued from Page 27*

List of requirements

For a list of requirements related to drugs covered under the medical benefit, see the **Requirements for drugs covered under the medical benefit – BCN HMO and Blue Cross PPO** document located on our ereferrals.bcbsm.com website.

We'll update the requirements list to reflect the changes for these drugs.

Blue Care Network and Blue Cross Blue Shield of Michigan reserve the right to review for medical necessity prior to the effective dates. A prior authorization approval isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.

As a reminder, you can always find information about authorization requirements for these drugs on the **Medical Benefit Drugs — Pharmacy** page in the BCN section of the ereferrals.bcbsm.com website.

Quarterly update: Medical drug authorization and site-of-care requirements for BCN HMO and Blue Cross' PPO members

Blue Care Network and Blue Cross Blue Shield of Michigan encourage proper utilization of high-cost medications that are covered under the medical benefit. As part of this effort, we maintain a comprehensive list of requirements for drugs that are covered under the medical benefit for Blue Cross' PPO and BCN HMOSM (commercial) members.

Please see below for medical drugs that had authorization or site-of-care updates or both during April, May and June of 2019:

HCPSC code	Brand name	Generic name
J1599	Asceniv™	immune globulin
J0584	Crysvita®	burosumab-twza
J1599	Cutaquig®	immune globulin
J3590	Evenity®	romosozumab-aqqp
J0517	Fasenra™	benralizumab
J3245	Ilumya™	tildrakizumab-asmn
Q5103	Inflectra®	infliximab-dyyb
J3397	Mepsevii™	vestronidase alfa-vjvk
J1301	Radicava®	edaravone
J1745	Remicade®	infliximab
Q5104	Renflexis®	infliximab-abda
J3490*	Spravato™	Esketamine
J1746	Trogarzo™	ibalizumab-uiyk
J3590	Ultomiris™	Ravulizumab
J3590*	Zolgensma®	onasemnogene abeparvovec-xioi

* This code will change to a unique code.

For a more detailed list of requirements related to drugs covered under the medical benefit, please visit the appropriate page on our ereferrals.bcbsm.com website.

- BCN's **Medical Benefit Drugs — Pharmacy** page
- Blue Cross's **Medical Benefit Drugs — Pharmacy** page

The authorization requirements apply only to groups that are currently participating in the standard commercial Medical Drug Prior Authorization program for drugs administered under the medical benefit. These changes don't apply to BCN AdvantageSM members, Medicare Plus BlueSM PPO or Federal Employee Program® members.

An authorization approval isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.



We're adding medications to the BCN Advantage and Medicare Plus Blue PPO Part B specialty prior authorization drug list

For dates of service on or after Oct. 1, 2019, the following medications will require prior authorization for BCN AdvantageSM and Medicare Plus BlueSM PPO:

- J1599 AscenivTM
- J0584 Crysvisa[®]
- J1301 Radicava[®]
- J0565 ZinplavaTM

BCN Advantage

For BCN Advantage, we require prior authorization for these medications for the following sites of care when you bill the medications as a professional service or as an outpatient-facility service and you bill electronically through an 837P transaction or on a professional CMS-1500 claim form:

- Physician office (place of service code 11)
- Outpatient facility (place of service code 19, 22 or 24)
- Home (place of service code 12)

We also require prior authorization when you bill electronically through an 837I transaction or using a UB04 claim form for a hospital outpatient type of bill 013x.

Medicare Plus Blue PPO

For Medicare Plus Blue, we require prior authorization for these medications for the following sites of care when you bill the medications electronically through an 837P transaction or on a professional CMS-1500 claim form:

- Physician office (place of service code 11)
- Outpatient facility (place of service code 19, 22 or 24)

Important reminder

You must obtain authorization prior to administering these medications. Use the NovoLogix[®] online tool to quickly submit your authorization requests. It offers real-time status checks and immediate approvals for certain medications. Also note:

- For BCN Advantage, if you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix.
- For Medicare Plus Blue, you can fax an **Addendum P form** to gain access to the NovoLogix online tool.

NovoLogix user interface enhancements coming soon

If you use NovoLogix[®] to submit prior authorizations for certain Part B medical specialty drugs, you'll soon see an enhanced user interface when you log in to the online tool. The enhancements will streamline the process of creating authorization requests.

The interface changes are minimal and easy to navigate, and you'll be able to switch between the current and enhanced interfaces while you adjust to the changes. We'll provide more information, such as user guides and training videos, as we get closer to the release date.

As a reminder, you can always find information about authorization requirements for these drugs on the ereferrals.bcbsm.com website:

- Blue Care Network page: **Medical Benefit Drugs — Pharmacy page**
- Blue Cross page: **Medical Benefit Pharmacy Drugs — Pharmacy page**

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2019 IVIG dosing strategy is changing, starting Oct. 1

Blue Care Network and Blue Cross Blue Shield of Michigan currently include immune globulin products in the prior authorization program under pharmacy and medical benefits for BCN HMO commercial and Blue Cross' PPO members. IVIG/SCIG products available for the medical benefit are also included in the Site of Care program.

Immune globulin replacement therapy is indicated for many labeled and off-label indications and traditionally is dosed using a patient's actual body weight. IVIG/SCIG (see list below) has been shown to have very little distribution into fat tissue and is only present in the intravascular space and extracellular fluids. Clinical literature supports alternative dosing strategies that provide comparable drug exposure without altering the clinical outcomes of treatment.

Drug name	HCPCS code
Asceniv™	J1599
Bivigam™	J1556
Carimune® NF	J1566
Cutaquig®	J1599
Cuvitru™	J1555
Flebogamma®	J1572
Gammagard® Liquid	J1569
Gammagard® S/D	J1566
Gammaplex®	J1557
Gamunex®-C	J1561
Hizentra®	J1559
Hyqvia®	J1575
Octagam®	J1568
Panzyga®	J1599
Privigen®	J1459

To minimize drug waste, reduce unnecessary drug exposure and decrease the risk of adverse events, we will update our dosing strategy for intravenous and subcutaneous immune globulin therapy.

Effective Oct. 1, 2019, we'll calculate doses using adjusted body weight for members who meet one of the following criteria:

- Body mass index is 30 kg/m² or greater
- Actual body weight is 20% to 30% higher than their ideal body weight

This applies to all members starting therapy on or after Oct. 1, 2019. Members currently receiving immune globulin will continue to receive their current dose until their prior authorizations expire.

This change does **not** apply to:

- Blue Cross' pediatric members 15 years old or younger
- Blue Cross' pediatric members 18 years old or younger weighing 50 kg or less
- Any member covered by Medicare Plus BlueSM PPO, BCN AdvantageSM or the Federal Employee Program®

We're contacting members currently on IVIG/SCIG therapy to let them know about this change.





Blue Cross and BCN launch new Preferred Drug List for group employees

Blue Cross Blue Shield of Michigan and Blue Care Network now offer the Preferred Drug List, a lower-cost drug formulary for self-funded and large group employees.

The Preferred Drug List offers therapeutically effective medications that have the greatest clinical value at the lowest net cost. Our Pharmacy and Therapeutics Committee of physicians and pharmacists reviews and approves medications based on clinical efficacy and safety. In addition, Blue Cross and BCN pharmacists review and update the drug list regularly to keep pace with the ever-changing prescription drug market.

Features of the **Preferred Drug List** include the following:

- Medications that have been selected for their clinical effectiveness, safety and maximized savings.
- Certain medications that do not provide greater clinical value than comparable or lower net-cost alternatives are excluded. Some examples include:
 - Medications with lower-cost generic equivalents
 - Medications with lower net-cost brand or lower-cost generic alternatives with the same therapeutic outcomes



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All BCN commercial members are moving to the exclusive specialty pharmacy network effective Jan. 1

Effective Jan. 1, 2020, Blue Care Network commercial members are moving to the Exclusive Specialty Pharmacy network for specialty pharmacy medications and must fill specialty drugs through AllianceRx Walgreens Prime or their local Walgreens retail store. This program does not apply to specialty medications administered under the medical benefit and certain members may be exempted from this program.

You may be aware that some Blue Cross Blue Shield of Michigan and BCN commercial members have already transitioned to this exclusive specialty network in 2019; this change is now applicable to all BCN commercial members beginning in 2020. This change does not apply to Medicare Advantage members.

Starting in October, AllianceRx Walgreens Prime will contact your patients who are affected by this change and advise them to speak to you about getting new prescriptions. If your patients don't already use a local retail Walgreens store or AllianceRx Walgreens Prime home delivery for specialty medications, we'll send you a letter about this change and you'll need to give your patients new prescriptions before Jan. 1, 2020. Members with this Exclusive Specialty program may be responsible for the full cost of their drugs **if they do not use our exclusive provider.**

To set up your patient with AllianceRx Walgreens Prime home delivery, send the specialty medication prescription along with all pertinent patient demographic information such as full name, date of birth, allergy information, phone and insurance number, to AllianceRx Walgreens Prime by one of the following methods:

- Fax: **1-866-515-1356**
- Electronically: E-prescribing name is AllianceRx WALGREENS PRIME-SPEC-**MI**
- Phone: **1-866-515-1355**
- For more information, visit alliancerxwp.com/hcp.

After AllianceRx Walgreens Prime receives the prescription, the pharmacy will need to contact your patient based on the information you provided and have the patient enroll with them before delivery can be arranged.

For a current list of specialty drugs in this program, go to bcbsm.com/specialtydrug. This list is updated monthly.



What is a seizure and how does it differ from epilepsy?

A **seizure** occurs from an episode of a sudden, uncontrolled electrical disturbance in the brain. It can cause abnormal movements and changes in awareness and behavior lasting anywhere from a few seconds to several minutes. **Epilepsy** is a condition characterized by recurrent seizures with no clear underlying cause. **Status epilepticus** describes a seizure that lasts longer than five minutes, or when seizures occur close together and the patient doesn't recover consciousness in between.

Depending on the type of seizure, signs and symptoms may include the following:

- A staring spell
- Uncontrollable jerking movements of the arms and legs
- Loss of consciousness or awareness
- Cognitive or emotional symptoms, such as fear, anxiety or déjà vu
- Temporary confusion following a seizure (postictal state)

Seizures can be caused by many underlying conditions:

- Congenital abnormalities
- Head injuries
- Poisoning
- Stroke
- Brain tumor

Documentation and coding tips

If known, provider documentation should specify the underlying cause of the seizure, such as:

- Low blood sugar
- Traumatic brain injury
- Alcohol or drug use, abuse, dependence or withdrawal

To assign a code properly, documentation of the seizure type is required. The following are a few common types of seizures:

- Tonic-clonic (grand mal)
- Myoclonic
- Atonic
- Tonic
- Clonic
- Absence (petit mal)

For greater specificity, providers should also document the status of the seizure:

- Intractable or not intractable
- Presence or absence of status epilepticus

Provider documentation must also include the treatment plan, if known, or plans to refer the patient to a neurologist or other specialist for treatment:

- Use of anti-convulsion medications such as carbamazepine, phenytoin, lamotrigine or levetiracetam
- Surgery
- Vagus nerve stimulation
- Responsive neurostimulation
- Deep brain stimulation

According to ICD-10-CM, a single seizure episode is classified to code R56.9, **unspecified convulsions**.

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Coding corner, continued from Page 33

Epilepsy, or recurrent seizures, is classified to category G40. The ICD-10-CM coding system subcategorizes epilepsy even further:

- Generalized versus localized epilepsy
- Localized epilepsy with localized onset versus simple partial seizures

In addition, separate codes identify idiopathic versus symptomatic epilepsy with a fifth character to specify whether the seizures are intractable and a sixth character to identify the presence or absence of status epilepticus.

Some examples of seizure disorder codes appear in the chart below:

Condition	ICD-10 code
Unspecified convulsions (seizures)	R56.9
Post traumatic seizures	R56.1
Epilepsy, unspecified, not intractable, without status epilepticus (seizure disorder)	G40.909
Generalized idiopathic epilepsy and epileptic syndromes, not intractable with status epilepticus	G40.301
Localization-related (focal or partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus	G40.109
Absence epileptic syndrome, intractable, with status epilepticus	G40.A11
Absence epileptic syndrome, not intractable, without status epilepticus	G40.A09
Epileptic seizures related to external causes, not intractable, without status epilepticus	G40.509

Sources:

www.mayoclinic.org

2019 ICD-10-CM Professional for Physicians

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

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:

- Reporting and coding debridement codes
- Diagnosis code reporting



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Billing Q&A

Question:
 I received an edit reducing the payment amount due to multiple procedure reduction. I attempted to submit a clinical edit appeal and it was returned. Can I appeal this edit?

Answer:
 A multiple procedure reduction is not an appealable explanation code. The multiple procedure reduction is applied in accordance with Chapter 1 of the *National Correct Coding Initiative Policy Manual*. The claim line has been processed with the reduced payment due to several possible reasons. Some of these reasons may include: multiple surgeries, co-surgeons, surgical teams, assistant surgeons or multiple radiology or cardiac procedures. These services are often indicated by a modifier on the claim line. Because the modifier or claim information indicates a need for payment reduction following the NCCI policy manual, they are not subject to appeal.

Question:
 I had a clinical edit appeals returned to me for invalid explanation codes. When I called Provider Inquiry, I was told to send a clinical edit appeal. What explanation code should I be using?

Answer:
 Remittance advice notices contain different columns; some are related to claim information and others are payment information. The area on a remittance advice to review for a clinical edit is under the explanation column and BCN Code. This is the code to submit on the clinical edit appeal. A complete list of appealable codes can be found here:

- Log in to Provider Secured Services
- Go to *BCN Provider Publications and Resources*
- Click on Billing/Claims.
- Scroll down to Clinical Editing Resources.

Explanation		
BCN Code	Reason Code	Remark Code



Question:
 I received a clinical denial that the units exceed the daily limit but there is a payment on the line stating the line was paid at 100%. Why was a clinical edit received that the units were exceeded?

Answer:
 BCN has daily limits set for certain procedure or HCPCS codes. If the claim line exceeds that limit, the allowed units will pay; the additional units receive an “exceeds daily limit” edit. Payment for the additional units can be made through appeal.

Our old claims processing system split these denials into two lines: one paid and a second denied. This made it clear as to how many units were denied. This split was not available with the new system and therefore the line pays, but also receives the clinical edit exceeds daily limit.

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Proper taxonomy required for certain BCN claims

Blue Care Network requires that providers include the proper taxonomy on claims for certain services to BCN HMOSM (commercial) and BCN AdvantageSM members, to facilitate correct reimbursement. This was effective Aug. 1.

This applies to the following types of claims:

- For home infusion therapy claims, use taxonomy 251F00000X.
- For ambulatory infusion center claims, use taxonomy 261QI0500X.
- For limited distribution pharmacy claims, use taxonomy 3336S0011X.

Your claims may be denied if you don't use proper taxonomy when submitting these claims to BCN.

Providers are already required to include proper taxonomy when submitting claims for these services when they are provided to Blue Cross' PPO (commercial) members.



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Reminder: We made some changes to the e-referral home page

We made an update to the e-referral system home page earlier this year to improve its performance for Blue Cross Blue Shield of Michigan and Blue Care Network cases, including commercial and Medicare Advantage. The e-referral system home-page dashboard displays only new or updated cases from the previous 60 days.

Important to know

Your cases will display faster on the home page. This is especially helpful if you typically have a lot of cases.

We don't delete cases that are past the 60-day display frame. You can access all your cases by searching for them with the reference number or the member's contract number.

Blue Cross and BCN will continue to make enhancements to the e-referral system to make it easier to use. Watch for future web-DENIS message and news items on the ereferrals.bcbsm.com website.

Contact eviCore for help in using the new eviCore provider portal for BCN PT, OT and ST authorizations

Need help submitting authorization requests or finding cases in the eviCore healthcare provider portal? Contact eviCore's Client & Provider Services department.

How to contact eviCore's Client & Provider Services department

Email clientservices@eviCore.com to get eviCore's assistance with authorization requests for outpatient physical, occupational and speech therapy and physical medicine services by chiropractors for BCN HMOSM or BCN AdvantageSM members. For urgent cases, call eviCore at 1-800-646-6418; select option 4.

When you send an email, you'll get a response that includes a ticket number. An eviCore representative will research your request and contact you.

Additional information

As a reminder, on May 27, 2019, eviCore healthcare started managing all authorization requests for outpatient PT, OT and ST by therapists and physical medicine services by chiropractors for BCN HMO and BCN Advantage members. This includes requests for both initial and follow-up services.

You can get additional information in the **Outpatient rehabilitation services: Frequently asked questions** document, which we've posted on [the PT, OT, ST webpage](#) in the BCN section of our ereferrals.bcbsm.com website.

Enter BCN retrospective authorization requests for cardiology and radiology services in e-referral

Effective immediately, enter retrospective authorization requests for cardiology and radiology services with dates of service prior to Oct. 1, 2018, in the e-referral system for BCN HMOSM (commercial) and BCN AdvantageSM members. eviCore healthcare no longer handles these requests.

Until recently, the e-referral system was programmed to block these requests. We've updated the e-referral system to accept these requests, so you no longer need to call BCN Utilization Management.

As a reminder, AIM Specialty Health® manages cardiology and radiology authorizations for BCN HMO (commercial) and BCN Advantage members with dates of service on or after Oct. 1, 2018.

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Updates to BCN referral and authorization requirements documents

We recently updated the **BCN Referral and Authorization Requirements** document.

The document now includes links to the preview questionnaires for all services for which questionnaires open in the e-referral system. This includes questionnaires that began opening on June 23, 2019.

We also moved the list of codes for services that require authorization to a separate **Procedure codes that require authorization** document. It lists each code — not code ranges — which means you can search for individual codes in the document or within the **ereferrals.bcbsm.com** website. In the BCN Referral and Authorization Requirements document, the page that previously listed the codes now includes a link to this new, separate document.

You can find this document in the BCN section of the **ereferrals.bcbsm.com** website. Click **Authorization Requirements & Criteria** on the left, and then scroll down and look under the “Referral and authorization information” heading.



How to submit authorization request for transgender services for University of Michigan employees

In the last issue of **BCN Provider News** we told you we’ve expanded BCN medical coverage for transgender employees of the University of Michigan, effective July 1. This applies to members covered by U-M Premier Care and GradCare plans.

You can identify BCN members who are eligible for these services by their group number, which is 00124316. The number is on the front of their University of Michigan-branded ID cards. As always, be sure to check web-DENIS for benefits and eligibility.

See the full article on **Page 5**.

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Blue Care Network offers 19 individual products for 2020

On October 1, consumers will be able to view health plans on the marketplace that are offered in their specific ZIP codes or counties. Enrollment takes place Nov. 1 through Dec. 15.

We're offering*:

- Three products in 15 Upper Peninsula counties
- Six products in 48 rural lower peninsula counties
- Thirteen products in 17 urban counties
- Nineteen products in three southeast Michigan counties

*Total number exceeds 19 because some plans are offered in multiple areas.

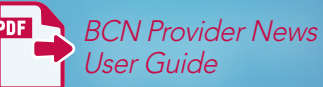
Please see [Individual products for 2020](#), continued on Page 2

Lower costs are at the heart of BCN Advantage plan features for 2020

Premiums decreased significantly for the 2020 BCN AdvantageSM Elements and Prestige plans. However, MyChoice Wellness, ConnectedCare and HealthySaver provider-specific plan premiums increased by a dollar. We'll also continue our two \$0 premium plans, Basic HMO-POS and HealthyValue.

- Our Prestige plan members will enjoy a \$400 lower out-of-pocket maximum for 2020, as well as see their specialist copayment drop from \$30 to \$20.
- Elements, HealthyValue and Basic members will spend less on primary care physician visits. Copayments decrease in the following plans: Elements from \$20 to \$10; HealthyValue from \$5 to \$3; Basic decreases to a \$0 primary care physician visit copay in most areas.
- In-network medical deductibles will drop \$10 for Basic, and Classic deductible will decrease from \$125 to \$0. These decreases are offset by \$500 out-of-network deductibles.

Please see [Lower costs](#), continued on Page 7



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Individual products for 2020, continued from Page 1

Prescription drug copayment change for individual plans

For silver and gold plans, we're changing the nonpreferred brand-name drug copay maximum from \$100 to \$150 after deductible. The Silver Extra plan will have copayment of \$150 **before** the deductible. This should lessen consumer confusion between preferred brand-name copayments and nonpreferred brandname copayments.

We're also changing the service area for Preferred HMO Silver Extra, Silver and Silver off-marketplace plans to be available for purchase in the lower peninsula only.

Online visit copays for individual plans

Online visit copayments are changing to \$0 before the deductible on all plans except for Bronze Saver HSA plans, which are changing to \$0 **after** the deductible. The change is for medical visits only. Mental health online visits are still available to individual product members, but the primary care physician copay will apply.

We've also made changes to our small and large group product offerings.

Small group products

We'll have a total of 41 plans for 2020 for the small group market. Our goal is to avoid unnecessary disruption for small groups. Cost-sharing changes have been made to meet 2020 actuarial values to certain plans.

Editor

Cindy Palese
bcnprovidernews@bcbsm.com

Provider Communications

Catherine Vera-Burgos, Manager
Elizabeth Donoghue Colvin
Jennifer Fry
Tracy Petipren
Deb Stacy

Market Communications
Publications

Cathy Rauckis

Contributors

William Beecroft, M.D.; Camillya Christian-Smith; Laura Cornish; Pharm. D; Amy Frady; Jody Gembarski; Clare Horvath; Joshua McCullough; Jacquelyn Redding

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Large group products

We've added a new *Preferred Drug List* (see article in the Sept.-Oct. issue of *BCN Provider News*, **Page 31**) in addition to the *Custom Drug List* and the *Custom Select Drug List*.

The *Preferred Drug List* is available with three- and five-tier prescription drug riders.

We are updating plans with \$1,350 HSA plans and replacing them with \$1,400 HSA plans to accommodate the \$1400/\$2800 minimum deductible IRS requirement. The change will take place on the group's 2020 renewal.

As always, check member eligibility and benefits at every visit before providing services. You can do this through web-DENIS or by calling Provider Inquiry at 1-800-344-8525.

Grievance process changing

The BCN member grievance process is changing to 180 days from date of discovery. It was previously two years.

Ask to see the latest member ID card

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

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Outpatient therapy benefit change for Jan. 1, 2020

Blue Care Network is changing its outpatient therapy visit limit to 60 visits per year for combination of therapies. Currently, the benefit is one period of treatment within 60 consecutive days per year for a combination of therapies. The change is effective Jan. 1, 2020 for large groups of 51 members and greater with the following certificates:

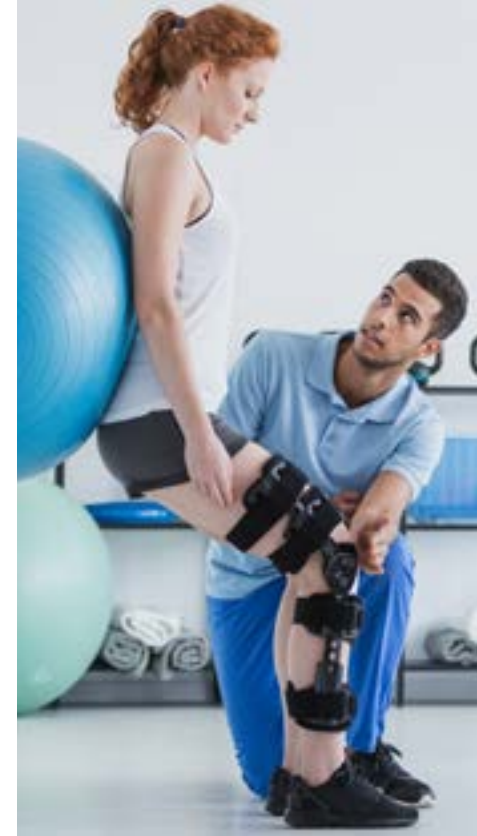
- Classic Large – CLSSLG
- High-Deductible Health Plan Large – HDHPLG
- Blue Elect Plus Large – BEPLG

The benefit enhancement is driven by the large number of member grievances about outpatient therapy limit and change in care management practices. Now, members who start physical therapy to avoid surgery and end up having surgery will be able to seek post-surgery physical therapy without exhausting their benefit.

This change does not affect:

- Employer plans with riders that amend the certificate limit
- Small groups
- Student health plans
- Large groups with the BCN1LG certificate
- Custom self-funded certificates
- Medicare plans

As always, check web-DENIS for eligibility and for outpatient therapy limit confirmation.



Direct reimbursement available to clinical nurse specialists, beginning Jan. 1

Clinical nurse specialists will have the opportunity to participate in Blue Cross Blue Shield of Michigan's Traditional and TRUST PPO networks and Medicare Plus BlueSM, as well as BCN HMOSM and BCN AdvantageSM, starting Jan. 1, 2020.

Participating clinical nurse specialists will receive direct reimbursement for covered services within the scope of their licensure at 85% of the applicable fee schedule, minus any member deductibles and copayments. This change affects Blue Cross and BCN benefit plans that cover services that clinical nurse specialists are licensed to provide. To find out if a patient has coverage, check web-DENIS for member benefits and eligibility or call Provider Inquiry at 1-800-344-8525.

Starting in October, clinical nurse specialists can find enrollment forms and practitioner agreements on bcbsm.com/providers. To find enrollment information, click on *Join Our Network*. Specific qualification requirements are identified within each agreement.

All applicants to the TRUST PPO, Medicare Plus Blue, BCN HMO and BCN Advantage networks must pass a credentialing review before participation. We'll notify applicants in writing of their approval status.

For more information, contact Provider Inquiry.

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We're expanding CAQH ProView 3.0 to include delegated credentialing practitioners

Blue Cross Blue Shield of Michigan and Blue Care Network are expanding the use of the CAQH ProView 3.0 application. The application will include enrollment demographic and credentialing data for delegated credentialing practitioners.

The purpose of this initiative is to:

- Streamline the data exchange process between delegated practitioner groups and Blue Cross
- Allow data to be exchanged consistently and more efficiently
- Improve our provider data quality for our members to view in our directories

We'll be accepting automated data feeds from CAQH ProView 3.0 into our provider data repository. This automated process will make it more efficient for us to maintain provider data and will reduce duplication of data submission for the delegated groups.

We expect to begin beta testing this electronic data exchange with the University of Michigan Medical Group and Genesys PHO for initial enrollment and changes in the first quarter of 2020 and for recredentialing during the summer of 2020.

Note: We still require signature documents for contracting. Continue to send these documents to the Provider Enrollment and Data Management department.

Reminder: Update or review your demographic data twice a year

Our Blue Cross Blue Shield of Michigan and Blue Care Network members rely on the online provider directory for accurate, up-to-date provider information, so it's important that you regularly confirm your demographic data.

Twice a year, our Provider Enrollment and Data Management team mails you your demographic data. When you receive this mailing:

- Review and confirm the accuracy of your demographic information.
- Respond to each mailing.

If you don't respond with information updates or confirm that your current information is correct, your demographic information won't appear in our online directory.

As data changes or updates are needed, send them to us by:

- **Mail**
Provider Enrollment — Attestation
20500 Civic Center Drive
Southfield, MI 48076-4115
H201 — PIAI
- **Fax**
1-844-216-4941
- **Email**
providerdataintegrity@bcbsm.com

If you have questions or need support with updating your data, go to bcbsm.com/providers or call Provider Enrollment at 1-800-822-2761.

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

Blue Cross Blue Shield of Michigan and Blue Care Network corporate offices will be closed on the following dates:

- Nov. 28 and 29 — Thanksgiving
- Dec. 24 and 25 — Christmas
- Dec. 31 and Jan. 1 — New Year's Eve, New Year's Day

During office closures, follow these guidelines when submitting inpatient authorization requests for BCN HMOSM (commercial) and BCN AdvantageSM members.

Acute initial inpatient admissions

Submit these authorization requests as well as concurrent reviews and discharge dates through the e-referral system, which is available 24 hours a day, seven days a week. If the e-referral system is not available, you can fax requests for inpatient admissions and continued stays to BCN HMO (commercial) at 1-866-313-8433 and to BCN Advantage at 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.

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

Post-acute initial and concurrent admission reviews

- For BCN HMO (commercial) members, submit these requests by fax at 1-866-534-9994. Refer to the document **Post-acute care admissions: Submitting authorization requests to BCN**
- For BCN Advantage members, naviHealth manages these authorizations. Refer to the document **Post-acute care services: Frequently asked questions for providers**.

Other authorization requests

The types of 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 total parenteral nutrition

Additional information

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

- Determining alternatives to inpatient admissions and triage to alternative care settings
- Arranging for emergency home health care, home infusion services and in-home pain control
- Arranging for durable medical equipment
- Handling emergency discharge planning coordination and authorization
- Handling expedited appeals of utilization management decisions
- Handling of urgent requests that need to be processed within 24 hours

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

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

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Online Training



Sign up for additional training webinars

Provider Experience is continuing its series of training webinars for health care providers and staff. The webinars help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

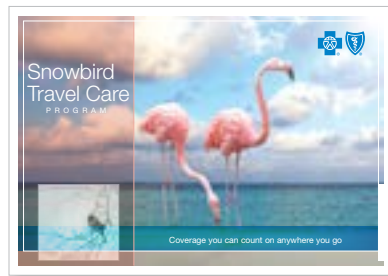
Here's how to register for the upcoming training webinars:

Webinar name	Date and time	Registration
AIM Specialty Health®— Medicare Advantage Medical Oncology	Thursday, Oct. 24, 9 to 10 a.m.	Click here to add to your calendar
AIM Specialty Health®— Medicare Advantage Medical Oncology	Wednesday, Nov. 6, noon to 1 p.m.	Click here to add to your calendar
Blue Cross 101 — Understanding the Basics	Thursday, Nov. 7, 10 to 11:30 a.m.	Click here to register
Blue Cross 101 — Understanding the Basics	Wednesday, Nov. 13, 3 to 4:30 p.m.	Click here to register
AIM Specialty Health®— Medicare Advantage Medical Oncology	Thursday, Nov. 21, 9 to 10 a.m.	Click here to add to your calendar

As additional training webinars become available, we'll communicate about them through web-DENIS, *BCN Provider News* or *The Record*.



Earlier this summer, we hosted webinars about AIM's medical oncology programs for BCN Commercial webinars. A **recording** is available at the ereferrals.com website on the provider training page.



New Snowbird Travel Care Program for members who travel

Our new Snowbird Travel Care Program for members traveling to Florida and Arizona offers a dedicated customer care line for BCN Advantage HMO-POSSM and Medicare Plus BlueSM PPO members to call for care coordination and assistance while wintering away from home.

Benefits include:

- Securing needed care with a participating (not necessarily in-network) Blue Cross Blue Shield physician
- Helping out-of-state providers collaborate with the member's Michigan primary care doctor
- Identifying local providers who can help manage routine acute conditions as well as specialists, if needed
- Offering expert knowledge in finding and securing community resources that are needed and available, such as adult day care, rehabilitation facilities, medications and durable medical equipment providers
- Finding a local participating pharmacy
- Assisting with care management issues

BCN and Blue Cross care managers will reach out to members to help them continue the treatment plan developed by you and your patients while they are on the road. We may reach out to you about patients participating in this initiative.

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Lower costs, continued from Page 1

Enhancements to optional supplemental dental, vision and hearing plans for HMO-POS

HMO-POS members who enroll in the Optional Supplemental Dental, Vision and Hearing plans will see enhancements to the vision and dental segments in 2020. The differences from 2019 are:

Vision

- In-network: Lenses are covered 100% every 24 months
- Out-of-network
 - Elective contacts or frames are reimbursed at 50% coinsurance up to \$300 for Package 1 and \$400 for Package 2
 - Lenses are reimbursed at 50% up to allowed amounts
 - Exams reimbursed at 50% coinsurance up to allowed amounts

Dental

- All out-of-network services are at 50% coinsurance
- In Package 2, all in-network dental services are now available out-of-network at 50% coinsurance

Plans available in 2019

The BCN Advantage plans available are unchanged for 2020. They are:

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

*Provider-specific, limited area coverage plans.

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Lower costs, *continued from Page 7*

BCN Advantage introduces a new over-the-counter benefit for 2020

An over-the-counter quarterly allowance for drugs and health-related products that do not need a prescription is new in 2020 for specific plans.

Items include allergy medications, antacids, cold and flu products, dental and denture care, eye and ear care, first aid, incontinence supplies, pain relievers and fever reducers, skin and sun care, supports and braces.

Elements members can use up to \$15 per quarter for these products. Classic and Prestige members have a \$25 per quarter benefit. The benefit must be used each quarter; there is no carryover. Basic members, who do not have a pharmacy benefit, and those who are in provider-specific plans do not have an over-the-counter allowance.

Important gap coverage news

- Gap Coverage added to the \$0 Select Care formulary Tier 6 — While in the coverage gap, members don't pay the requisite 25% for drugs covered under Tier 6; they continue to pay \$0 at preferred pharmacies and \$5 at standard pharmacies.



Blue Cross and Blue Care Network Medicare Advantage plans achieve four-star ratings from CMS

Our overall 2020 star rating ...
4 out of a possible 5 stars



Blue Cross Blue Shield of Michigan and Blue Care Network both received four-star ratings from the Centers for Medicare & Medicaid Services for 2020 for their Medicare Advantage health plans. The Medicare Star program is a nationally recognized measurement program that provides an overall rating of a health plan's quality and performance for the types of services each plan offers.

Measurements can range from one star (lowest) to five stars (highest). Attaining a four-star or higher level is a moving target because the bar is set higher each year and is harder for all health plans to hit year-after-year.

The BCN AdvantageSM rating reflects just under 20% of our membership in our Medicare Advantage plans.

Together, these results mean 100% of our members across the country are covered by four-star plans, making us one of an elite few that can stake that claim.

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Reminder: Oncology management program effective for Medicare Advantage plans in January

A new utilization management program for medical oncology drugs for Medicare Plus BlueSM PPO and BCN AdvantageSM members will begin in January 2020. Providers will need to obtain authorizations from AIM Specialty Health[®] for some medical oncology and supportive care medications.

This program became effective for BCN HMOSM (commercial) members in August 2019.

See the Sept.-Oct. *BCN Provider News*, Page 10, for details about the program.

Join a webinar to learn more

Non-clinical provider staff can learn about the new medical oncology program and how to use the AIM *ProviderPortal*SM by attending a webinar.

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

Thursday, Oct. 24, 9 to 10 a.m.

Wednesday, Nov. 6, 12 to 1 p.m.

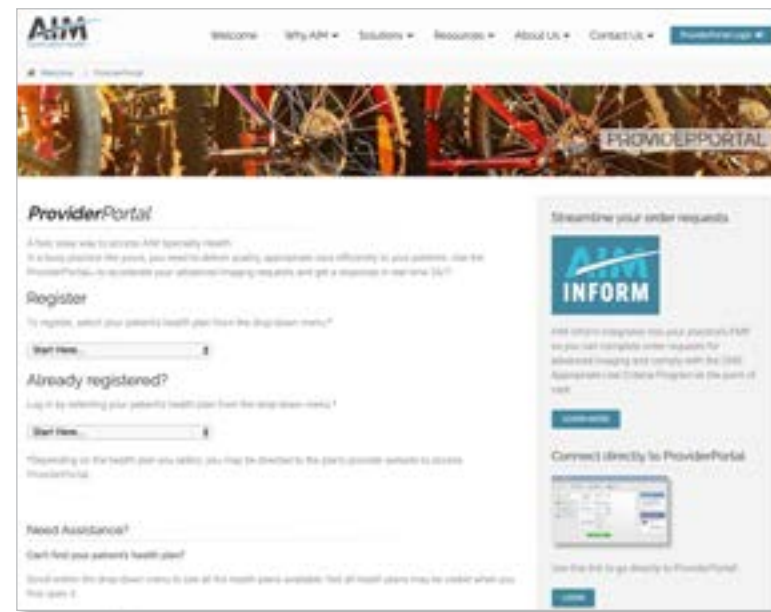
Thursday, Nov. 21, 9 to 10 a.m.

Thursday, Dec. 12, 9 to 10 a.m.

Wednesday, Dec. 18, 12 to 1 pm

Thursday, Jan. 9, 2020, 9 to 10 a.m.,

Wednesday, Jan. 22, 2020, 12 to 1 p.m.



AIM Provider Portal

The AIM *ProviderPortal*SM will be available on Dec. 16. Providers will need to request authorizations from AIM for medical oncology drugs. You can view a list of medications managed by AIM on our erferrals.bcbsm.com website. Information about the provider portal is available at the AIM website. For information about registering for and accessing AIM *ProviderPortal*, see the Frequently asked questions page on the AIM Specialty Health website.

Clinicians are encouraged to learn more at aimspecialtyhealth.com/oncology/BCBSM and to view a short video that describes the need for clinical pathways and how these were developed. Click on the link to the video and use AIMONCOLOGY as the password to view the video – **Clinician Overview – Medical Oncology Program video**, running time 11 minutes, 47 seconds.

Frequently-asked questions

We've posted a frequently asked questions document about the Oncology Management Program on erferrals.bcbsm.com. To access it, follow these steps:

- Click on *Blue Cross* or *BCN*.
- Click on *AIM-Managed Procedures*.
- Under Resources, click on **Oncology Management Program: Frequently asked questions for providers**.

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BCN Advantage DRG clinical validation audits began Sept. 1

HMS®, an independent company working for Blue Cross Blue Shield of Michigan, began auditing BCN AdvantageSM-reimbursed diagnosis-related group claims for clinical and coding validation starting Sept. 1, 2019.

In the audits, HMS reviews medical records to ensure that claims are billed in accordance with coding guidelines and that diagnoses are supported by documentation in the medical record.

As part of the auditing process, you should be prepared to share medical records for review. After an audit, HMS will send you the findings and information on how you can request an appeal, if necessary.

The purpose of the DRG clinical audit is to:

- Confirm compliance with national coding guidelines
- Ensure documentation supports the diagnoses and procedures reported
- Detect, prevent and correct waste and abuse
- Facilitate accurate claim payment

HMS will hold webinars for providers with information on the overall DRG clinical validation process and helpful tips.

DRG clinical validation audits are completed in three phases. See the scope of each phase and the data period for each phase in the chart below.

Phase 1: Sept. 1, 2019 through Nov. 30, 2019	Providers receive audit finding letters, but no recoupment will come from Blue Care Network. Audits are educational only.	Data period: Dates of service Jan. 1 through April 30, 2019
Phase 2: Dec. 1, 2019 through Feb. 28, 2020	Recoupment begins on claims with DRG findings. Providers won't be charged for appeals on claims.	Data period: Dates of service May 1 through Nov. 30, 2019
Phase 3: March 1, 2020	DRG clinical validation audits are fully implemented. Providers follow existing audit and appeal process. Recoupment occurs.	Claims selected from those not previously selected within the proper audit review period.

Questions? During an audit, you can call 1-866-875-1749 to speak with an HMS representative.

BCN Advantage audits to use Sepsis-3 criteria

HMS® began auditing BCN AdvantageSM-reimbursed diagnosis-related group claims for clinical and coding validation on Sept. 1, 2019. (See separate article above.)

The audits will review medical records to ensure that:

- Claims were billed in accordance with coding guidelines
- Diagnoses were supported by documentation in the medical record

Regarding a sepsis diagnosis, BCN Advantage will use Sepsis-3 as the evaluation criteria for payment purposes. Sepsis-3 is the most recent evidence-based definition of sepsis, defined as a life-threatening organ dysfunction caused by a dysregulated host response to infection.

Learn more about Sepsis-3 criteria by reviewing the article titled **Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)**, published in JAMA®.

Be ready to share medical charts for review during an audit. After an audit, HMS will send the findings and information on how you can ask for an appeal, if necessary.

If you have questions during an audit, call 1-866-875-1749 to speak with an HMS representative.

Medicare Plus BlueSM PPO-reimbursed diagnosis-related group claims are being audited in the same way. We communicated this in the October issue of *The Record*.

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Skilled nursing facilities must follow CMS guidelines for issuing NOMNC forms to Medicare Advantage members

BCN AdvantageSM and Medicare Plus BlueSM PPO members sometimes remain in skilled nursing facilities for days beyond the service end date on the *Notice of Medicare Non-Coverage* form. Sometimes the extended stay is due to a provider's failure either to deliver a completed NOMNC form in a timely manner or to comply with Centers for Medicare & Medicaid Services guidelines to respond to requests from Livanta, LLC, the quality improvement organization assigned to Medicare Advantage members in Michigan. This results in days added to the member's stay that may not be medically necessary.

On behalf of Blue Cross Blue Shield of Michigan, naviHealth will issue an administrative denial for these days if they occur because the SNF provider didn't handle the NOMNC in accordance with CMS guidelines. In an administrative denial, the authorization is approved but the reimbursement for the extra days is denied.

Examples of improper handling and delivery of the NOMNC include:

- *Late delivery of the NOMNC.* Members must receive the NOMNC 48 hours before the planned discharge date.
Note: naviHealth completes as much of the NOMNC as possible and tells the provider when to issue the NOMNC.
- *Failure to fill out the NOMNC completely.* All fields in the NOMNC must be completed, including all date and signature fields. For more information, see the **Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123.**
- *Not submitting the requested medical information to the QIO in a timely manner, when the member appealed the service end date with the QIO*

Note: To view CMS instructions about appropriate delivery of the NOMNC, see sections 260.2 to 260.4.5 of the **CMS Manual System: Pub 100-04 Medicare Claims Processing, Transmittal 2711.**

When SNF providers have repeated difficulties handling the NOMNC according to CMS guidelines, their naviHealth care coordinators will reach out to provide education about CMS guidelines and health plan requirements. If, after receiving education, a SNF provider continues to have difficulties, naviHealth will deliver an administrative denial letter to the provider when members stay beyond the end date stated on the NOMNC.

The administrative denial letter will include details on the specific CMS guideline violations. Blue Cross and Blue Care Network will hold the provider responsible for the additional days the member stayed in the SNF. Per CMS guidelines, providers can't bill members for the additional days.

You can find information about CMS guidelines and Medicare Plus Blue and BCN Advantage requirements in the following locations.

- **Medicare Claims Processing Manual, Chapter 30:** See section "260.3.6 — Financial Liability for Failure to Deliver a Valid NOMNC."
- **Medicare Plus Blue PPO Manual:** See the Utilization Management section. Look under the "Post-acute care skilled nursing, inpatient rehabilitation and long-term acute care facilities" heading.
- **BCN Provider Manual:** See the **BCN Advantage chapter.** Look in the "BCN Advantage provider appeals" section.

As a reminder, naviHealth manages authorization requests for Medicare Plus Blue and BCN Advantage members admitted to post-acute care on or after June 1, 2019. For details, see the **Post-acute care services: Frequently asked questions by providers** document.

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



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Study calls incidence of untreated mental illness and substance abuse 'staggering'

Hundreds of thousands of Michigan residents with a mental illness or substance use disorder are untreated, a crisis compounded by a shortage of health professionals and treatment facilities, according to the findings of a **report** released July 30. Commissioned by the Michigan Health Endowment Fund, the analysis cites anxiety disorders, depression and alcohol use disorder as among conditions most left untreated. The fund is a grant-making arm of Blue Cross Blue Shield of Michigan. (See related article in the behavioral health section titled, **Study says many Michiganders with mental illness fail to receive treatment**, [Page 18](#).)

Patients taking opioids could face health care access problems

Taking opioids for chronic pain may make it hard to find primary care, according to a **University of Michigan Health Lab blog**. According to a new study, 40% of 194 primary care clinics contacted said they wouldn't accept a new patient who takes Percocet daily for pain from a past injury, no matter what kind of health insurance they had. Another 17% said they would want more information before deciding whether to take on the patient. However, the team did find that larger clinics and those that offer safety net coverage were three times more likely than others to accept patients who currently take opioids for chronic pain. The findings were published in **JAMA Network Open**.

Michigan doctors writing fewer opioid prescriptions

Michigan doctors wrote 1.4 million fewer opioid prescriptions in 2018 — a 15% drop — than they did in 2017, according to newly released data from state officials, **MLive.com** reported July 1. Overall, the number of prescriptions of controlled substances dropped 11.5% in 2018. It's the biggest year-over-year decrease in prescriptions Michigan has seen in recent history, a decline that began in 2015. Part of that is due to the state's tracking system, called the Michigan Automated Prescription System, or MAPS, which launched in 2017.

Where did all the pain pills go?

New information provides a look at where the drugs responsible for the opioid epidemic ended up, the **Detroit Free Press** reported July 19. Michigan was flooded with almost 3 billion prescription pain pills between 2006 and 2012, fueling the opioid crisis, according to a **Washington Post** analysis of a government database. Ogemaw County, home to the northern Michigan communities of West Branch and Rose City, had the heaviest saturation of pills: 125.7 pills per person a year. Overall, it received just over 19 million pills.

Please see [Opioids](#), continued on Page 13

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[Feedback](#)**Opioids**, continued from Page 12

Number of Michigan's drug overdose deaths down slightly

Are the country's united efforts to fight the opioid epidemic starting to have an effect? New information shows that may be the case. The **Detroit Free Press** reported July 19 that the number of drug overdose deaths declined slightly in Michigan and across the nation in 2018, according to preliminary information released by the U.S. Centers for Disease Control and Prevention. Drug overdose deaths fell 3.7% in Michigan, from 2,690 in 2017 to 2,591 in 2018, according to the CDC report. Nationally, there were about 68,557 overdose deaths, a 5% decline from 72,224 deaths in 2017. It is the first decline in drug overdose deaths since 1990.

Helping expectant mothers with mental illness, substance abuse

Blue Cross recently awarded a \$90,000 grant to Cherry Health in Grand Rapids to help fund services for high-risk expectant mothers with mental illness, substance use disorder or insufficient prenatal care. The grant supports Blue Cross' mission to address the growing opioid epidemic in Michigan.

Pilot program helps members understand surgery alternatives

Blue Care Network is starting a pilot in October to help members understand and make decisions about shoulder, back, hip and knee surgeries.

We've entered into an agreement with 2nd.MD, which gives members access to personalized second opinions (by video or phone) from medical specialists at top institutions.

The pilot is only available for BCN commercial individual business accounts. Talking to specialists from the company is voluntary.

"More than 100 Kent County residents died of an opioid overdose in 2017," said Kelley Root, West Michigan regional sales director at Blue Cross. "We also know from the National Institute of Drug Abuse that untreated opioid use disorder during pregnancy can have devastating consequences on an unborn child."

Cherry Health is Michigan's largest federally qualified health center. More than 20% of its patients are uninsured, and 95% earn below the federal poverty level.

The grant is part of Blue Cross' "Strengthening the Safety Net" program. The program has provided more than \$14 million in grants since 2005.

Prescribing opioids for a sprained ankle?

While ankle sprain injuries are common, a new report from **Michigan Medicine** suggests that the rate of opioids prescribed to those patients has become uncommonly high. The authors urge fellow physicians to be aware of the current treatment guidelines.

The benefits to members considering surgery include:

- Providing members with access to specialists at top institutions, including Massachusetts General, Mayo Clinic and Hospital for Special Surgery
- Helping patients make better decisions and understand alternatives to surgery, if appropriate

The pilot will affect a small number of BCN members. We'll evaluate the results before determining whether to continue or expand the program.

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Remind patients to get the flu vaccine

Most people who get the flu experience a mild illness but won't need medical care or antiviral drugs. Most will recover in less than two weeks without treatment. But because of possible complications, the Centers for Disease Control and Prevention recommends flu vaccinations for everyone age 6 months and older, and especially for those at higher risk of complications. This group includes:

- Adults age 65 and older
- Children younger than age 2
- Pregnant women and women up to two weeks after the end of pregnancy
- American Indians and Alaska natives
- People who live in nursing homes and other long-term care facilities

Additionally, certain chronic conditions, such as heart disease, asthma, diabetes and chronic obstructive pulmonary disease, increase a patient's risk of complications due to the flu.

There are also other health conditions that put patients at a higher risk for complications. Some of these include:

- Blood disorders, such as sickle cell disease
- Cystic fibrosis
- Kidney disorders
- Liver disorders
- Patients with a body mass index of 40 or higher
- Patients with a weakened immune system due to a condition or medications
- Neurologic and neurodevelopment conditions





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:

We have numerous requests for inpatient admissions for patients with chief complaint of abdominal pain, suspicious of cholecystitis. However, imaging findings show cholelithiasis, no evidence of cholecystitis. Interventions are medical, non-surgical. No findings of ascending cholangitis or biliary sepsis, just gallstones. No other findings except for cholelithiasis. Would it be appropriate to use the Cholecystitis subset to review this despite no evidence of cholecystitis? If not, what other subsets would be reasonable to use?

Answer:

Cholelithiasis may lead to cholecystitis due to blockage of the ducts or irritation from the stones, but cholelithiasis is not cholecystitis and cannot be applied to this criterion as such. The Acute Cholecystitis subset should not be used for a patient with cholelithiasis but not cholecystitis, and it should not be used for surgical patients.

The General Medical subset may be appropriate at the Observation level of care, pain, severe or the Acute level of care for jaundice (if this is true for this patient).

Question:

Under the Infection: General Subset, Laboratory result indicative of infection, source, Effluent Smear. Is a wound culture considered an effluent smear?

Answer:

"Effluent" is defined in the note attached to the criteria:

"Effluent is the liquid by-product of any internal organ eliminated through a surgically placed drain. It is generally applied only to liquids that are expected to be sterile at the point the drain is installed. It is not applied to liquids that are externally collected through normal body excretions (for example, feces or clean-catch urine)."

A wound culture is not the liquid by-product of an organ, so cannot be used to meet this criterion. Wound infection is addressed in the Infection: Skin subset.

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

- Measurement of exhaled nitric oxide and exhaled breath condensate in the diagnosis and management of respiratory disorders
- Orthopedic applications of stem-cell therapy (including allografts and bone substitutes used with autologous bone marrow)

Covered services

- Transcatheter mitral valve repair
- Hyperbaric oxygen therapy
- Corneal collagen cross-linking
- Pneumatic compression pumps and appliances for venous ulcers
- Leadless cardiac pacemakers
- Aqueous shunts and stents for glaucoma
- Myoelectric prosthetic and orthotic components for the upper limb
- Pneumatic compression pumps and appliances (Flex touch™ System) for lymphedema
- Intermittent (72 hours or greater) or continuous invasive glucose monitoring
- Phrenic nerve stimulation and diaphragm pacing
- Telemedicine services



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Quality corner: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

What does this measure focus on?

Initiation and engagement of alcohol and other drug dependence treatment is a HEDIS® measure. It looks at the percentage of patients ages 13 or older with a new episode of alcohol or other drug abuse or dependence.

Two parts are examined:

- Initiation of AOD treatment — Treatment must be initiated within 14 days of the diagnosis. Treatment can be initiated through:
 - An inpatient alcohol or other drug admission
 - An outpatient visit
 - An intensive outpatient encounter
 - A partial hospitalization
 - Telehealth
 - Medication treatment (also known as medication-assisted treatment, or MAT)
- Engagement of AOD treatment — Considered complete if the **first** bullet and **one** of the other two are completed.
 - Member initiated treatment (above)
 - Member whose initiation of AOD treatment was not a medication treatment: Member received two or more AOD engagement visits or one medication treatment event 34 days after the initiation treatment
 - Member whose initiation of AOD treatment was a medication treatment: Two or more AOD engagement events (only one can be a medication treatment event) within 34 days after the initiation event

Why is this important?

Higher morbidity and mortality rates are associated with substance abuse than any other preventable health problem. The treatment costs of health conditions caused by substance abuse are a strain on the health care system, totaling more than \$165 billion each year in health care expenditures alone. Unfortunately, even though treatment of AOD dependence leads to improved health and productivity, only 10% of the 23.1 million Americans who need treatment actually receive it, according to a 2012 estimate from the National Institute on Drug Abuse.

Ensuring patients get care and it counts

Many providers do administer the care, but HEDIS looks at specific timeframes and circumstances to ensure the best quality. Providers need to keep timing in mind.

- If you diagnose a patient with AOD dependence, schedule a visit at your own practice or refer the patient to a behavioral health provider as soon as possible so treatment can be started within 14 days of the diagnosis.
- Schedule engagement events within 34 days of the initiation event.

HEDIS also specifies certain stipulations when looking at what does and doesn't count. These two important tips can affect whether the service is considered complete by HEDIS standards:

- The date of an eligible AOD diagnosis and the initiation visit can be on the same day, but must be with two different providers, unless the provider is offering medication treatment
- The patient can complete more than one engagement visit on the same day, but the visits must be with different providers. Engagement visit and engagement medication treatment can be on the same date with the same provider.

Note: For members in the “other drug abuse or dependence” cohort (for example, members with an AOD diagnosis unrelated to alcohol or opioids), medication treatment does not meet the criteria for either initiation or engagement.

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Reminder: Blue Cross and BCN now accepting applied behavior analysis claims with 2019 procedure codes

Blue Cross Blue Shield of Michigan and Blue Care Network began accepting claims for behavior analysis services billed with the following codes, for dates of service on or after June 1:

- *97151
- *97152
- *97153
- *97154
- *97155
- *97156
- *97157
- *97158
- *0362T
- *0373T

Claims billed with the following codes will still be honored:

- H0031
- H0032
- H2019
- H2014
- S5108
- S5111

This applies to Blue Cross' PPO and BCN HMOSM members. All services continue to require authorization.

Billing guidelines

We've updated the ABA billing guidelines to reflect the 2019 codes. Look for the updated guidelines on the Autism pages within Provider Secured Services.

To find them, visit bcbsm.com/providers and log in to Provider Secured Services. Then:

To access the **BCN Autism** page:

- Click *BCN Provider Publications and Resources* (on the right).
- Click *Autism* (in the left navigation).
- Click *Applied Behavior Analysis Billing Guidelines and Procedure Codes* under the "Autism provider resource materials" heading.

To access the **Blue Cross Autism** page:

- Click *BCBSM Provider Publications and Resources* (on the right).
- Click *Clinical Criteria & Resources* (in the left navigation).
- Scroll down and click *Autism* (in the Resources section).
- Click *Applied Behavior Analysis Billing Guidelines and Procedure Codes* under the "Autism provider resource materials" heading.

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Study says many Michiganders with mental illness fail to receive treatment

More than 650,000 Michiganders with a mental illness and over 500,000 with a substance use disorder fail to receive any treatment for their conditions, according to a new study by Altarum, a nonprofit health care consulting institute, which examined access to behavioral health services in Michigan by payer type.

Populations with the highest share of individuals going untreated for a mental illness include the uninsured (65%) and Medicaid enrollees (49%), while populations with the highest share of people going untreated for a substance use disorder include the privately insured (87%) and Medicare Advantage enrollees (80%).

The study was commissioned and funded by the Michigan Health Endowment Fund to better understand the current state of access in order to address gaps in care amid rising rates of behavioral health-related conditions in Michigan and across the United States, especially among young adults.

Behavioral health conditions that are most prevalent among Michiganders are also the most likely to go untreated. For instance, 46% of people with anxiety disorders, 53% of people with depressive episodes, and 85% of people with alcohol use disorders are not treated for their conditions.

The report defines treatment as receiving any care at all, and not necessarily what may be considered the appropriate type and volume of care for the condition. The assessment was conducted using administrative claims data from 2016. Details on data sources and methods are documented in the **full report**. A one-page **summary** is also available.

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

Unmet need for behavioral health care in Michigan

Some key findings from the study

- Thirty-eight percent of the 1.76 million Michiganders who experience any mental illness are not receiving care. The most common unmet needs for mental illnesses are anxiety disorder and depressive episode.
- Among the 638,000 Michiganders with a substance use disorder, only 20% receive treatment, leaving more than 500,000 with an unmet need for care. Alcohol, cannabis and opioids are the most common substances resulting in a use disorder.
- The prevalence of any mental illness and substance use disorder are highest among Medicaid enrollees, the uninsured and adolescents.
- Expanding access to behavioral health care in all of Michigan to the same rates of care seen in the best access areas of the state would improve access for 236,400 people with a mental illness and 87,500 people with a substance use disorder.

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Michiganders, *continued from Page 18*

Barriers to behavioral health access

Michigan, like most of the country, has a shortage of psychiatrists and other behavioral health providers. Central Michigan has the largest share of untreated individuals with a mental illness (41%) and West Central Michigan the largest share of untreated individuals with a substance use disorder (83%). Altarum's analysis shows that shortages of psychiatrists and other behavioral health providers are especially concentrated in the northern half of the lower peninsula and parts of the upper peninsula. Additionally, Michigan has 11 child and adolescent psychiatrists per 100,000 people, far short of the recommended ratio of 47 to 100,000.

The study also includes analysis of data from the 2016 National Survey on Drug Use and Health, which show that cost of care, lack of transportation, and public awareness and perceptions about behavioral health care are also barriers to access.

Strategies to expand behavioral health services

The study authors recommend a near-term goal of achieving the state's best level of access—defined as having the smallest share of currently untreated individuals—for all regions across the state. In such a case, an additional 236,400 residents would receive mental health services, and an additional 87,500 would receive substance use disorder services.

The report contains 15 strategies for achieving the best level of access across the state that address the barriers of provider shortages, affordability and patient willingness to seek care. The six top recommendations are:

- Increasing retention of behavioral health providers in Michigan
- Removing restrictions on the scope of practice to fully leverage all members of the health care team
- Using lay providers, such as peer support specialists
- Using telemedicine to reach people in rural areas and those unable to travel
- Expanding access to services in schools
- Integrating primary care and behavioral health care delivery.

Altarum is a nonprofit organization that creates and implements solutions to advance health among vulnerable and publicly insured populations.

New program offers subspecialty certification in addiction medicine

Michigan State University, University of Michigan, Wayne State University and Spectrum Health are offering a program to help providers apply for addiction medicine subspecialty certification. The program is called MI Cares. There are now only 200 addiction medicine and addiction psychiatry specialists in the state of Michigan.

The program's goals are to:

- Educate providers on how to successfully enter the specialty of addiction medicine by 2021
- Properly assess a provider's current roles and responsibilities and how they can translate to meet the time-in-practice requirements for addiction medicine certification
- Identify areas outside of direct patient care to ensure required hours of experience in addiction medicine research, teaching activities and administration are met, utilizing collaborative resources
- Provide a robust overview of the addiction medicine core content for the board exam
- Provide an efficient and streamlined process for providers applying for addiction medicine subspecialty certification

For information or to enroll in the program, go to micares.msu.edu.

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Children on certain antipsychotic medications require routine blood monitoring

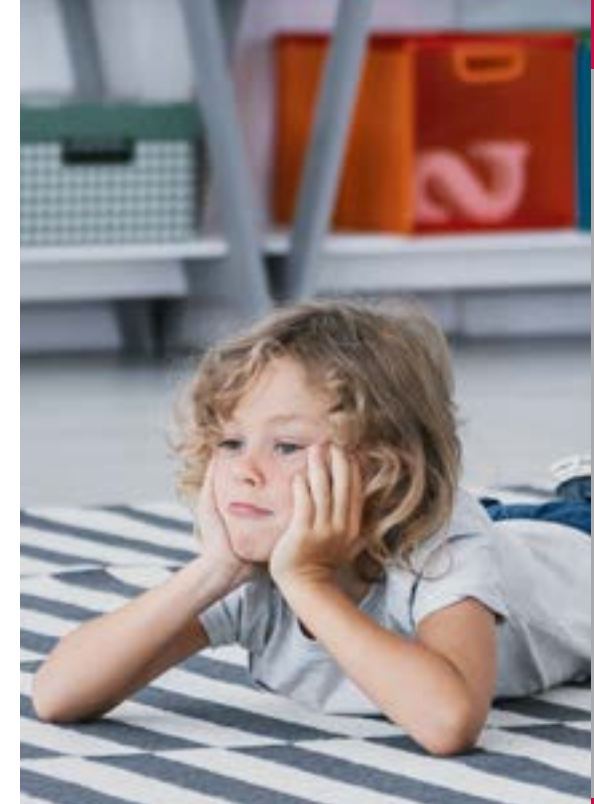
The American Academy of Child and Adolescent Psychiatry recommends routine blood monitoring for children on antipsychotic medications with potentially adverse side effects that include weight gain and diabetes. The HEDIS® measure is **Metabolic Monitoring for Children and Adolescents on Antipsychotics**.

We've sent letters to physicians who have patients taking certain medications to remind them to do routine blood monitoring. It's important that these patients receive these tests annually:

- At least one test for blood glucose or HbA1c
- At least one test for LDL-C or cholesterol

If you have questions, call BCN Behavioral Health at 1-800-482-5982 from 8 a.m. to 5 p.m. Monday through Friday.

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Blue Care Network offers crisis assessment and placement program with Common Ground

Blue Care Network's Behavioral Health department has entered into an agreement with Common Ground to provide crisis evaluation for members receiving behavioral health services, starting Oct. 1. We're responding to a need for quality of care, timely evaluation and appropriate level of placement and stabilization for members.

Common Ground can assist with on-site facility and community-based emergency assessments with placement into the most appropriate level of care. Common Ground also provides access to a multitude of community-based resources. The program can also assist those who have a history of being non-adherent or non-responsive to traditional behavioral health services or are at risk for decompensation.

Common Ground professionals are approved by Blue Care Network under this initiative to complete a crisis assessment and treatment plan in collaboration with providers to ensure that a clinical service plan is in place.

We're communicating to providers and emergency room physicians to let them know they can work with Common Ground to assess patients who choose to participate in this service. BCN-contracted facilities can benefit by working collaboratively with the Common Ground team on-site to confirm placement for inpatient, partial or other special services.

Currently, these assessments and placements are available in Oakland County. We plan to develop these services in southeast counties, mid-Michigan counties and on the West side of the state.

Providers who want to refer patients for assessment or placement can call Common Ground at 248-456-1991.

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Concurrent billing is allowed for some ABA procedure codes for commercial members

Board-certified behavior analysts can bill for services provided to the same client by two providers at the same time for the following applied behavior analysis procedure codes. This was effective Sept. 1, 2019:

- *97153 and *97155
- *97154 and *97155

This applies to Blue Cross' PPO (commercial) and BCN HMOSM (commercial) members.

We updated the *Applied Behavior Analysis Billing Guidelines and Procedure Codes* document to reflect this change. To access this document:

- Visit bcbsm.com/providers.
- Click *Login*.
- Log in to Provider Secured Services.
- Click *web-DENIS* on the Provider Secured Services welcome page.
- Click *BCN Provider Publications and Resources*.
- Click *Autism* on the left.
- Click *Applied Behavior Analysis Billing Guidelines and Procedure Codes* under the Autism provider resource materials

*CPT codes, descriptions and two-digit modifiers only are copyright 2018 American Medical Association. All rights reserved.

We've updated medical record documentation requirements for ABA services

We updated the medical record documentation requirements for applied behavior analysis services to clarify documentation requirements for services involving tutors and technicians.

These guidelines apply to services for Blue Cross' PPO (commercial) and BCN HMOSM (commercial) and members.

You can view the guidelines by visiting ereferrals.bcbsm.com, clicking *BCN* or *Blue Cross* and then clicking *Behavioral Health*. Finally, click the **Documentation requirements for applied behavior analysis services** link.

You can also view the guidelines within Provider Secured Services. Here's how:

- Visit bcbsm.com/providers.
- Click *Login* and log in to Provider Secured Services.
- Click *web-DENIS*.
- Click *BCN Provider Publications and Resources*.
- Click *Autism*.
- Click *Documentation requirements for applied behavior analysis services*.

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Best Practices

Childhood immunizations

Interview with Dr. Judy Tosto,
IHA Canton Family Medicine

What accounts for the high childhood immunization rates in your practice?

First and foremost, all the providers in our office have established trusting relationships with our families, allowing parents and patients to ask questions about immunizations in a safe and nonjudgmental environment. The ability to have clear, comfortable and open communication with your child's medical provider is paramount.

We also have a nurse in our office who functions as a panel coordinator whose job it is to review the Michigan Care Improvement Registry daily. She can see which patients are behind on their vaccines and will call parents to get these children in for nurse visits to get them caught up on vaccinations.

In addition, our medical assistants review the immunization registry at every visit, regardless if it's a sick visit or well child exam. If a child is behind on a vaccine, it will be offered at a sick visit if the child is well enough to receive it.

Our receptionists also ensure that parents schedule the next well child exam at check out. All members in our office — receptionists, medical assistants, nurses, nurse practitioners and pediatricians — play an important role in keeping up our high childhood immunization rates.



Dr. Judy Tosto and patient Colin Lambert

Photo by Deepa Elangainathan

What are the specific challenges related to flu vaccines?

Giving flu vaccines in a timely fashion can be challenging due to the seasonality of administration of the vaccine. If a child doesn't have a well child exam scheduled during the fall or early winter, parents may not remember to call the office to get the vaccine, or it may not be convenient to come back to receive it. It also isn't a required vaccine for school entrance, so there may be less motivation for parents to give the vaccine to their children.

Perhaps a bigger issue is the common misconception that influenza is the "stomach flu" that causes fever and diarrhea. Many parents and patients are unaware that influenza is a potentially life-threatening respiratory illness. In addition, the normal side effects of the vaccine, such as low-grade fevers and body aches, can be misinterpreted as actually having influenza.

We tackle all these challenges by educating parents and patients about the importance of flu vaccine and making the vaccine easily accessible for our pediatric population. We offer flu clinics on the weekends to accommodate working families. We also offer online scheduling for nurse visits. We also offer the flu vaccine to the siblings and parents of patients we're seeing on a particular day.

Please see [Immunizations](#), continued on Page 23

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What kind of patient education do you offer about immunizations?

We give every newborn family a binder explaining our office policies and the Centers for Disease Control and Prevention's recommended immunization schedule that we follow. The binders include educational handouts, or vaccine information statements, published by the CDC.



These go over what each vaccine is, why it's important to get the vaccine, potential reactions, contraindications to getting the vaccine and what to do if a problem occurs. We also provide these handouts at each well child exam where we're administering a vaccine.

Our office sponsors a monthly prenatal night where expectant families or those looking for a new pediatrician can ask questions and learn about our policies.

Potential patients are always welcome to schedule a meet-the-doctor interview if they're looking for a new pediatrician. Usually, many vaccine questions are asked at these interviews.

Is there targeted education about the flu vaccine?

Each provider at our office educates patients and families about the importance of flu vaccine during well child exams during cold and flu season. We explain how prevalent flu is and the serious complications that can occur. As with all vaccines, being vaccinated against influenza is also about protecting those around you, especially if you spend time around infants who are too young to get the vaccine, children who are immunocompromised or senior citizens.

Often, we can convince parents and patients who were initially hesitant to get the vaccine.

Remind your patients of the importance of colorectal cancer screening

Colorectal cancer is the third most common cancer diagnosed in both men and women in the United States, according to the American Cancer Society. Your patient may be under the assumption that a colonoscopy is the only way to test for colorectal cancer. Talk to your patients about the importance of early detection and the types of tests available, including those that are non-invasive.

There are many screenings available for patients to choose from and it's important for providers to document the type of screening performed or any exclusions in the patient's medical record. Exclusions for this HEDIS® measure have changed to include advanced illness and frailty of the patient.

View the Colorectal Cancer Screening tip sheet to learn more about the measure, information to include in a patient's record, CPT codes that should be included in claims and tips for talking with patients. You can find it in Provider Secured Services. Go to *BCN Provider Publications and Resources*. Click on *Clinical Quality Corner* under Other Resources. Then scroll down to Star Measure tip sheets.

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What are some of the challenges to getting 100% of your patients vaccinated?

Perhaps the biggest challenge is social media. Myths about vaccines, vaccine fears and anecdotal experiences are easily and widely communicated and propagated.

IHA has had a policy for a few years that we're unable to accept families who decline to vaccinate their children according to the CDC schedule. When that policy went into place, we grandfathered our current families who have decided to not vaccinate or vaccinate on a delayed schedule. We obviously have some work to do with those families and continue to offer education every opportunity that we can.

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Save time and submit prior authorization requests electronically for pharmacy benefit drugs

Providers can now use their electronic health record or CoverMyMeds®* to submit prior authorizations for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members with commercial pharmacy benefits.

Electronic prior authorization, or ePA, replaces faxing and phone calls so providers can focus less on administrative tasks and more on patient care. Other benefits of ePA include automatic approvals for select drugs and improved turnaround time for review and decisions. It's easy for prescribers, nurses and office staff to use. All documentation and requests are kept conveniently in one place.

Here are some answers to frequently asked questions about ePA:

Why should I use ePA?

You'll save time. You can send 11 ePAs in the time it takes to fax just one (based on Comcast and Verizon broadband rates and fax speed of 33.6 kbps) and patients can receive medications faster.

The process is easy and intuitive. Providers and authorized personnel can use the electronic health record, or EHR, tool or log in online.

What is the cost of ePA?

Some EHR vendors charge an additional fee for this added functionality. There is no cost to use online portals.

What makes ePA better?

Both the online portals and ePA within your electronic health record make it easy to submit fully electronic requests and give you:

- Clear direction on clinical requirements
- The ability to attach documentation, if required
- Secure and efficient prior authorization administration all in one place
- The capability to proactively renew existing prior authorizations up to 60 days before they expire
- Streamlined questions pertaining only to information needed for the prior authorization

How do I get started?

ePA can integrate into your current electronic health record workflow. Check with your vendor to ensure you have the latest software version enabling ePA.

If ePA in your electronic health record tool isn't available, create a free account online for the tool that works best for your office. Registration is free and takes only a few minutes.

To complete an ePA, follow these steps:

1. Go to covermymeds.com/epa/express-scripts.
 - Create a free account if you don't already have one.
2. Start a prior authorization
 - Click *New Request* and enter the patient's state and medication.
 - Type Blue Cross Blue Shield of Michigan into the Plan, PBM and Form Name field.
 - Select the appropriate form and click *Start Request*.
3. Complete
 - Enter all demographic fields marked Required and click *Send to Plan*.
 - Complete the returned list of patent-specific, clinical questions marked Required.
4. Confirmation
 - Click *Send to Plan* again to complete the ePA request.
 - After Blue Cross or BCN has reviewed your submitted prior authorization request, the determination will appear in your CoverMyMeds account.

Approval decisions are often returned within moments of submission depending on the complexity or need for further review.

If you have questions, call the Pharmacy Help Desk at 1-800-437-3803.

Click [here](#) for a brochure detailing the benefits of ePA.

* Other free ePA services include Surescripts® and ExpressPath®

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We'll cover hemophilia drugs under the pharmacy benefit for most commercial HMO and PPO members, starting Jan. 1

Blue Cross Blue Shield of Michigan and Blue Care Network will change how we cover hemophilia drugs, starting Jan. 1, 2020. If a member has Blue Cross or BCN pharmacy coverage, all hemophilia drugs should be billed under the patient's pharmacy benefits.

This change doesn't affect all commercial members. For example, if a member has pharmacy coverage through a company other than Blue Cross or BCN, hemophilia drugs will continue to be covered under the medical benefit.

To determine whether this change applies to a specific member:

- For BCN HMOSM members, review the member's benefits in web-DENIS.
- For Blue Cross' PPO members, review the member's benefits in Benefit Explainer.

We'll notify affected members of these changes. Members don't have to do anything. Their medication and treatment won't change.

What changes will occur on Jan. 1, 2020?

For affected members, hemophilia drugs and supplies that are currently covered under the medical benefit will be covered under the pharmacy benefit. In addition:

- Members will be limited to a 30-day supply of hemophilia drugs.
- The hemophilia drug Hemlibra[®] will continue to require authorization.

Which groups and members are affected?

This change affects most commercial Blue Cross' PPO and BCN HMO members who have Blue Cross or BCN pharmacy coverage, including those covered by individual plans and those covered through groups with administrative service contracts.

Note: ASC groups can opt out of the program. Groups that opt out will continue to use the medical benefit for hemophilia drugs.

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Hemophilia drugs, continued from Page 25

Which groups and members aren't affected?

The following groups and members aren't affected:

- HMO and PPO members with a carved-out pharmacy benefit
- Medicare and Medicaid members
- Groups with pharmacy benefits that involve limited and religious accommodations that cover only the pharmacy benefits mandated by the Affordable Care Act

How will this change affect members who are currently undergoing hemophilia therapy?

There won't be any change to members' therapy. Drug selection, dosage and frequency will remain the same. Members will continue to receive care from their current providers.

These hemophilia drugs are being added to the formulary as branded, nonspecialty medications. Depending on their pharmacy benefits, copays may increase for some members.

How will providers and specialty pharmacies know to bill the pharmacy benefit starting Jan. 1, 2020?

We'll send letters to providers and specialty pharmacies about billing Blue Cross and BCN members under the pharmacy benefit, unless the member's group has opted out of the hemophilia program.

If a hemophilia drug is processed under the pharmacy benefit and the group has opted out, a point-of-sale message will let the specialty pharmacy know immediately that the place of service isn't covered. The provider or specialty pharmacy will be instructed to bill the medical benefit, as they did previously.

Why are we making this change?

Quality of care: We provide our members access to the best health care at the lowest cost. By adding this drug class to the pharmacy benefit, we can continue to offer hemophilia therapy to our members while increasing the quality of care and possibly reducing the cost to the plan and our members.

Data capability: We'll be able to get real-time data about units dispensed, dosing and the dates on which each member receives medication. This data isn't always available under the medical benefit. In addition, we can see where the member is receiving therapy and direct him or her to higher-quality centers with better pricing.

Evenity will be added to the Medicare Part B medical drug prior authorization list in November

We're adding Evenity® (J3111) to the Medicare Plus BlueSM PPO and BCN AdvantageSM Part B medical drug prior authorization lists.

For dates of service on or after Nov. 1, 2019, Evenity will require prior authorization.

See article on [Page 36](#) for details.

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We'll stop covering Zytiga 500mg starting Nov. 1

We'll no longer cover Zytiga® (abiraterone) 500mg, starting Nov. 1, 2019. However, members can continue to fill their prescriptions for Zytiga 500mg until Jan. 1, 2020. If they fill prescriptions for Zytiga 500mg on or after this date, they'll be responsible for the full cost.

Members can continue their current treatment with **generic** Zytiga 250mg and may pay less for this prescription than what they pay currently.

The following table includes some information to compare the available strengths of Zytiga.

Zytiga strength	Available as generic drug	Member cost	Number of tablets per day (for 1000mg dose)
250mg	Yes	Generic specialty copayment	4
500mg	No	Full cost (not covered)	2

We'll let members know about this change and encourage them to speak with their doctors about getting a prescription for generic Zytiga 250mg and to discuss any concerns.

For a complete list of covered drugs go to bcbsm.com/pharmacy and click Drug lists.

If you have questions, call the Pharmacy Services Clinical Help Desk at 1-800-437-3803 and select option 1.



Did you know?

Approximately 16 million Americans have chronic obstructive pulmonary disease, or COPD. *Here's an overview of COPD and tips for documenting and coding it appropriately.*

About COPD

COPD is a chronic inflammatory lung disease that results in the obstruction of smaller airways within the lungs. Symptoms may be mild at first, beginning with a cough and shortness of breath with exertion. As it progresses, shortness of breath worsens and may be present at rest. Abnormal levels of oxygen and carbon dioxide in the blood may also be found in patients with advanced COPD. Ultimately, progression of the disease leads to chronic respiratory failure.

COPD is a collective term that includes three specific diseases:

- Chronic bronchitis
- Emphysema
- Asthma with chronic obstruction

Emphysema is characterized by the slow progressive destruction of lung tissue, mainly the small air sacs in the lungs known as alveoli. This interferes with outward air flow from the lungs.

Chronic bronchitis mainly causes inflammation of the bronchial tubes, which allows mucus to build up and obstruct the airways. It also causes some constriction and narrowing of the airways. Patients with longstanding asthma may develop chronic obstruction of the airways and chronic inflammation, similar to chronic bronchitis.

Most patients with COPD have a combination of both emphysema and chronic bronchitis features. Emphysema features will be predominant in some patients, while chronic bronchitis features will be predominant in others.

Symptoms of COPD can vary from one patient to the next, but common symptoms are:

- Shortness of breath
- Frequent coughing, with or without mucus production
- Fatigue
- Wheezing
- Tightness in the chest

Stages of COPD

The stages of COPD are based on the forced expiratory volume, or FEV1. This is the maximal amount of air someone can forcefully exhale in one second. It is then converted to a percentage of normal. The lower the FEV1, the more severe the disease.

- Stage I (early or mild) — FEV1 about 80% or more of normal
- Stage II (moderate) — FEV1 between 50% and 80% of normal
- Stage III (Severe) — FEV1 between 30% and 50% of normal
- Stage IV (very severe or end stage) — FEV1 less than 30%, or people with low blood oxygen levels and a Stage III FEV1

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COPD, continued from Page 28

Treatments for COPD

- Bronchodilators to open airways — Most come in the form of inhalers. Both short- and long-acting bronchodilators are available.
- Steroids — These reduce inflammation, swelling and mucus production. Less swelling allows more space through which air can travel. Steroids can be inhaled, taken orally or injected.
- Immunization — Centers for Disease Control and Prevention recommends that individuals with COPD get flu and pneumococcal vaccinations to help protect against complications of COPD.
- Oxygen therapy — Because COPD can lower blood oxygen levels, this treatment provides the body the extra oxygen it needs.

Documentation and coding tips

Always document and code COPD to the highest specificity. **The term “COPD” is less specific than the individual diseases it includes.** If a patient predominantly exhibits features of one specific disease over another, such as emphysema, chronic obstructive asthma or chronic bronchitis, then this should be documented rather than COPD.

Since conditions under the COPD umbrella can be coded in a variety of ways, the final code selection must consider all the specific details of a patient’s condition as documented by the provider.

With the increased specificity in documentation required by ICD-10-CM guidelines, here are some key points to remember:

- Specify the **acuity**: acute, chronic, intermittent or chronic with an acute exacerbation.
- Describe the **severity**: mild, moderate or severe.

- Document **clinical signs** and **symptoms**: coughing, wheezing, sputum production, shortness of breath.
- List any history of **tobacco use**, environmental exposure or occupational exposure.
- Note **any diagnostics test**: ABGs (arterial blood gas test), PFTs (pulmonary function test), chest X-rays.
- Document any **treatment**: oxygen, bronchodilators, steroids, pulmonary rehabilitation.

Some examples of COPD codes are given in the chart below:

ICD-10-CM category	Condition
J41.0	Simple chronic bronchitis
J42	Unspecified chronic bronchitis
J43.1	Panlobular emphysema
J43.9	Emphysema, unspecified
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified
J45.901	Unspecified asthma with (acute) exacerbation
J45.909	Asthma, unspecified
J96.10	Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia

Sources:

- copdfoundation.com
- mayoclinic.org
- 2019 ICD-10-CM Professional for Physicians

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

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Use correct coding to avoid some clinical edits

Do you see trends in the clinical edits that you receive? Some of these edits can be avoided through use of correct coding or consistent, detailed modifier use and ICD-10 coding.

If you're receiving consistent edits on one particular CPT code or diagnosis code, review the information to see if adding a specific modifier or diagnosis code will provide more detail to the claim line.

Here are modifiers that provide more specificity. (Note that modifiers 25 and 59 are not good examples of more specificity.)

- LT and RT, 76 and 77, or the approved behavioral health modifiers
 - For example, if physician A reads a two-view complete shoulder X-ray and physician B reads a second film from a separate session, physician B should report 73030-26, 77, and RT/LT.

Diagnosis codes should be billed to the same, high level specificity. When an unspecified ICD-10 code is selected, but there is an alternative code with a specific added detail of the condition, the specific code should be reported.

- The ICD-10 official guidelines offer the proper use of the appropriate level of detail.
- Using codes with greater specificity could potentially help avoid a clinical edit.
 - One example would be a three-character code (category) requiring a fourth character (subcategory) with a notation in red under the category stating, *Code first the underlying physiological condition*. That notation applies not only to the category but also to the subcategories below each category. Submitting the underlying physiological condition first followed by the intended code can avoid an edit.

Facilities: CMS guidelines for billing more than one emergency room visit on the same date

Facilities can bill for two emergency room visits on the same date when multiple medical visits occur on the same day in the same revenue center, but visits were distinct and independent visits.

The Centers for Medicare & Medicaid Services guidelines specify that the first emergency room visit claim should be reported with the revenue code 045X plus an evaluation and management code with ancillary services rendered on that day.

Then on the second claim, report only the unrelated emergency room visit (revenue code 045X plus E&M code) with condition code G0.

Clinical editing billing tips

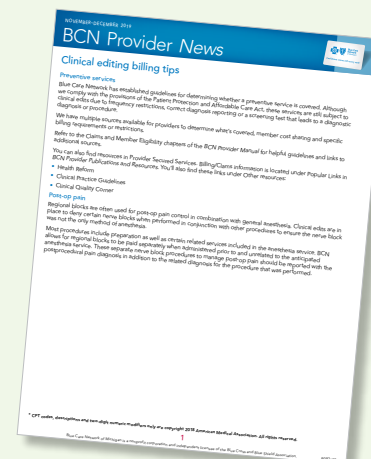
In most issues, we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that the performed procedure is correctly reported to us.

This issue's tip includes:

- Preventive services
- Post-op pain



Clinical editing
billing tips



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Reminder: New edits for claims reporting V, W, X or Y diagnosis codes

Beginning Oct. 7, 2019, BCN HMOSM and BCN AdvantageSM electronic claims submitted with a diagnosis involving an external cause of morbidity reported as primary or principal will receive an EDI front-end edit on either a 277CAP transaction or a R277CAI (Institutional) or R277CAH (Professional) report.

These edits will apply to electronic claims with ICD-10 codes V00 through Y99 submitted to either BCN HMO or BCN Advantage. Currently, claims with V, W, X or Y diagnosis codes get denied by BCN, but beginning on Oct. 7 these claims will instead get a front end edit.

Institutional edits:

- F112 EXTERNAL CAUSE OF INJURY NOT VALID AS PRINCIPAL DIAGNOSIS
- F113 EXTERNAL CAUSE OF INJURY NOT VALID AS ADMITTING DIAGNOSIS
- A3:254 or A3:232 in the 277CAP transaction

Professional edit:

- P112 EXTERNAL CAUSE OF INJURY NOT VALID AS PRINCIPAL DIAGNOSIS
- A3:254 in the 277CAP transaction

We previously communicated this information in a web-DENIS message on Aug. 28.

Call the EDI help desk at 1-800-542-0945 if you have questions.

How to bill vision exams for University of Michigan student health plan members

Here's how to bill vision exams for BCN HMOSM (commercial) members covered under these University of Michigan student health plans:

- Domestic Student Health Plan, available starting Aug. 24, 2019
- International Student and Scholar Health Plan, available starting Sept. 1, 2019

To bill vision exams for these members, do the following:

- **For members 19 years old and older, bill BCN directly.** This applies to procedure codes *920XX and *992XX. Vision exams for members 19 and older are covered under the member's medical benefits.
- **For members younger than 19, bill VSP[®] Vision Care.** Vision exams for members younger than 19 are covered under the member's vision benefits.

Typically, for most plans, you'd bill vision exams to VSP for all age groups. However, for the University of Michigan student health plans, vision exams are covered differently than they are for most other plans and you need to bill them differently. We first communicated about this in a web-DENIS message in September.

You can check web-DENIS to confirm the member's date of birth and coverage under one of the University of Michigan student health plans, and then bill according to the instructions outlined in this article.

If you have questions or want to confirm that a member is covered under the University of Michigan student health pediatric vision plan administered through VSP, you can call VSP at the number on the back of the member's BCN member ID card.

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Reminder: naviHealth authorizes PDPM levels for Medicare Advantage SNF admissions, starting Oct. 1

naviHealth authorizes patient-driven payment model levels during a patient's stay (from preservice through discharge) for Medicare Plus BlueSM PPO and BCN AdvantageSM skilled nursing facility admissions with dates of service on or after Oct. 1, 2019. This aligns with the Centers for Medicare & Medicaid Services payment methodology. As a result, the payment methodology will change from RUG levels to PDPM levels on Oct. 1, 2019.

We first communicated this change in late July.

When submitting claims for stays with dates of service starting on or before Sept. 30, 2019, and extending through or beyond Oct. 1, you need to include both the resource utilization group levels and the PDPM levels that naviHealth authorized.

You can view additional information on [The Patient Driven Payment Model \(PDPM\) — Information and Resources for Provider Partners](#) page of the naviHealth website.

As a reminder, naviHealth manages authorization requests for Medicare Plus Blue PPO and BCN Advantage members admitted to post-acute care on or after June 1, 2019. For details, see the [Post-acute care services: Frequently asked questions by providers](#) document.



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New and updated questionnaires now open in e-referral system

New and updated questionnaires started opening in the e referral system for certain procedures on Aug. 25 and on Sept. 29, 2019. In addition, new and updated preview questionnaires, authorization criteria and medical policies are available on the ereferrals.bcbsm.com website.

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

New questionnaires

Effective Aug. 25, questionnaires started opening for the first time in the e-referral system for authorization requests for BCN HMOSM and BCN AdvantageSM for the procedures listed below, which already require authorization.

Service	Age	Procedure codes
Bariatric surgery — BCN HMO	Adult and adolescents	*43644, *43645, *43770, *43771, *43772, *43773, *43774, *43775, *43842, *43843, *43845, *43846, *43847, *43848, *43886, *43887, *43888 and *44130
Bone-anchored hearing aid	Adult and pediatric (5 years old and older)	*69714, *69715, *69717 and *69718
Cardiac rehabilitation — BCN HMO	Adult and pediatric	*93797 and *93798 (for select diagnoses)
Cardiac rehabilitation — BCN Advantage		
Pregnancy termination — BCN HMO	Adult	*01966, *59100, *59840, *59841, *59850, *59851, *59852, *59855, *59856, *59857, *59866, *88304, *88305, S0190, S0191, S0199, S2260, S2265, S2266 and S2267
Pregnancy termination — BCN Advantage		
Pulmonary rehabilitation	Adult and pediatric	G0237, G0238, G0239, G0302, G0303, G0304, G0424 and S9473
Radiofrequency ablation, peripheral nerves	Adult	*64640
Visual training, orthotic and pleoptic	Adult and pediatric	*92065

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Questionnaires, continued from Page 33

Updates to existing questionnaires

In addition, updated questionnaires started opening in the e-referral system on the dates specified below for BCN HMO, BCN Advantage and Medicare Plus BlueSM PPO authorization requests (unless otherwise noted), for the following services.

- Cervical spine surgery — Aug. 25; opens only for BCN HMO and BCN Advantage
- Cervical spine fusion with artificial disc replacement — Sept. 29
- Cholecystectomy (laparoscopic) — Aug. 25; opens only for BCN HMO and BCN Advantage
- Dental anesthesia or repair of trauma to natural teeth — Sept. 29; opens only for BCN HMO and BCN Advantage
- Endovascular intervention, peripheral artery — The updated questionnaire for this service was originally scheduled to open starting on July 28 for Medicare Plus Blue requests but actually started opening on Aug. 25.
- Ethmoidectomy — Aug. 25
- Hammertoe correction surgery — Aug. 25
- Hip arthroplasty, total, revision — Aug. 25
- Knee arthroplasty, total, revision — Aug. 25
- Noncoronary vascular stents — Sept. 29
- Sacral nerve neuromodulation/stimulation — Aug. 25
- Sinusotomy, frontal, endoscopic — Aug. 25
- Sleep studies, outpatient facility or clinic-based setting — Aug. 25; opens only for BCN HMO and BCN Advantage
- Vascular embolization or occlusion of hepatic tumors (TACE/RFA) — Aug. 25

Preview questionnaires

For all of these services, you can access preview questionnaires at ereferrals.bcbsm.com. The preview questionnaires show the questions you'll need to answer in the actual questionnaires that open in the e-referral system. This can help you prepare your answers ahead of time.

To find the preview questionnaires:

- For BCN: Click *BCN* and then click **Authorization Requirements & Criteria**. Scroll down and look under the *Authorization criteria and preview questionnaires* heading.
- For Medicare Plus Blue: Click *Blue Cross* and then click **Authorization Requirements & Criteria**. In the Medicare Plus Blue PPO members section, look under the *Authorization criteria and preview questionnaires — Medicare Plus Blue PPO* heading.

Authorization criteria and medical policies

We also posted links to the pertinent authorization criteria and medical policies on the *Authorization Requirements & Criteria* pages.

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Don't add clinical documentation to denied requests in the e-referral system

When we deny an authorization request in the e-referral system, we contact your office to inform you of that determination and then we close the case, which means that the case no longer appears in our queues.

We don't receive notification of changes to authorization requests that have been closed.

For this reason, we ask that you don't submit additional clinical documentation or make any other changes on denied requests. Instead, submit the clinical documentation during the appeals process. This will help to ensure that we see and review the additional documentation.

The denial letter includes instructions for submitting an appeal.

You can also find information about appealing utilization management decisions in the following chapters of the *BCN Provider Manual*.

- **BCN HMO:** See the **Care Management** chapter. Look in the "Appealing utilization management decisions" section.
- **BCN Advantage:** See the **BCN Advantage** chapter. Look in the "BCN Advantage provider appeals" section.

Authorization requirement changes for BCN members

We've made changes in authorization requirements for these procedures: transcatheter aortic valve implantation and replacement, endometrial ablation and excisional breast biopsy procedures.

Transcatheter aortic valve implantation and replacement procedures no longer require authorization and clinical review for BCN HMOSM (commercial) and BCN AdvantageSM members.

You no longer need to submit clinical documentation for these requests. However, this procedure requires plan notification to facilitate claims payment. Refer to the **e-referral User Guide** for instructions on how to submit a plan notification.

This change applies to the following procedure codes: *33361, *33362, *33363, *33364, *33365, *33366, *33367, *33368 and *33369.

Neither plan notification nor authorization are required for endometrial ablation and excisional breast biopsy procedures for BCN HMOSM (commercial) and BCN AdvantageSM members. Standard regional referral requirements still apply. For example, a global referral is still required where applicable.

This change applies to the following procedure codes:

- Endometrial ablation: *58353, *58356 and *58563
- Excisional breast biopsy: *19101, *19120, *19125 and *19126

*CPT codes, descriptions and two-digit modifiers only are copyright 2018 American Medical Association. All rights reserved.

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Evenity will be added to the Medicare Part B medical drug prior authorization list in November

We're adding Evenity® (J3111) to the Medicare Plus BlueSM PPO and BCN AdvantageSM Part B medical drug prior authorization lists.

For dates of service on or after Nov. 1, 2019, Evenity will require prior authorization.

BCN Advantage

For BCN Advantage, we require authorization for this medication for the following sites of care when you bill the medication as a professional service or as an outpatient facility service, and when you bill electronically through an 837P transaction or on a professional CMS-1500 claim form:

- Physician office (place of service code 11)
- Outpatient facility (place of service code 19, 22 or 24)
- Home (place of service code 12)

We also require authorization when you bill electronically through an 837I transaction or using a UB04 claim form for a hospital outpatient type of bill 013x.

Medicare Plus Blue PPO

For Medicare Plus Blue, we require authorization for this medication for the following sites of care when you bill the medication electronically through an 837P transaction or on a professional CMS-1500 claim form:

- Physician office (place of service code 11)
- Outpatient facility (place of service code 19, 22 or 24)

Important reminder

You must obtain an authorization before administering this medication. Use the NovoLogix® online tool to submit your authorization requests. It offers real-time status checks and immediate approvals for certain medications.

If you need access to Provider Secured Services or the NovoLogix online tool

If you have access to Provider Secured Services but you need access to NovoLogix, do one of the following:

- For BCN Advantage, access to Provider Secured Services gives you automatic access to NovoLogix. There's nothing more you need to do.
- For Medicare Plus Blue, if you have a Type 1 (individual) NPI and you checked the "Medical Drug PA" box when you completed the Provider Secured Services Application form, you already have access to NovoLogix. If you didn't check that box, you can complete an **Addendum P form** to request access to NovoLogix and fax it to the number on the form.

If you need to request access to Provider Secured Services, complete the **Provider Secured Services Application** form and fax it to the number on the form.

To access NovoLogix through Provider Secured Services

1. Visit bcbsm.com/providers.
2. Click *Login*.
3. Log in to Provider Secured Services.
4. Click one of the following links on the Provider Secured Services welcome page.
 - *BCN Medical Benefit – Medication Prior Authorization*
 - *Medicare Advantage PPO Medical Benefit – Medication Prior Authorization*
5. Enter or select your NPI and click *Go*.

If you can't log in to Provider Secured Services, call 1-877-258-3932 Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

If you have questions about authorizations, you can call the Pharmacy Clinical Help Desk at 1-800-437-3803 Monday through Friday from 9 a.m. to 4 p.m. Eastern time.

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Take a few minutes to tell us how satisfied you are with our utilization management services

Blue Cross Blue Shield of Michigan and Blue Care Network want to know how satisfied you are with our utilization management services. Let us know by completing a short **survey**. The survey opened Oct. 14 and closes on Dec. 1, 2019.

Encourage your office colleagues, including physicians, nurses and referral coordinators, to take the survey as well. Your responses will help us evaluate our efforts and make improvements to our utilization management processes to better support you as you care for our members.



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