

# BCN Provider News



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## No referral required for approved BCN providers offering medication-assisted treatment for opioid use disorders

Blue Care Network no longer requires a referral for approved specialists or primary care physicians providing medication-assisted treatment, or MAT, for opioid use disorders involving these medications:

- Buprenorphine (for opioid use disorders)
- Naltrexone for extended-release injectable suspension (Vivitrol®)

We're making this change as part of our efforts to address the opioid use epidemic. In the past, we've required a referral for MAT services when provided by someone other than the member's primary care physician. We hope this change will make it easier for our members to access the treatment they need.

MAT services don't currently require authorization for in-network providers and that will continue to be the case.

Here are some important things you should know:

- This change applies to MAT services for BCN HMO<sup>SM</sup> (commercial) members.

Note: As a reminder, we do not accept referrals of BCN Advantage<sup>SM</sup> members to in-network providers. See the article, **BCN no longer accepts referrals for BCN Advantage members staying in-network**, on page 7 of the March-April 2019 BCN Provider News.

See Blue Cross, BCN to support providers who offer comprehensive opioid treatment, Page 24

Please see [Opioid Use](#), continued on Page 21



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User Guide

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## Provider Outreach is now Provider Engagement and Transformation

Provider Outreach has been renamed Provider Engagement and Transformation. The department of provider consultants will continue to provide education on Blue Cross Blue Shield of Michigan and Blue Care Network processes and programs.

“Our team’s primary focus is on building and maintaining a strong provider network,” said Donna LaGosh, director, Provider Engagement and Transformation for the East, Mid and Southeast Regions. David Brown, director, Provider Engagement and Transformation for the West Region agrees. “Consultants help introduce providers to new programs and help providers have a successful relationship with Blue Cross and BCN,” said Brown.

Over the next few months, we’ll be changing the language to Provider Engagement and Transformation in our provider manuals and on our websites. But don’t worry, provider consultants are still available to help with your education needs.

If you need a reminder on where to find information, see our article, *How to find help*, on **Page 3**.



Donna LaGosh



David Brown

## BCN Health e-Blue guide available for providers

We’ve put together a guide to help providers use the BCN Health e-Blue<sup>SM</sup> system. This step-by-step guide shows providers how to find patient detail including eligibility, treatment opportunities by condition and measure, diagnosis gaps and more.

Providers can find this guide on BCN Health e-Blue:

- Visit [bcbsm.com/providers](https://bcbsm.com/providers).
- Click *Login*.
- Log in to Provider Secured Services using your user ID and password.
- Click *BCN Health e-Blue*.
- Click *BCN Health e-Blue User Guide* under *Help Documents* in *Resources*.

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

Each Healthy *Blue* Living<sup>SM</sup> 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 get 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.

### 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 Basic<sup>SM</sup> 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](https://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

## Reminder

## How to find help

You're trying to get your work done and you run into a Blue Cross or BCN question or problem that you need to solve. Where do you turn?

### Check for help online

You can often save time by looking up information online. Log in to [bcbsm.com](https://bcbsm.com) and look in one of our provider manuals or view documents within *BCBSM Provider Publications and Resources* or *BCN Provider Publications and Resources*. If your question is about authorizations or referrals, you may be able to find your answer at [ereferrals.bcbsm.com](https://ereferrals.bcbsm.com).

### Call Provider Inquiry

If you can't find your answer online, your first call should be to Provider Inquiry if the question is general in nature or related to claims, benefits or eligibility. Automated information is available 24 hours a day, seven days a week. Plus, you can speak to a Provider Inquiry representative during regular business hours. If your issue isn't satisfactorily resolved, ask the representative to escalate your inquiry to a senior representative.

- 1-800-344-8525 for professional medical providers
- 1-800-482-4047 for vision and hearing providers
- 1-800-249-5103 for facility providers

### Consult our provider resource guide

If your question is specific to behavioral health, web technical assistance, pharmacy or several other topics, you can consult our [provider resource guide](#). (Blue Cross phone numbers are on the first page and BCN phone numbers are on the second page.)

Please see [Finding Help](#), continued on Page 4

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## Updated *Finding your plans and network* guide is now available

The updated *Finding your plans and networks* guide is available and includes a newly revised Blue Cross Blue Shield of Michigan and Blue Care Network list of health plans and provider networks.

This guide helps providers navigate the **Find a Doctor** site on [bcbsm.com](http://bcbsm.com) and identifies the plans they accept and the provider networks to which they belong.

When you look yourself up using the Find a Doctor search, you'll find a list of health plans that you can accept. You can use the "Finding your plans and networks" list to help determine the provider networks to which you belong.

The *Finding your plans and networks* guide can be found on web-DENIS. When logged in, follow these steps:

1. Click on *BCBSM Provider Publications and Resources*.
2. Click on *Newsletters and Resources*.
3. Under *Products*, click *Products and Networks*.
4. Click on *Finding your plans and networks*.

You can also find the guide within BCN Provider Publications and Resources.

1. Click on *BCN Provider Publications and Resources*.
2. Under *Products*, click *BCN Products*.
3. Click *Finding your plans and networks*.

Consider keeping a list at your front desk of the health plans accepted by each provider in your office and the provider networks to which they belong. This can help staff answer patient questions.

If you have questions about your network status, call Provider Enrollment and Data Management at 1-800-822-2761. You'll need the following three items when contacting us:

- National Provider Identifier
- The last four digits of the provider's Social Security number (for an individual provider) or tax ID (for a group)
- Primary address and phone number

**Finding Help**, continued from Page 3

### Contact a provider consultant

Requests for educational assistance for professional providers should come through a physician organization or medical care group administrator, if you have one. Here's how to find your provider consultant:

- Primary care physicians and medical care groups can look on the **physician organization consultant list**.
- Specialists and other professional providers — To find your list:
  - Go to [bcbsm.com/providers](http://bcbsm.com/providers).
  - Click on *Contact Us* in the upper right corner.
  - Under *Physicians and professionals*, click on either *Blue Cross Blue Shield of Michigan provider contacts* or *Blue Care Network provider contacts*.

- Click on *Provider consultants* and select your geographic region. (View our **map** to confirm your region.)
- Hospitals and other facility providers – To find your list:
  - Go to [bcbsm.com/providers](http://bcbsm.com/providers).
  - Click on *Contact Us* in the upper right corner.
  - Under *Hospitals and facilities*, click on either *Blue Cross Blue Shield of Michigan provider contacts* or *Blue Care Network provider contacts*.
  - Click on *Provider consultants* and select your geographic region. (View our **map** for facility providers to confirm your region.)



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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:

- 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 HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> 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 isn't available, 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 before admitting the member.

# Network Operations

## 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 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 the upcoming training webinars:

Webinar name	Date and time	Registration
AIM Specialty Health® — Medicare Advantage Medical Oncology	Thursday, January 9, 9 to 10 a.m.	<a href="#">Click here to join session</a>
AIM Specialty Health® — Medicare Advantage Medical Oncology	Wednesday, January 22, 12 to 1 p.m.	<a href="#">Click here to join session</a>
Hyaluronic Acid Knee Injections — Preferred vs. Non-preferred	Thursday, January 30, 1 to 1:30 p.m.	<a href="#">Click here to register</a>
Hyaluronic Acid Knee Injections — Preferred vs. Non-preferred	Tuesday, February 11, 1 to 1:30 p.m.	<a href="#">Click here to register</a>
Hyaluronic Acid Knee Injections — Preferred vs. Non-preferred	Tuesday, February 18, 10 to 10:30 a.m.	<a href="#">Click here to register</a>

We've also posted recordings of previous webinars. You can find them on the *Learning opportunities* and *Provider Training* pages. Here's how to find the links:

#### For BCN

- Log in to Provider Secured Services.
- Go to *BCN Provider Publications and Resources*.
- Click on *Learning opportunities* under Other Resources.

#### For Blue Cross

- Log in to Provider Secured Services.
- Go to *BCBSM Newsletters and Resources*.
- Click on *Provider Training* under Popular links.

As additional training webinars become available, we'll communicate about them through web-DENIS, *BCN Provider News*, or *The Record*.



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Blue Care Network recognizes the positive impact that online patient portals and member health plan accounts have on improving patient connections, leading to better experiences for patients and providers.

We've put together the following resources to help you engage members with your practice's patient portal, as well as Blue Cross' online member account tools:

## Webinar: Let Us Help You Help Them: Your Patients' Experience

Watch a recorded presentation to learn about the value of patient portals, how to foster and improve patient engagement with portals and how our member account streamlines accessibility for your patients and makes more efficient use of your time.

Find it on the Provider Secured Services' *BCN Provider Publications and Resources Learning opportunities* page and on the *BCBSM Newsletters and Resources Provider Training* page.

**[bcbsm.com/ordertoolkit](https://bcbsm.com/ordertoolkit)** is the easy-to-remember address of the online *Patient Digital Engagement Toolkit* order form. Use it to order our member account registration and mobile app materials. More members with registered Blue Cross accounts add up to fewer inquiries about billing and other coverage-related questions. Active users understand their health plan better, which makes them more prepared and satisfied with the services your practice provides.

## Six tips for improving patient engagement with your practice's portal

Physicians and staff should have a basic knowledge of the features of your own patient portal and should be able to offer suggestions about its benefits, how to use it and provide handouts when appropriate.

1. Mention the portal in on-hold messaging and voicemail recordings. Include features patients will enjoy and how to sign up. Emphasize conveniences, such as ability to schedule appointments or to request medications 24/7.
2. Put flyers and posters where patients are waiting for appointments and have time to read.
3. Add a tagline on appointment cards, statements and newsletters, such as: "Tired of playing phone tag? Sign up for our patient portal."
4. Include portal registration details in checkout materials.
5. Put a login link at the top of your website's homepage.

## Why improve patient usage of portals?

Online portals offer a convenient and timely method of communication between your practice and patients. Additionally, portals streamline administrative tasks, such as new patient registrations, check-ins and appointment scheduling. Increasing awareness of available self-service tools can deliver better workflows and satisfaction for practices and patients.

Keep information secure flyer available for provider offices

The *Keep office information secure* **flyer** has been redesigned and updated (dated September 2019) and is now available for providers. This flyer offers tips on how providers can make their patients' information more secure including reminders to create strong, unique passwords, using separate Wi-Fi networks and protecting PHI.

Find this flyer on [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) under *Quick Guides*.





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# Prior authorization list for Medicare Part B medical specialty drugs is changing in February

We're adding the following medications to the Medicare Plus Blue<sup>SM</sup> PPO and BCN Advantage<sup>SM</sup> Part B specialty prior authorization drug list. These specialty medications are administered in outpatient sites of care, such as a physician's office, an outpatient facility or a member's home.

The following medications will require authorization for dates of service on or after Feb. 3, 2020:

- J3490/C9399 Beovu<sup>®</sup>
- J3590 Zolgensma<sup>®</sup>
- J3590 Skyrizi<sup>™</sup>
- J3490 Spravato<sup>™</sup>
- J7170 Hemlibra<sup>®</sup>
- J1555 Cuvitru<sup>™</sup>
- J1599 Panzyga<sup>®</sup>
- Q4074 Ventavis<sup>®</sup>

## How to bill

For Medicare Plus Blue and BCN Advantage, we require authorization for these medications for the following sites of care when you bill the medications as a professional service or 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 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 obtain authorization before administering these medications. Use the NovoLogix<sup>®</sup> online tool to submit your authorization requests. It offers real-time status checks and immediate approvals for certain medications. Also note:

- 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 Access 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.
- For BCN Advantage, if you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix.

If you need to request access to Provider Secured Services, complete the **Provider Secured Access Application** form and fax it to the number on the form.

## List of requirements

For a list of requirements related to drugs covered under the medical benefit, please see the **Medical Drug and Step Therapy Prior Authorization List**.

The authorization requirements for these drugs will be reflected on the drug list on Jan. 1, 2020.





# Get ready for annual visits for your Medicare Advantage patients

In the new year, you'll start seeing new and existing BCN Advantage<sup>SM</sup> patients for their Welcome to Medicare visits, annual wellness visits or routine physical exams. Here's some important information about these different visits to help you prepare:

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

## Welcome to Medicare visit

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

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

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

During this visit, you should:

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

- Review potential risk for depression and patient level of safety.
- Offer to talk about creating advance directives.
- Educate the patient on preventive services and prescribe appropriate services.
- Create a screening schedule (checklist) for appropriate preventive services.
- Give flu and pneumococcal shots, and referrals for other care, if needed.

Billing code for Welcome to Medicare visit, also called initial preventive physical examination
G0402

## Annual wellness visit

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

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

Services at the annual wellness visit include:

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

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## Annual Visits, continued from Page 9

- Educate on preventive services and prescribe appropriate services
- A review and update of the screening schedule (checklist) for appropriate preventive services
- Advance care planning

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

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

G0439 — Annual wellness visit (subsequent)

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

### Routine physical exam

This exam is typically covered annually by the patient's Medicare Advantage health care plan. These exams are part of preventive services that aren't part of the Welcome to Medicare or annual wellness visit.

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

- A visual inspection
- Palpitation
- Auscultation
- Manual examination

### Billing codes for annual exams or physicals

#### New patient

\*99386 (40-64 years old)

\*99387 (65 years and older)

#### Established patient

\*99396 (40-64 years old)

\*99397 (65 years and older)

### Care plans

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

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

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

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

These visits benefit both you and your patient by:

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

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

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

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## Providers need to get authorization for out-of-network visits

We require providers who refer their BCN Advantage<sup>SM</sup> patients to out-of-network providers to get authorization for those visits. If the services are not authorized, the member isn't responsible for any costs apart from their applicable deductible, copayments or coinsurance.

Likewise, if a member thinks a service is covered because he or she was referred by an in-network provider, the rendering physician can't bill the patient for that service other than applicable deductible, copayments or coinsurance.

The Centers for Medicare & Medicaid Services requires that we educate our contracted physicians about specific items and services that are covered by our Medicare Advantage plans. If you're unclear, contact us to request an authorization before providing the service or referring a member to an out-of-network provider.

Make sure you seek authorization for services for providers that are considered out-of-network. And remember to always check web-DENIS for plan eligibility and benefits.

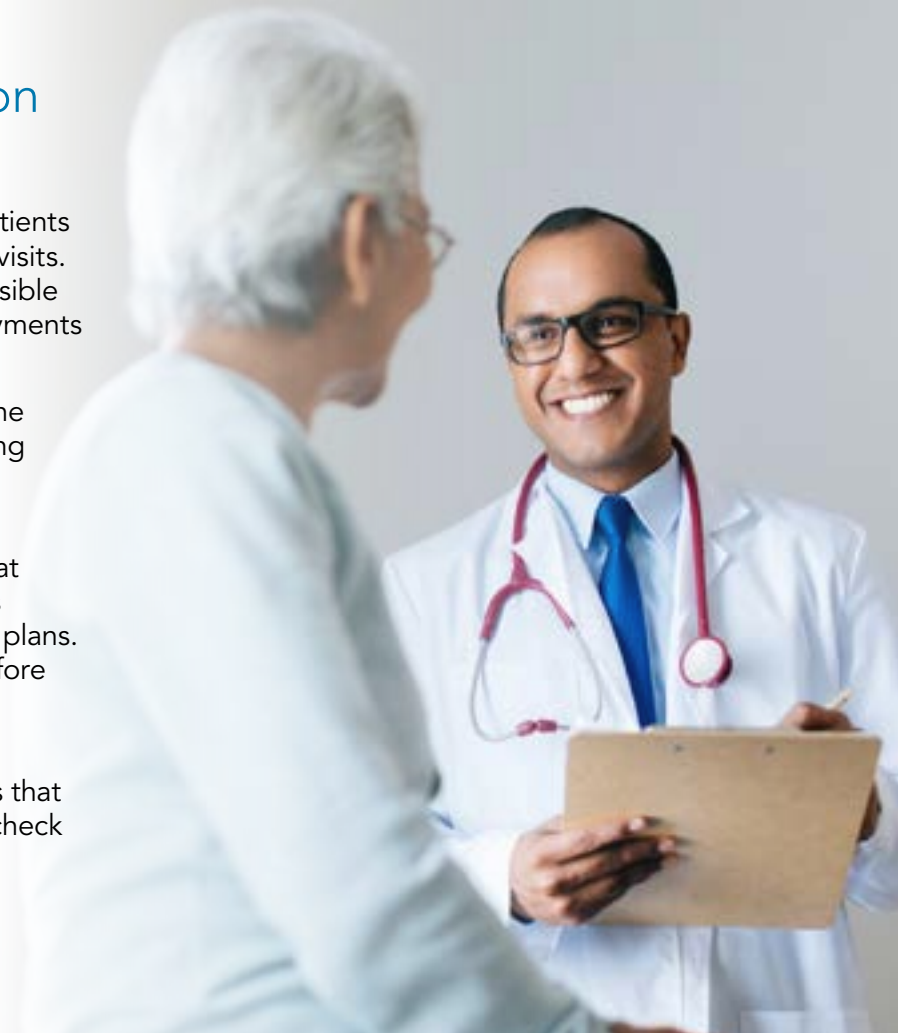
## Reminder

## BCN Advantage product changes for 2020 include premium decreases

We announced BCN Advantage<sup>SM</sup> product changes for 2020 in the previous issue. Premiums decreased significantly for some plans.

We also introduced an over-the-counter benefit and a new Snowbird Travel Care program for seniors who spend time outside of Michigan.

See the **November-December 2019** issue for details. Articles appear on pages 1, 7 and 8 of the issue.





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## Reminder

### AIM oncology webinars available in January for BCN Advantage

Non-clinical provider staff can learn about the new medical oncology program and how to use the AIM *ProviderPortal*<sup>SM</sup> by attending a webinar. Dates are available in January.

As a reminder, providers will need to obtain authorizations from AIM Specialty Health® for some medical oncology and supportive care medications, beginning in January. See the article on Page 9 of the November-December 2019 *BCN Provider News* for details.

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. It should automatically change to Eastern time.)

**Thursday, Jan. 9, 2020, 9 to 10 a.m.,**

**Wednesday, Jan. 22, 2020, 12 to 1 p.m.**

Providers need to use the AIM *ProviderPortal* to obtain authorizations for some medical oncology medications starting in January. For information about registering for and accessing AIM *ProviderPortal*, see the **Frequently Asked Questions** page of the AIM website.

### Document and use the body mass index assessment in the primary care setting

When collecting documentation on height and weight in the medical record, don't forget to calculate the patient's body mass index. BMI is considered the most efficient and effective method for assessing excess body fat.

Careful monitoring of BMI will help health care providers identify adults who are at risk and provide focused advice and services to help them reach and maintain a healthier weight.

There is a HEDIS® star measure that assesses adults ages 18 to 74 who had an outpatient visit with BMI documentation in the past two years. Documented calculation of BMI is commonly overlooked. We can't meet the criteria for this measure without it.

View the star measure tip sheet on the right for ICD-10 codes to include on claims and tips for talking with patients who are at increased risk of developing diseases associated with obesity.

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



*Star measure  
tip sheet*

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## Options for treatment-resistant depression

By Dr. Kristyn Gregory



For many patients experiencing major depressive disorder, antidepressants and therapy can bring relief and allow them to regain function. However, a subset of the population with the disorder, classified as treatment-resistant depression, doesn't respond to standard treatments.

Treatment-resistant depression, also called TRD, is characterized as a major depressive disorder that persists even after adequate antidepressant therapy. While there is a lack of consensus on a definition of TRD, a patient is generally considered therapy-resistant when consecutive treatments with two different antidepressant products — used for a sufficient length of time and at an adequate dose with affirmation of treatment adherence — fail to induce a clinically meaningful improvement.

TRD is by no means a rare disorder. Current estimates show prevalence ranging from 10% to 29% of adults with major depressive disorder having symptoms that don't respond significantly to treatment, according to a peer-reviewed article in [PLOS Journal](#).

Strategies for treatment-resistant depression can be classified into optimization (increasing the dose), augmentation (with an additional agent or therapy), combination (two or more anti-depressants), switching (to an agent in another class) and somatic **therapies** (electroconvulsive therapy and transcranial magnetic stimulation).

In addition to the above strategies, Blue Care Network provides coverage for these treatment options with prior authorization.

**ECT**

Electroconvulsive therapy, or ECT, is considered a somatic therapy and is one of the oldest treatments available for both depression and treatment-resistant depression. ECT, used in large-scale clinical studies of depression, has been found to be more effective than antidepressant drugs. **ECT** is a valid therapy for the treatment of depression, including severe and resistant forms. In addition to being effective, ECT acts quicker than traditional antidepressants that can take six to eight weeks to have the desired effect. The need for anesthesia, as well as memory and cognitive concerns, can limit the use of ECT in some patients.

Please see [From the medical director](#), continued on Page 14

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

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From the medical director, continued from Page 13

### TMS

Transcranial magnetic stimulation, or TMS, sends bursts of energy from electromagnets to specific areas of the brain to affect nerve cell communication. The procedure can be done in a physician's office and is noninvasive. Sessions last about 30 minutes and treatment is generally delivered five days a week for four to six weeks.

Accrued **evidence** from meta-analyses suggests that TMS has moderate effect in both major depressive disorder and treatment-resistant depression, comparable, though less robust, to those seen in patients treated with ECT, and similar to those seen with antidepressant treatment in TRD. Predictors of response include lower age, lower degrees of treatment resistance and the absence of comorbid anxiety or psychotic symptoms.

### Esketamine (Spravato nasal spray)

Spravato™ is a non-competitive N-methyl D-aspartate receptor antagonist indicated, in conjunction with an oral antidepressant, for the treatment of treatment-resistant depression in adults. Spravato gained approval from the U.S. Food and Drug Administration for TRD in adults on March 5, 2019. It is intended for patient administration under the direct observation of a health care provider and requires that patients are monitored by a health care provider for at least two hours after administration.

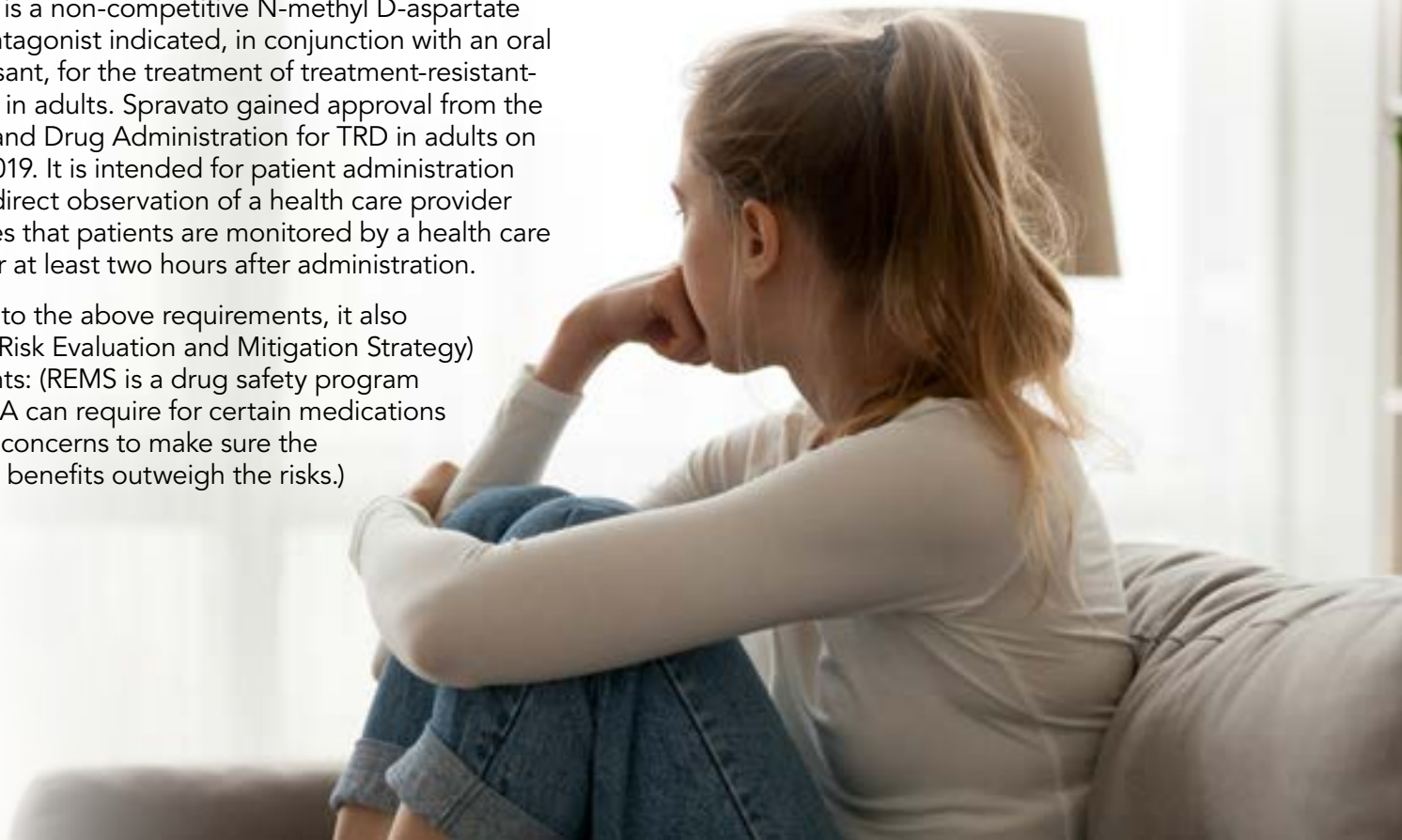
In addition to the above requirements, it also has REMS (Risk Evaluation and Mitigation Strategy) requirements: (REMS is a drug safety program that the FDA can require for certain medications with safety concerns to make sure the medication benefits outweigh the risks.)

- Spravato is available only through a limited distribution program that is part of the SPRAVATO™ REMS program.
- All health care settings and pharmacies must be certified in the Spravato REMS program before they can purchase, dispense or supervise administration of Spravato.
- All patients must be enrolled in the Spravato REMS program before they can receive the drug.

The process is described more in depth at the **Spravato website**.

Get information about BCN prior authorization for Spravato in the document, **Blue Cross and BCN utilization management medical drug list**.

You can find instructions on how to access the Novologix application on the **ereferrals.bcbsm.com** website.



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## Help patients get annual health screenings

Blue Care Network is preparing for annual HEDIS medical 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 collaboration in making HEDIS 2020 a success.

As part of our joint effort in making this happen, we've created this checklist for you to help patients take care of their health.

- ✓ Get an early start with patients in 2020. 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 ( $\leq 139/89$ ), 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 lower.
- ✓ For members discharged from an inpatient setting, complete a medication reconciliation within 30 days of discharge.

- ✓ Review history and order colon cancer screening, if needed (age 50 to 75, colonoscopy every 10 years). For patients that refuse a colonoscopy, suggest they complete a FOBT or FIT-DNA test.
- ✓ Order a mammogram for women ages 50 to 74 (if they haven't completed one in the last 24 months) and a cervical cancer screening for women ages 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.
- ✓ 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 adolescent immunizations: Check immunization record on MCIR and schedule visits to have complete and timely immunizations.

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

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

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## Criteria corner

*Blue Care Network uses Change Healthcare's InterQual® Level of Care when conducting admission and concurrent review activities for acute care hospitals. To ensure that providers and health plans understand the application of the criteria and local rules, BCN provides clarification from Change Healthcare on various topics.*

### Question:

For Adult/Geriatric Psychiatry – Inpatient – Episode Day 2-13 – Symptoms Improving or Expected to Improve and Not Clinically Stable for Discharge – Finding Present within Last 24 Hours – Positive Acute Psychotic Symptoms Uncontrolled, would this also include an exacerbation of chronic symptoms?

For instance: If a patient was chronically psychotic at baseline (responding to internal stimuli, paranoid ideation without risk of harm to self or others, delusional but without risk of harm to self or others), but was experiencing an increase in the severity of these symptoms (auditory hallucinations telling them to harm themselves, paranoid to the point of refusing medications), would we be able to select this criteria point?

### Answer:

Yes, acute exacerbation of a chronic issue may be used to apply criteria, as long as "Finding present within last 24 hours" is true.

### Question:

The Intervention criteria point found across several levels of care, Modification of the treatment plan based upon patient response to the plan (as in Adult/Geriatric Psychiatry or Child/Adolescent Psychiatry – Inpatient – Episode Day 2-13 and 14-X), doesn't have a footnote with additional information.

Are there scenarios or examples that would demonstrate to new staff what these sorts of modifications would include? Things like adjustments to medications and changes in one-to-one staffing status are addressed elsewhere in the criteria.

### Answer:

A modification to the treatment plan can include increasing contacts with therapists, adding an additional family meeting, ordering consultants or psychological testing. The goal is to ensure that active treatment is being provided.

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## February focus is on heart health

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

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

### Risk factors that can't be controlled

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

### 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
- Diet

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

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

Refer to the MQIC guidelines for **lipid screening and management** and **Management of overweight and obesity in adults** for more information.

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





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## Tools to help educate your pregnant patients

Everyone expects pregnancy to bring an expanding waistline. But some women are surprised when other body changes occur, such as:

- Body aches
- Fatigue
- Heartburn
- Morning sickness

All these changes make it important for women to see their doctor for prenatal care not only for the baby, but for themselves.

The U.S. Department of Health and Human Services' [website on women's health](#) offers information on body changes and pregnancy-related discomfort to help educate women on what to expect and how to manage symptoms. The site addresses such symptoms as body aches, breast changes, dizziness, hemorrhoids and nasal problems.

The number of prenatal tests that women are expected to get can also be confusing and overwhelming. Expectant mothers may wonder what kind of prenatal tests need to be done and why. Share the *Common prenatal tests* flyer below that lists common prenatal tests, with your patients. For more information about pregnancy care and tests, go to [womenshealth.gov](#).

### Resources

Blue Cross offers the Pregnancy Assistant program through Blue Cross Health & Well-Being, powered by WebMD®. It provides information and activities for women who are pregnant, planning to become pregnant or those supporting someone who's pregnant.



WebMD Health Services is an independent company supporting Blue Care Network by providing health and well-being services.

## 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

- Cryoablation of peripheral nerves (IOVERA®System)
- In-office needle arthroscopy

### Covered services

- Transcatheter aortic valve implantation for aortic stenosis
- Intravitreal corticosteroid implants
- Light and laser therapy for vitiligo and atopic dermatitis
- Refractive keratoplasties, phototherapeutic keratectomy and implantation of intrastromal corneal ring segments
- Stereotactic radiosurgery and stereotactic body radiotherapy
- Amniotic membrane and amniotic fluid
- Sleep disorders, diagnosis and medical management
- Urinary biomarkers for cancer screening, diagnosis and surveillance
- Heart-kidney transplant combined
- Lung/double lung and liver transplant combined
- Moderate penetrance variants associated with breast cancer in individuals at high breast cancer risk
- Genetic testing — molecular markers in fine needle aspirates (FNA) of the thyroid
- KRAS, NRAS and BRAF variant analysis in metastatic colorectal cancer
- Fecal calprotectin



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## Blue Cross co-sponsors medication-assisted waiver training courses

# Battling the opioid epidemic



The Michigan Center for Clinical Systems Improvement and Michigan Opioid Collaborative are hosting the American Society of Addiction Medicine: Treatment of Opioid Use Disorder course, which will provide the required eight educational hours to obtain the medication-assisted treatment waiver to prescribe buprenorphine in office-based treatment of opioid use disorders.

In partnership with MOC, Mi-CCSI (through a secured grant with the state of Michigan) is providing these scholarships to attend and complete the in-person training:

- \$500.00 for providers, MD and DO
- \$250 for NP/PAs

Payment goes to the first 15 registrants. If you have questions, email Amy Wales at [amy.wales@miccsi.org](mailto:amy.wales@miccsi.org) or call 1-616-551-0795, ext. 11

**Use the links below to register.**

**January 20, 2020 | 8 am - 5 pm**

Lyon Meadows Conference Center  
53200 Grand River Ave.  
New Hudson, MI 48165

**April 27, 2020 | 8 a.m. – 5 p.m.**

Hagerty Center, Rm A+B  
715 E. Front St.  
Traverse City, MI 49686

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## We've discontinued our fax line for the Behavioral Health Incentive Program

We suspended the Behavioral Health Incentive Program self-reported Therapeutic Alliance and Primary Care Physician Contact measures on July 2018. Since these submissions are no longer accepted, we've discontinued the BHIP fax line.

## Coordination between primary care physician and behavioral health professional is essential to diagnose and treat ADHD

Research shows that many children with attention deficit hyperactivity disorder aren't treated consistently, if they get treatment at all.

The American Academy of Pediatrics recommends a multidisciplinary approach to diagnose and treat ADHD. This includes coordination between the patient's pediatrician and a behavioral health professional.

ADHD is one of the most common mental disorders affecting children. The average age of diagnosis is 7 years old, and symptoms usually first appear between 3 and 6 years old.

Eleven percent of American children have been diagnosed with ADHD and 6.1% are treated with medications, according to the healthline.com, a health information website.

The National Institute of Mental Health Multimodal Treatment Study on ADHD demonstrated that significant improvement in behavior can be achieved in children who receive carefully monitored medication in combination with behavioral treatment.

Follow-up Care for Children Prescribed ADHD Medication is one of the HEDIS® measures. It evaluates the effectiveness of care by measuring the percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one within 30 days of initiating the ADHD medication. For more information on the measure, refer to the HEDIS tip sheet below.



**ADHD HEDIS**  
Tip Sheet

Providers can also reference clinical practice guidelines on our secure provider portal and Michigan Quality Improvement Consortium **guidelines** for ADHD. An MQIC app for Android and iOS devices is available at Google Play and the App store.

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

### References:

Retrieved from [ncqa.org/hedis/measures\\*\\*\\*](https://ncqa.org/hedis/measures***)

1. Visser, S.N., M.L. Danielson, R.H. Bitsko, J.R. Holbrook, M.D. Kogan, R.M. Ghandour, ... & S.J. Blumberg. 2014. "Trends in the parent-report of health care provider-diagnosed and medicated attention-deficit/hyperactivity disorder: United States, 2003-2011." *Journal of the American Academy of Child & Adolescent Psychiatry*, 53(1), 34-46.
2. The American Psychiatric Association. 2012. Children's Mental Health. [psychiatry.org/mental-health/people/children\\*\\*\\*](https://psychiatry.org/mental-health/people/children***)
3. Center for disease Control and Prevention. (2017, April 10). *Behavior therapy for young children with ADHD*. Retrieved from Center for disease Control and Prevention: <https://www.cdc.gov/ncbddd/adhd/behavior-therapy.html>
4. Healthline (2019) Retrieved from <https://www.healthline.com/health/adhd/facts-statistics-infographic>



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## Opioid Use, continued from Page 1

- This applies only to providers identified in the BCN claims system as offering MAT and only to claims with diagnosis codes F10 through F1999, F55 through F558, F01 through F09, F20 through F54, and F59 through F99.
- You must bill using procedure codes \*99201 through \*99205 (for initial visits) and \*99212 through \*99215 (for subsequent office visits).
- You must bill modifier 25 with both initial and subsequent visits.
- Behavioral health providers must submit MAT claims using the appropriate procedure codes, with modifier 25 as the primary modifier and their appropriate behavioral health modifier as a secondary modifier on the claim line.

If you're a primary care physician who is paid through capitation, you can also submit claims for reimbursement of MAT services; these services will be paid on a fee-for-service basis outside of your capitation.

### How to qualify for approval as a MAT provider

Providers must qualify to be reimbursed for MAT services by us.

First, whether you're a specialist or a primary care physician, you must let us know that you offer MAT services so we can verify your qualifications and update our systems. To notify us, email [BCNContracts@bcbsm.com](mailto:BCNContracts@bcbsm.com) and request a copy of the *MAT Questionnaire*.

\*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2019 American Medical Association. All rights reserved.

Next, you must complete the questionnaire, indicating, among other things, the types and location of the MAT services you provide, and return it to us.

Once we approve you as a MAT provider, your MAT claims will be eligible for reimbursement without a referral on record.

### Check our online provider directory

You can check our online provider directory to determine whether you're already approved as a MAT provider.

Providers who are approved for MAT show "Medication Assisted Treatment (MAT) for Opioid Use - Suboxone/Buprenorphine" or "Medication Assisted Treatment (MAT) for Opioid Use - Vivitrol/Naltrexone" as an area of focus.

To check our online directory:

1. Visit [bcbsm.com](http://bcbsm.com).
2. Click Find-a-Doctor.
3. Click **Search without logging in**.
4. Click *Doctors by name*.
5. Enter your name.
6. Click the search icon.
7. Scroll down and review the "Areas of Focus" designated for you.

Members can also use the online provider directory to locate providers who are approved for MAT.

## Reminder

## Michigan board-certified behavior analysts must be licensed starting Jan. 7 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 to be eligible for reimbursement from Blue Cross and Blue Care Network. BCBA's without licenses aren't eligible for reimbursement for services provided on or after Jan. 7, 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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## We're sending reminders to patients to adhere to ADHD follow-up visits

We're sending letters to encourage members whose children have received a prescription for attention deficit hyperactivity disorder medication to see their physicians for follow-up visits as outlined in the ADHD HEDIS® measure.

Children 6 to 12 years old should see a physician within 30 days of first being prescribed medication to treat ADHD. If they stay on the medical for at least 210 days, they should have two follow-up visits with nine months after the initiation phase.

We're also sending letters to remind physicians to schedule the follow-up visits as noted in the HEDIS measure.

Physicians may need to adjust a medication dose or discuss strategies to alleviate side effects. We also encourage you to coordinate care with other behavioral health physicians or primary care doctors who are seeing your patients.

Telehealth visits are acceptable for the continuation and maintenance phase visits. However, only one of the two visits may be a telephone visit. (See the HEDIS tip sheet and article on [Page 20](#) for more information.)

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

## Governor Whitmer signs bill maintaining current practice standards for licensed professional counselors

Governor Gretchen Whitmer has signed a bill into law maintaining that licensed professional counselors can continue their clinical practices without interruption. This move blocks new rules recently drafted by the Michigan Department of Licensing and Regulatory Affairs that would have prohibited licensed professional counselors from clinically diagnosing and providing psychotherapy to their clients. **Public Act 96 of 2019** also makes training requirements for LPCs match up with current practice. The law is effective Jan. 27, 2020.

Blue Cross Blue Shield of Michigan and Blue Care Network will continue working with licensed professional counselors as they're currently contracted with no interruption in providing services to our members.

## Encourage follow-up care after emergency room visits

In the United States, 18% of adults and 13% to 20% of children experience mental illness, according to the National Committee for Quality Assurance.

Follow-up care for mental health issues is crucial to:

- Decrease repeat visits to the emergency room
- Improve physical and mental function
- Increase compliance with follow-up instructions

In 2016, NCQA also found that 20.1 million Americans older than age 12 were classified as having a substance use disorder. The study showed timely follow-up care for these individuals helped to reduce:

- Substance use
- Future ER use
- Hospital admissions and length of stay

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## Blues Brief debuts Behavioral health edition

We've introduced a special issue of *Blues Brief* that covers topics of interest to behavioral health providers. It'll be published at least annually.

*Blues Brief*, *BCN Provider News* and *The Record* are available by email subscription.

To add *Blues Brief* to your subscriptions, click the *Manage Subscriptions* link at the bottom of your *BCN Provider News* or *The Record* newsletter emails. You can also visit the subscription page at [bcbsm.com/providers](https://bcbsm.com/providers) to choose your preferred *Blues Brief* versions and manage your other subscriptions.

## BCN behavioral health fee schedule for 2020 now available

The BCN behavioral health fee schedule for 2020 is now available on our website.

This fee schedule is effective for services on or after Jan. 1, 2020. It applies to Michigan behavioral health professional providers participating with the BCN HMO<sup>SM</sup> and BCN Advantage<sup>SM</sup> provider networks.

You can access the 2020 BCN behavioral health fee schedule on BCN's Behavioral Health page within Provider Secured Services. To access this document:

- Visit [bcbsm.com/providers](https://bcbsm.com/providers).
- Click *Login*.
- Log in to Provider Secured Services using your user ID and password.
- Click *BCN Provider Publications and Resources* on the right side of the Provider Secured Services welcome page.
- Click *Behavioral Health*.
- Look under the "General resources" heading.

## Blue Cross co-sponsors medication-assisted treatment waiver training

The Michigan Center for Clinical Systems Improvement and Michigan Opioid Collaborative are hosting the American Society of Addiction Medicine: Treatment of Opioid Use Disorder course, which will provide the required eight educational hours to obtain the medication-assisted treatment waiver to prescribe buprenorphine in office-based treatment of opioid use disorders.

See article on **Page 19** for details and registration links.

## New MAT incentive part of BHIP program

In 2020, BCN will add a new incentive opportunity for psychiatrists who deliver medication-assisted treatment to patients diagnosed with opioid use disorder. The \$500 incentive will pay based on each patient who is treated with naltrexone or buprenorphine. (Methadone is not part of this incentive opportunity.)

The incentive is available to providers who are currently providing MAT or those who choose to begin this as a new service.



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## Blue Cross, BCN to support providers who offer comprehensive opioid treatment

Blue Cross Blue Shield of Michigan and Blue Care Network will implement the Centers for Medicare & Medicaid Services program that encourages providers to offer the comprehensive range of opioid treatment services that many patients need. You can view the CMS final rule on this program, which was published in the **Federal Register**.

### What this means

Starting Jan. 1, 2020, Blue Cross and BCN will use bundled rates to reimburse providers who offer certified opioid treatment programs, or OTPs. The bundled payment includes both drug and non-drug components and may allow for intensity add-on codes to be used when needed.

This will apply to services for our Medicare Advantage members (Medicare Plus Blue<sup>SM</sup> PPO and BCN Advantage<sup>SM</sup>) and our commercial members (Blue Cross' PPO and BCN HMO<sup>SM</sup>).

Once this change goes into effect, certified OTPs may qualify for bundled reimbursement.

Look for updates in future issues of *The Record* and *BCN Provider News* as well as web-DENIS messages and news items on our [ereferrals.bcsbm.com](http://ereferrals.bcsbm.com) website.

Blue Cross and BCN will implement this program beginning Jan. 1, 2020, as required by the SUPPORT Act. For Blue Cross and BCN members, applicable member cost-sharing amounts will apply. See sidebar about the SUPPORT program.

Here's some additional information you need to know.

### What is an OTP?

The treatment of opioid dependence with medications is governed by the Certification of Opioid Treatment Programs, 42 Code of Federal Regulations (CFR) 8. This regulation created a system to accredit and certify opioid treatment programs. OTPs provide medication-assisted treatment along with counseling and other services for people diagnosed with an opioid use disorder. SAMHSA's Division of Pharmacologic Therapies oversees the certification of OTPs.

For information on how to obtain OTP certification, visit SAMHSA's **Certification of Opioid Treatment Programs** webpage.

### What's next?

Remember to watch for our upcoming communications on OTPs.



## About the CMS SUPPORT program

Section 2005 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act established a new Medicare Part B benefit for opioid use disorder treatment services, including medications for medication-assisted treatment, furnished by opioid treatment programs.

To meet this statutory requirement, CMS has finalized the following:

- Definitions of OTP and OUD treatment services
- Enrollment policies for OTPs
- Methodology and estimated bundled payment rates for OTPs that vary by the medication used to treat OUD and service intensity, and by full and partial weeks
- Adjustments to the bundled payment rates for geography and annual updates
- Flexibility to deliver the counseling and therapy services described in the bundled payments by two-way interactive audio-video communication as clinically appropriate
- Zero beneficiary copayment for a time-limited duration

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## HEDIS 2019 results

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

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

Blue Care Network noted the following areas of improvement in 2019:

### Commercial

- Adult BMI assessment
- Antidepressant medication management — effective acute and continuation phase treatment
- Appropriate testing for children with pharyngitis
- Appropriate treatment for children with upper respiratory infection (inverted rate)
- Asthma medication ratio
- Avoidance of antibiotic treatment in adults with acute bronchitis (inverted rate)
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening in women
- Childhood immunizations — combo 10
- Colorectal cancer screening
- Comprehensive diabetic care — HbA1c testing, poorly controlled >9.0% (inverted rate), control <8%, eye exam, blood pressure control
- Controlling high blood pressure
- Emergency department utilization
- Follow-up care after hospitalization for mental illness — seven days and 30 days

- Follow-up care for children prescribed ADHD medication — initiation, continuation and maintenance phase
- Immunization for adolescents — Combo 2
- Initiation and engagement of alcohol and other drug dependence treatment — engagement phase
- Medication management for people with asthma
- Pharmacotherapy management of COPD exacerbation — bronchodilators and systemic corticosteroid
- Plan all-cause readmissions
- Prenatal and postpartum care — timeliness of prenatal care and postpartum care
- Statin therapy for patients with cardiovascular disease — adherence
- Statin therapy for patients with diabetes — adherence
- Weight assessment and counseling for children and adolescents — nutrition counseling and physical activity counseling
- Well-child visits in the first 15 months of life — six or more visits
- Well-child visits in the third, fourth, fifth and sixth years of life

### Marketplace or Qualified Health Plan

- Adult BMI assessment
- Annual monitoring for patients on persistent medications
- Antidepressant medication management — effective acute and continuation phase treatment
- Appropriate testing of children with pharyngitis
- Appropriate treatment for children with upper respiratory infection (inverted rate)
- Cervical cancer screening
- Childhood immunizations — combo 3
- Colorectal cancer screening
- Comprehensive diabetes care — HbA1c control < 8.0%, eye exam, medical attention for nephropathy

Please see [HEDIS results](#), continued on Page 26

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### HEDIS results, continued from Page 25

- Controlling high blood pressure
- Immunization for adolescents — combo 2
- Medication management for people with asthma
- Plan all-cause readmissions
- Prenatal and postpartum care — timeliness of prenatal care
- Use of imaging studies for low back pain (inverted rate)
- Weight assessment and counseling for children and adolescents — BMI %, nutrition counseling and physical activity counseling
- Well-child visits in the third, fourth, fifth, and sixth years of life

### Medicare

- Adult BMI assessment
- Antidepressant medication management — effective acute and continuation phase
- Breast cancer screening
- Colorectal cancer screening
- Comprehensive diabetic care — HbA1c testing, poorly controlled >9.0% (inverted rate), control <8%, eye exam, blood pressure control, medical attention for nephropathy
- Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis
- Initiation and engagement of alcohol and other drug dependence treatment — initiation phase
- Hospitalizations for potentially preventable complications
- Medication reconciliation post-discharge
- Non-recommended PSA-based screening in older men
- Osteoporosis management in women who had a fracture
- Persistence of beta-blocker treatment after heart attack
- Pharmacotherapy management of COPD — systemic corticosteroid and bronchodilators
- Plan all-cause readmissions

- Statin therapy for patients with cardiovascular disease — therapy and adherence
- Statin therapy for patients with diabetes — therapy and adherence

Thank you to all our affiliated practitioners for providing quality care to our members and allowing us to conduct medical record reviews for HEDIS and various audits.

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

We're involved in activities throughout the year that positively impact our HEDIS rates, including:

- Physician Quality Rewards Program which is tied to some of the HEDIS measures
- Health e-Blue<sup>SM</sup> website
- Member gaps in care letters
- Member outreach reminder telephone calls
- Member and physician education through publications
- Member health fairs
- Care management calls and letters
- Member incentive programs
- HEDIS interventions
- HEDIS/CAHPS summits

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

If you'd like more information about HEDIS, call the Quality Management & Population Health Department at 1-855-228-8543.



*HEDIS 2019  
Commercial  
results*



*HEDIS 2019  
Marketplace/  
QHP results*



*HEDIS 2019  
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## Tips to manage acute low back pain in adults

According to the Michigan Quality Improvement Consortium, 90% of low back pain episodes resolve within six weeks, regardless of treatment. Typically, imaging isn't required within the first six weeks, unless red flags are present. Red flags include:

- Cauda Equina Syndrome
- Cancer
- Infection
- Spinal fracture
- Loss of bladder control or bowel control

Without red flags, a conservative approach is preferred. You might recommend that the patient:

- Stay active as tolerated by pain.
- Avoid bed rest.
- Do back exercises and stretches.
- Be careful of injuries.
- Use over-the-counter pain relievers.

MQIC published **Management of Acute Low Back Pain in Adults** as a guideline for providers.

It recommends focusing on patient reassurance, detailed history and physical exam, therapy, referrals and medication strategies.



## Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure changes for 2020

The HEDIS® 2020 measure, Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis, has changed for 2020 to include members 3 months and older. It previously included members 18 to 64.

This measure assesses whether a member received an antibiotic on or three days after the diagnosis of acute bronchitis or bronchiolitis. Members who didn't receive an antibiotic medication indicates appropriate treatment for this condition.

The measure is now episode-based (previously a member-based measure), meaning the member is eligible for the measure for every diagnosis of acute bronchitis or bronchiolitis.

Certain comorbid conditions or competing diagnoses can exclude the member from the measure. These conditions or diagnoses include COPD, HIV, malignant neoplasms and pharyngitis.

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



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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 that focus on improving health outcomes for BCN members. Examples include member and provider incentives, reminder mailings, phone calls, newsletter articles and educational materials. We use medical record reviews and quality studies to monitor compliance with the guidelines.

## Document and use the body mass index assessment in the primary care setting

When collecting documentation on height and weight in the medical record, don't forget to calculate the patient's body mass index. BMI is considered the most efficient and effective method for assessing excess body fat.

See details in the article on **Page 12**.



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## Ketoprofen 25 mg will require authorization and have new quantity limits for BCN HMO and Blue Cross PPO commercial members

The following changes are coming for Blue Cross' PPO (commercial) and BCN HMO<sup>SM</sup> (commercial) members:

- For new courses of treatment involving ketoprofen 25 mg that begin on or after Dec. 1, 2019, you'll have to obtain authorization. If you don't obtain authorization, the member may be responsible for the full cost of the drug.
- Effective March 1, 2020, ketoprofen 25 mg will be limited to four capsules per day or 120 capsules per 30 days. Requests for Blue Cross Blue Shield of Michigan and Blue Care Network to cover greater quantities will need to include documentation showing that the greater quantity is medically necessary.

Members who start taking ketoprofen before Dec. 1, 2019, can continue their treatment courses. However, as of March 1, 2020, you'll need to obtain authorization for these members to continue therapy.

For treatment courses starting on or after Dec. 1, 2019, you'll need to obtain authorization before members begin taking ketoprofen.

We'll notify affected members of these changes, and we'll encourage them to talk to you if they have concerns.

Authorization isn't a guarantee of payment. Health care providers need to verify eligibility and benefits for members.

These requirements don't apply to Medicare Plus Blue<sup>SM</sup> PPO or BCN Advantage<sup>SM</sup> members.

## We're adding some medications to the Part B specialty prior authorization drug list

We're adding some medications to the Medicare Plus Blue<sup>SM</sup> PPO and BCN Advantage<sup>SM</sup> Part B specialty prior authorization drug list. These specialty medications are administered in outpatient sites of care, such as a physician's office, an outpatient facility or a member's home.

See the full article on [Page 8](#) for details.

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## We'll change how we cover some drugs, starting Jan. 1

We'll change how we cover some brand name and generic drugs, starting Jan. 1, 2020. We'll also set new quantity limits on certain drugs.

We continuously review prescription drugs to provide the best value for our members, control costs and make sure our members are using the right medication for the right situation.

**Note:** Changes vary by drug list as specified below. For a complete list of covered drugs go to [bcbsm.com/pharmacy](https://bcbsm.com/pharmacy) and click *Drug lists*.

These changes apply to members with commercial pharmacy benefits (not Medicare D). They don't apply to the Federal Employee Program®.

### Preferred Drug List changes

#### Drugs on the Preferred Drug List that will have a higher copayment

The brand-name drugs that will have a higher copayment are listed with the covered preferred alternatives that have similar effectiveness, quality and safety. The example brand names of covered alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Nonpreferred drugs that will have a higher copayment	Common use	Covered preferred alternatives
Absorica®	Acne	Amnesteem®, Claravis®, Myorisan®, Zenatane®
Amitiza®	Constipation	lactulose, Linzess®, Trulance®
Arcapta Neohaler®	Respiratory conditions	Serevent Diskus®
Atrovent HFA®	Respiratory conditions	Atrovent solution®, Incruse Ellipta®
Byvalson®	Heart conditions	Bystolic® plus Diovan®, Tenormin® plus Diovan®, Toprol XL® plus Diovan®
Fulphila®	Hematopoietic agent	Neulasta®, Udenyca®
Gralise®	Neuropathic pain	Cymbalta®, Elavil®, Neurontin®, Tofranil®, Ultram®
Hexalen®	Chemotherapy	Go to <a href="https://bcbsm.com">bcbsm.com</a> for a complete list of covered alternatives. Members should discuss treatment options with their doctors.
Moxeza®	Antibiotic	Ciloxan® drops, Garamycin®, Tobrex® drops, Vigamox®
Relenza®	Influenza	Tamiflu®
Sancuso®	Nausea and vomiting	Emend® capsules, Kytril®, Zofran®
Tabloid®	Chemotherapy	Go to <a href="https://bcbsm.com">bcbsm.com</a> for a complete list of covered alternatives. Members should discuss treatment options with their doctors.
Xofluza®	Influenza	Tamiflu®
Zontivity®	Heart conditions	Aspirin plus Plavix®, Effient®

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## Drug coverage, continued from Page 30

### Drugs on the Preferred Drug List that won't be covered

The brand-name and generic drugs that won't be covered are listed with the covered preferred alternatives that have similar effectiveness, quality and safety. Unless noted, both the brand name and available generic equivalents won't be covered. The example brand names of covered alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs to be excluded	Common use	Covered preferred alternatives
Akynzeo®	Nausea and vomiting	Emend® capsules, Kytril®, Varubi® tablets, Zofran®
Altabax®	Skin conditions	Bactroban® ointment, gentamicin cream, ointment
Amrix®	Muscle relaxants	Flexeril®, Norflex®, Parafon Forte DSC® 500 mg, Robaxin®, Zanaflex®
Aubagio®	Multiple sclerosis	Gilenya®, Mayzent®, Tecfidera®
Bactroban® cream	Skin conditions	Bactroban® ointment, gentamicin cream, ointment
Conzip®, tramadol extended-release biphasic capsules	Pain (opioid)	Ryzolt®, Ultram®
Denavir®	Skin conditions	Generic oral antivirals (Famvir®, Valtrex®, Zovirax®); Zovirax® ointment
Diabetes meters and test strips: All <b>except</b> Freestyle and OneTouch	Diabetes	Freestyle and OneTouch meters and test strips
Doral®	Insomnia	Ambien®, Ambien® CR, Lunesta®, Restoril®, Sonata®
Emend® powder packets for suspension	Nausea and vomiting	Emend® capsules, Kytril®, Varubi® tablets, Zofran®
Epaned®	Heart conditions	Vasotec®
Fibricor®	High cholesterol	Lofibra®, Tricor®, Trilipix®
Firdapse®	Lambert-Eaton myasthenic syndrome	Ruzurgi®
Generic Kristalose®	Constipation	lactulose
Granix®	Hematopoietic agent	Nivestym®, Zarxio®
Indocin® suspension	Pain (non-steroidal anti-inflammatory (NSAID))	Generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®)
Jadenu®, Sprinkle	Chelating agent	Desferal®
Lorzone®	Muscle relaxants	Flexeril®, Norflex®, Parafon Forte DSC® 500 mg, Robaxin®, Zanaflex®
Mulpleta®	Thrombocytopenia	Doptelet®
Onzetra Xsail®	Migraines	Amerge®, Frova®, Imitrex®, Imitrex® nasal spray, Maxalt®
Orfadin®	Hereditary tyrosinemia Type 1	Nityr®
Pandel®	Skin conditions	Diprosone® lotion; Elocon® cream, lotion, solution; Kenalog® ointment, spray; Synalar® ointment; Westcort® ointment

Please see [Drug coverage](#), continued on Page 32



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## Drug coverage, continued from Page 31

Drugs to be excluded	Common use	Covered preferred alternatives
Pennsaid® 2%	Pain (non-steroidal anti-inflammatory (NSAID))	Flector® patches, Pennsaid® 1.5%
Qbrexelis®	Heart conditions	Prinivil®
Sitavig®	Antiviral	Famvir®, Valtrex®, Zovirax®
Striverdi Respimat®	Respiratory conditions	Serevent Diskus®
Subsys®	Pain (opioid)	Actiq®, Dilaudid®, morphine sulfate IR, oxycodone IR
Tivorbex®	Pain (non-steroidal anti-inflammatory (NSAID))	generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®)
Tudorza®	Respiratory conditions	Incruse Ellipta®
Vivlodex®	Pain (non-steroidal anti-inflammatory (NSAID))	generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®)
Xatmep®	Immunosuppressant	methotrexate tablet
Xerese®	Skin conditions	generic oral antivirals (Famvir®, Valtrex®, Zovirax®); Zovirax® ointment
Zipsor®	Pain (non-steroidal anti-inflammatory)	generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®)
Zovirax® cream	Skin conditions	generic oral antivirals (Famvir®, Valtrex®, Zovirax®); Zovirax® ointment

## Clinical Drug List and Custom Drug List changes

### Drugs on the *Clinical Drug List* and *Custom Drug List* that will have a higher copayment

The brand-name drugs that will have a higher copayment are listed with the covered preferred alternatives that have similar effectiveness, quality and safety. The example brand names of covered alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Nonpreferred drugs that will have a higher copayment	Common use	Covered preferred alternatives
Alocril®	Allergies	Alrex®, Bepreve®, Elestat®, Opticrom®, Optivar®, Pataday®, Patanol®, Pazeo®
Alomide®	Allergies	Alrex®, Bepreve®, Elestat®, Opticrom®, Optivar®, Pataday®, Patanol®, Pazeo®
Granix®	Hematopoietic agent	Nivestym®, Zarxio®
Neupogen®	Hematopoietic agent	Nivestym®, Zarxio®

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## Drug coverage, continued from Page 32

### Drugs on the *Clinical Drug List* and *Custom Drug List* that won't be covered

The brand-name and generic drugs that won't be covered are listed with the covered preferred alternatives that have similar effectiveness, quality and safety. Unless noted, both the brand name and available generic equivalents won't be covered. The example brand names of covered alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs to be excluded	Common use	Covered preferred alternatives
Aerospan®	Respiratory conditions	Arnuity Ellipta®; Asmanex®, HFA; Flovent® HFA, Diskus; Pulmicort Flexhaler®; Pulmicort solution®; Qvar RediHaler®
Altabax®	Skin conditions	Bactroban® ointment; gentamicin cream, ointment
Amrix®	Muscle relaxants	Flexeril®, Norflex®, Parafon Forte DSC® 500 mg, Robaxin®, Zanaflex®
Aplenzin®	Mood disorders	Wellbutrin®, Wellbutrin® SR, Wellbutrin® XL
Bactroban cream®	Skin conditions	Bactroban® ointment; gentamicin cream, ointment
Conzip®, tramadol extended-release biphasic capsules	Pain (opioid)	Ryzolt®, Ultram®
Denavir®	Skin conditions	Zovirax® ointment
Doral®	Insomnia	Ambien®, Ambien® CR, Lunesta®, Restoril®, Sonata®
Fibricor®	High cholesterol	Lofibra®, Tricor®, Trilipix®
Forfivo® and bupropion XL 450mg tablet	Mood disorders	Wellbutrin®, Wellbutrin® SR, Wellbutrin® XL
Indocin® suspension	Pain (non-steroidal anti-inflammatory (NSAID))	generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®)
Kristalose®	Constipation	lactulose
Lazanda®	Pain (opioid)	Actiq®, Dilaudid®, morphine sulfate IR, oxycodone IR
Lorzone®	Muscle relaxants	Flexeril®, Norflex®, Parafon Forte DSC® 500 mg, Robaxin®, Zanaflex®
Nascobal®	Vitamins	cyanocobalamin injection (vitamin B-12)
Pandel®	Skin conditions	Diprosone® lotion; Elocon® cream, lotion, solution; Kenalog® ointment, spray; Synalar® ointment; Westcort® ointment
Xerese®	Skin conditions	generic oral antivirals (Famvir®, Valtrex®, Zovirax®); Zovirax® ointment
Zovirax® cream	Skin conditions	generic oral antivirals (Famvir®, Valtrex®, Zovirax®); Zovirax® ointment

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## Drug coverage, continued from Page 33

### Custom Select Drug List changes

#### Drugs on the Custom Select Drug List that will have a higher copayment

The brand-name drugs that will have a higher copayment are listed with the covered preferred alternatives that have similar effectiveness, quality and safety. The example brand names of covered alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Nonpreferred drugs that will have a higher copayment	Common use	Covered preferred alternatives
Alocril®	Allergies	Alrex®, Bepreve®, Elestat®, Opticrom®, Optivar®, Pataday®, Patanol®, Pazeo®
Alomide®	Allergies	Alrex®, Bepreve®, Elestat®, Opticrom®, Optivar®, Pataday®, Patanol®, Pazeo®

#### Drugs on the Custom Select Drug List that won't be covered

The brand-name and generic drugs that won't be covered are listed with the covered preferred alternatives that have similar effectiveness, quality and safety. Unless noted, both the brand-name and available generic equivalents won't be covered. The example brand names of covered alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs to be excluded	Common use	Covered preferred alternatives
Aerospan®	Respiratory conditions	Arnuity Ellipta®; Asmanex®, HFA; Flovent® HFA, Diskus; Pulmicort Flexhaler®; Pulmicort solution®; Qvar RediHaler®
Brand Harvoni®	Hepatitis	Epclusa®, Zepatier®
Chorionic gonadotropin®	Infertility	Pregnyl®
Exalgo®	Pain (opioid)	Butrans®, Duragesic®, methadone, MS Contin®, Opana ER®, Ultram ER®
Fibricor®	High cholesterol	Lofibra®, Tricor®, Trilipix®
Granix®	Hematopoietic agent	Nivestym®, Zarxio®
Indocin® suspension	Pain (non-steroidal anti-inflammatory (NSAID))	generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®)
Neupogen®	Hematopoietic agent	Nivestym®, Zarxio®
Novarel®	Infertility	Pregnyl®

### Quantity limits

These drugs will have changes to the amount that can be filled. These changes apply to all drug lists.

Drug	Quantity limit effective Jan. 1, 2020
Lyrica® capsules (all strengths)	Three capsules daily
EpiPen®, EpiPen® Jr., epinephrine auto- injector, Symjepi®	Four pens per fill, maximum of eight pens per year

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## Blue Care Network will no longer cover select drugs under the medical benefit for commercial members starting in February

BCN HMO<sup>SM</sup> commercial plans will no longer cover the following medications when administered by a doctor or other health care professional under the medical benefit. This is effective Feb. 1, 2020.

HCPCS billing code	Short description	Brand name
J0135	Adalimumab injection	Humira®
J1438	Etanercept injection	Enbrel®
J1595	Injection glatiramer acetate	Copaxone®
J1826/Q3027/Q3028	Interferon beta-1a injection	Avonex®, Rebif®
J1830	Interferon beta-1b / .25 mg	Betaseron®, Extavia®
J2941	Somatropin injection	-
J3110	Teriparatide injection	Forteo®
J8515	Cabergoline, oral 0.25 mg	-
S0136	Clozapine, 25 mg	-
S0137	Didanosine, 25 mg	Videx®
J2170	Mecasermin injection	Increlex®
J1324	Enfuvirtide injection	Fuzeon®

These therapies can be safely and conveniently self-administered in the home and don't require administration by a health care professional.

Blue Cross isn't making any other changes to the management of these therapies. All are covered by BCN HMO prescription drug plans and are available through pharmacies that dispense specialty drugs. Your patients can also find them through an AllianceRx Walgreens Prime Specialty Pharmacy.

As with any specialty drug, members should call their retail pharmacy first to see if that particular medicine is available.

We'll send a letter to the affected members to advise them to talk to their doctors about this change and to prescribe this medication for purchase from a pharmacy. Providers who continue to administer these medications to their patients on or after Feb. 1 will be responsible for the cost.



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## We'll cover select hyaluronic acid products, starting Jan. 1

Blue Cross Blue Shield of Michigan and Blue Care Network will consider the following hyaluronic acid products to be either covered or preferred under the medical benefit, effective Jan. 1, 2020.

- Durolane®
- Euflexxa®
- Gelsyn-3™
- Supartz FX™

We'll consider the following to be either noncovered or nonpreferred hyaluronic acid products, also effective Jan. 1: Gel-one®, GenVisc 850®, Hyalgan®, Hymovis®, Monovisc®, Orthovisc®, Synvisc®, Synvisc-One®, TriVisc®, Visco-3™, Synjoyn™ and Triluron™.

This change will apply to Blue Cross' PPO (commercial), Medicare Plus Blue<sup>SM</sup> PPO, BCN HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members. This change won't apply to self-funded General Motors, Fiat Chrysler Automobiles, Ford Motor Company and UAW Retiree Medical Benefit Trust commercial groups.

### Blue Cross' PPO and BCN HMO commercial members

- Members who began receiving noncovered hyaluronic acid products before Jan. 1, 2020, can continue their treatment courses to completion. For future treatment courses that begin on or after Jan. 1, 2020, we encourage providers to talk to their patients about using a covered hyaluronic acid product.

- For treatment courses that begin on or after Jan. 1, 2020, we'll require members to use a covered hyaluronic acid product; these products don't require authorization.
- We'll deny claims for noncovered hyaluronic acid drugs.
- We'll notify affected members of these changes and encourage them to discuss treatment options with you.

### Medicare Plus Blue and BCN Advantage members

- Members who began receiving nonpreferred hyaluronic acid products before Jan. 1, 2020, can continue their treatment courses to completion. For future treatment courses that begin on or after Jan. 1, 2020, we encourage providers to talk to their patients about using a preferred hyaluronic acid product.
- For treatments on or after Jan. 1, 2020, we'll require members to use preferred hyaluronic acid products; these products won't require authorization. If you select a nonpreferred hyaluronic acid product for a member, you'll have to obtain authorization.

The U.S. Food and Drug Administration has approved 16 hyaluronic acid products. To date, no study has shown that one hyaluronic acid product is superior to others.

**Note: See [Page 6](#) for dates and registration information on hyaluronic acid webinars.**

## 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.

For details, read the article on Page 24 of the November-December [BCN Provider News](#).

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Nearly 1.5 million people in the United States — 70% of whom are women — have rheumatoid arthritis, or RA. Symptoms usually begin between the ages of 30 and 60, but may occur later in life for men. A family history increases the odds of having RA; however, most people with RA have no family history. Although the exact cause of RA is unknown, scientific evidence shows that genes, hormones and environmental factors play a role in the abnormal response of the immune system.

### Documentation and coding tips

- Information about coding for RA can be found in Chapter 13 (“Diseases of the Musculoskeletal System and Connective Tissue”) of the ICD-10-CM coding book. Look under “Inflammatory polyarthropathies (M05-M14).”
- Involvement of any joints, body systems and organs should be specified in order to code RA to the highest specificity.
- Most codes have site and laterality designations. Site represents the joint or organ involved.
- For categories where no “multiple site” codes are provided, and more than one joint or organ is involved, multiple codes should be used to represent the different sites involved.
- Rheumatoid factor test results and interpretation should be documented to code to the highest specificity.

The chart below gives some examples of rheumatoid arthritis with or without rheumatoid factor, and with or without organ and systems involvement:

Condition	ICD-10 code
Rheumatoid lung disease with rheumatoid arthritis of right shoulder	M05.111
Rheumatoid vasculitis with rheumatoid arthritis of left hip	M05.252
Rheumatoid arthritis of right ankle and foot with involvement of other organ and systems	M05.671
Rheumatoid arthritis with rheumatoid factor of left knee without organ or systems involvement	M05.762
Rheumatoid polyneuropathy with rheumatoid arthritis of right hip	M05.551
Rheumatoid heart disease with rheumatoid arthritis of right elbow	M05.321
Rheumatoid arthritis with rheumatoid factor of left shoulder without organ or systems involvement	M05.712

### Sources:

- [arthritis.org](http://arthritis.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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## How to submit multiple-line surgery claims for a hospital-based facility

When submitting a multiple-line surgery in a hospital-based facility to Blue Care Network, there are guidelines you need to follow for correct reimbursement. One of the frequent errors we receive is submitting each surgery line with charges.

You need to enter the total amount for the surgery charges on the first surgery line and zero on each additional surgery line. All lines submitted are considered in the reimbursement. Claims need to be submitted this way because the processing system rolls the lower RVU lines up to the highest for the correct reimbursement amount. Typically, the procedure with the highest relative value unit should be listed first.

For more information, refer to the Claims chapter in the *BCN Provider Manual* or the document *Multiple-line surgery in a hospital-based facility*.

- Log in to Provider Secured Services.
- Go to *BCN Provider Publications and Resources*.
- Click on *Billing/Claims* in the left-hand navigation.
- Scroll down to Facility Claims/Billing Instructions.
- The document is listed under Outpatient services.

## 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 tips include:

- Applying ICD-10 codes
- Clinical editing appeals reminders
- Procedures with pay percent reductions



*Clinical editing  
billing tips*

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# We've made changes in authorizing human organ transplants for BCN members

We've changed the authorization process for human organ transplants for BCN HMO<sup>SM</sup> and BCN Advantage<sup>SM</sup> members, starting Nov. 1, 2019.

## Here's what's staying the same:

- Continue to submit transplant authorization requests either through the e-referral system or by calling BCN Utilization Management at **1-800-392-2512**.
- Continue to fax your initial clinical information to BCN Utilization Management at **1-800-675-7278**.

## Here's what's changing:

- **Checklist for additional clinical information, if required.** If we need additional clinical information, you'll receive a checklist from the corporate Human Organ Transplant Program unit. It'll include these important numbers:
  - Fax: **1-866-752-5769**  
Use this number to submit additional clinical information.
  - Phone: **1-800-242-3504**  
Human Organ Transplant Program unit.  
Call this number with any questions after you submit your initial request.
- **Two authorization numbers.** You'll receive two authorization numbers for approved requests — one for the transplant procedure and one for the inpatient stay. (Before Nov. 1, you received only one authorization number that covers both the procedure and the stay.)
- **Where to find the authorization numbers.** Once we make a decision, you'll see both authorization numbers in the e-referral system. You'll also receive a letter that will show both numbers. We'll fax the letter to the person who requested the authorization. (Before Nov. 1, you saw one number in the e-referral system and didn't receive any letters.)
- **Attachment A included.** For approved authorizations, the letter you receive will include the *Human Organ Transplant Program Attachment A: Authorization Form*. This will indicate that your claim will be reimbursed with a global rate, which includes payment for both the procedure and the inpatient stay. (Before Nov. 1, you didn't receive this form for BCN authorizations.)
- **You must initiate reauthorization after one year.** If the patient doesn't receive the transplant within one year of the initial authorization date, you must request a new authorization either through the e-referral system or by calling BCN Utilization Management at **1-800-392-2512**. (Prior to Nov. 1, the reauthorization request was handled internally by BCN.)

We're working to minimize any inconvenience in how we handle this authorization process. If you have any questions or need after-hours assistance, call **1-800-242-3504**.



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## We're aligning peer-to-peer review request processes for acute non-behavioral health non-elective inpatient admissions

The process for requesting a peer-to-peer review with a Blue Cross Blue Shield of Michigan or Blue Care Network medical director for acute non-behavioral health, non-elective inpatient admissions is now the same for all lines of business.

It applies to inpatient admission authorization requests denied for Blue Cross' PPO, Medicare Plus Blue<sup>SM</sup> PPO, BCN HMO<sup>SM</sup> and BCN Advantage<sup>SM</sup> members.

Here's what you need to know:

- Submit all requests using the **Physician peer-to-peer request form** (for non-behavioral health cases). Complete and fax the form to 1-866-373-9468, from 8 a.m. to 5 p.m. Eastern time (except weekends and holidays).
  - **Note:** We'll reach out to you the next business day. The peer-to-peer review will be held Monday through Friday between 9 a.m. and 4 p.m. Eastern time (except holidays).
- Using the form is optional for now but will be **mandatory** starting Jan. 1, 2020.
  - **Note:** Continue to call 1-866-346-7299 for Blue Cross' PPO and Medicare Plus Blue peer-to-peer review requests through the end of the year. The number will be taken out of service Jan. 1, 2020.
- The request process is not changing for BCN HMO and BCN Advantage. Currently, you submit BCN requests using the form. It's the process for Blue Cross' PPO and Medicare Plus Blue requests that's changing.
- The form is available on our [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website, on the **Blue Cross Authorization & Requirements & Criteria page** and the **BCN Authorization & Requirements & Criteria page**. We've updated the form for use with all lines of business.

### Additional information

For information about requesting peer-to-peer reviews on denied authorization requests for various types of services, read **How to request a peer-to-peer review with a Blue Cross or BCN medical director**. This document is also available on the Blue Cross and BCN Authorization Requirements & Criteria pages on [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com).

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## BCN to deny claims for unauthorized outpatient toxicology lab services by non-JVHL labs starting Jan. 1

Blue Care Network will deny claims for outpatient toxicology laboratory services provided by an out-of-network laboratory without authorization from Joint Venture Hospital Laboratories, starting Jan. 1. This applies to BCN HMO<sup>SM</sup> (commercial) claims.

BCN contracts with JVHL to provide the statewide provider network for all outpatient laboratory services. This means:

- Claims for outpatient toxicology laboratory services are eligible for payment only if the service provider is affiliated with JVHL or proper authorization is obtained from JVHL for out-of-network services.
- Claims for outpatient laboratory services must be submitted to JVHL.
- Referring providers should use JVHL network laboratories.
- To obtain a service that is not provided by a JVHL laboratory, you must first submit a request for clinical review to JVHL.

### What you need to know

- The physician who orders the toxicology laboratory services is responsible for knowing whether the laboratory is in network and whether the procedure is covered by BCN. This information can be verified by JVHL.
- The procedure must be properly authorized before the service is provided and the specimen is directed to an out-of-network laboratory.
- A provider may not balance bill a BCN member whose toxicology laboratory services are denied as out of network.

For help identifying a JVHL network laboratory, call the JVHL administrative offices at 1-800-445-4979. JVHL business hours are 8 a.m. to 4:30 p.m. Eastern time, Monday through Friday; they're closed from noon to 1 p.m. You can leave a message 24/7.

## Updated e-referral questionnaires coming for BCN and Medicare Plus Blue PPO

By Jan. 26, 2020, we expect the following updated questionnaires to open in the e referral system for certain procedures. In addition, we'll update preview questionnaires, authorization criteria and medical policies on the [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website as updated questionnaires are released.

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

### Updates to existing questionnaires

Updated questionnaires will open in the e-referral system for BCN HMO, BCN Advantage and Medicare Plus Blue<sup>SM</sup> PPO authorization requests (unless otherwise noted) for the following services:

- Deep brain stimulation — Opens only for BCN HMO and BCN Advantage members
- Hip replacement surgery, initial

Please see [e-referral questionnaires](#), continued on Page 42

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- Hyperbaric oxygen — Opens only for BCN HMO members
- Hyperbaric oxygen — Opens only for BCN Advantage members
- Knee arthroscopy, chondroplasty — Opens only for BCN HMO and BCN Advantage members
- Knee arthroscopy, diagnostic — Opens only for BCN HMO and BCN Advantage members
- Knee arthroscopy, limited synovectomy — Opens only for BCN HMO and BCN Advantage members
- Knee arthroscopy, major synovectomy — Opens only for BCN HMO and BCN Advantage members
- Knee arthroscopy, removal of loose body or foreign body — Opens only for BCN HMO and BCN Advantage members
- Knee arthroscopy, removal or stabilization of intra-articular osteochondral lesion — Opens only for BCN HMO and BCN Advantage members
- Knee arthroscopy, resection or repair of stable or unstable meniscus tear — Opens only for BCN HMO and BCN Advantage members
- Knee replacement, initial nonunicondylar
- Knee replacement, initial unicondylar
- Other lumbar spine surgery procedures — Opens only for BCN HMO and BCN Advantage members
- Shoulder replacement surgery, initial

In addition, we'll simplify the questionnaires for some authorization requests as follows:

- We'll replace the *Spinal cord stimulator or epidural or intrathecal catheter (trial or permanent placement)* questionnaire with the following three questionnaires:
  - Spinal cord stimulator — For BCN HMO members
  - Spinal cord stimulator — For Medicare Plus Blue and BCN Advantage members
  - Intrathecal catheter — For Medicare Plus Blue, BCN HMO and BCN Advantage members

- We'll combine the *Breast reduction, adult* and the *Breast reduction, adolescent* questionnaires for BCN HMO and BCN Advantage members into a single Breast reduction questionnaire for both adult and adolescent BCN HMO and BCN Advantage members.

## Preview questionnaires

For all these services, you can access preview questionnaires at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). They show the questions that are in the e-referral system to help you prepare your answers ahead of time.

To find the preview questionnaires:

- For BCN: Click *BCN* and then **Authorization Requirements & Criteria**. Scroll down and look under the Authorization criteria and preview questionnaires heading.
- For Medicare Plus Blue: Click *Blue Cross* and then **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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# Providers will need to submit authorization requests to TurningPoint for musculoskeletal procedures with a date of service on or after June 1

Providers will need to submit authorization requests through TurningPoint Healthcare Solutions for musculoskeletal surgical procedures, with a date of service on or after June 1, 2020. This includes spine and joint replacement surgeries and other related procedures. We're also expanding the number of musculoskeletal services requiring authorization. This change will apply to BCN HMO<sup>SM</sup> (commercial), BCN Advantage<sup>SM</sup> and Medicare Plus Blue<sup>SM</sup> PPO.

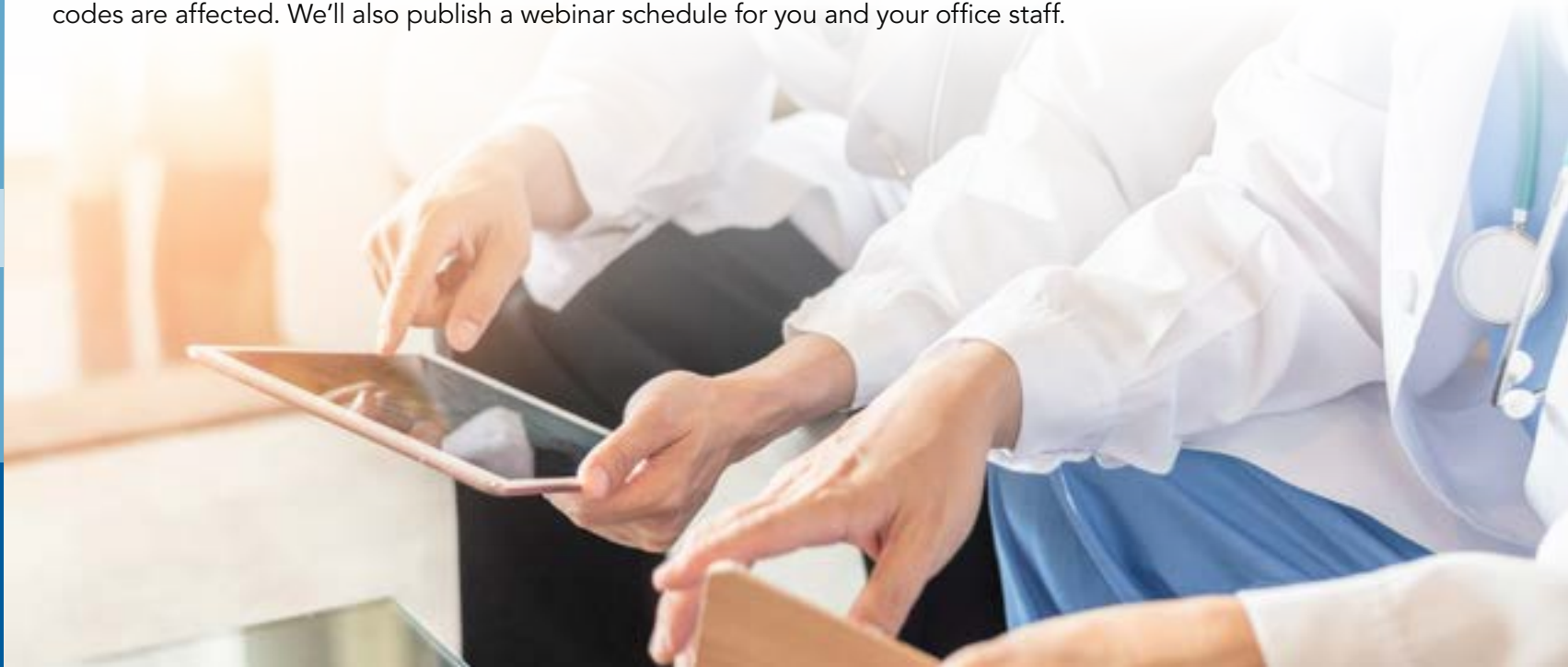
In selecting TurningPoint, we're working toward aligning all utilization management for specific musculoskeletal procedures under one umbrella for BCN HMO (commercial), BCN Advantage and Medicare Plus Blue PPO product lines. TurningPoint specializes in musculoskeletal utilization management and offers provider-friendly systems with a specialized focus on improving patient outcomes.

Here are some things you should know:

- For procedures currently authorized by BCN, such as joint replacements and arthroscopies:
  - If the date of service is **before June 1, 2020**, providers should continue to seek authorization through e-referral.
  - If the date of service is **on or after June 1**, providers should seek authorization through TurningPoint.

TurningPoint will be able to begin receiving authorization requests on May 1, 2020.
- If there are new codes requiring authorization from TurningPoint that don't require prior authorization today, providers will need to seek authorization from TurningPoint, **but not until May 1, 2020**, when their phone and fax lines and provider portal will be active. This applies to procedures for dates of service **on or after June 1, 2020**.

We'll provide more information in the next issue about how to submit authorizations to TurningPoint and which procedure codes are affected. We'll also publish a webinar schedule for you and your office staff.





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## e-referral upgrades coming in February

Two new enhancements are coming to the e-referral system mid-February 2020. Individual users will be able to flag referrals and authorizations that they determine need follow up for any reason. Each Details page will include a My List check box. Selecting the box adds it to My List and displays a flag next to the record in Search results and on the Home page; deselecting removes it. You will be able to flag up to 150 cases.

- A new feature in the My List page and the Case Communications panel will let you see at a glance if you have read a specific incoming communication. Unread communications will display a blue dot on the envelope icon. Once read, the icon will change to just the envelope.

To learn more about these changes, please attend one of our upcoming *Learning to use the New Features of e-referral* webinars:

- **Tuesday, January 21, 10 to 10:30 a.m.**
- **Thursday, January 23, 1 to 1:30 p.m.**
- **Tuesday, January 28, 2 to 2:30 p.m.**
- **Wednesday, January 29, 11 to 11:30 a.m.**
- **Tuesday, February 4, 10 to 10:30 a.m.**
- **Thursday, February 6, 1 to 1:30 p.m.**

The **e-referral User Guide** and **e-Learning modules** will be updated on the **Training Tools page** of [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) to reflect these changes. Please watch [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) for the latest updates and information.

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