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Blue Care Network to kick off smoking cessation campaign this fall

Members and providers can earn valuable incentives

In the last issue of *BCN Provider News*, we told you about a major tobacco cessation initiative that will begin in the fall.

BCN has launched a year-long campaign aimed at decreasing the percentage of our members who smoke. The campaign provides incentives and support for providers to counsel their patients about the benefits of remaining tobacco free.

Research shows that patients are more likely to quit when physicians advise them about smoking cessation and provide counseling, support and information about medications, when appropriate.

At the same time, BCN's secondary goal is to increase our CAHPS® scores in the area of smoking cessation. The annual Consumer Assessment of Healthcare Providers and Systems Survey asks members in a random mailing if they have received information and counseling about smoking cessation. It's important that members answer "Yes." These responses are used by the National Committee for Quality Assurance for network accreditation purposes.

BCN will kick off the program with a mailing of our *Good Health* magazine to members in the early fall. The issue will include a business reply card with several questions related to smoking. We will follow up with a mailing that offers some smoking cessation resources and gives members an opportunity to go online to receive a 16-page *Quit Guide* from BCN.

BCN will also offer incentives for members, office staff and providers. The incentives for members and office staff will begin this fall and continue monthly. The provider incentive will continue quarterly at BCN's discretion.

The incentives are outlined on **Page 3**. Please share this information with your office staffs and members.



Inside this issue...

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[Quit Guide PDF](#)

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



[BCN Provider News User Guide PDF](#)



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BCN offices closed for holiday

Blue Care Network offices will be closed on Monday, Sept. 1. When Blue Care Network offices are closed, call the BCN After-Hours Care Manager Hot Line at 1-800-851-3904 and listen to the prompts for help with:

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

Note: Precertifications for admissions to skilled nursing facilities and other types of transitional care services should be called in during normal business hours unless there are extenuating circumstances that require emergent placement.



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

Do not use this number to notify BCN of an admission for commercial or BCN AdvantageSM members. Admission notification for these members can be done by e-referral, fax or phone the next business day.

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

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References to "Blue Care Network" and "BCN" in this publication refer to all Blue Care Network of Michigan, Blue Care of Michigan, Inc., BCN Services Company and Blue Cross Complete of Michigan products, except where noted otherwise. Clinical information in this issue is consistent with *BCN Clinical Practice Guidelines* and applies to the care of BCN and BCN subsidiary/affiliate corporation members regardless of product. More information is available in the BCN Provider Manual on web-DENIS. Specific benefit information is available on web-DENIS, CAREN or by calling Provider Inquiry.

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Smoking cessation, continued from Page 1

Member incentives

- Members who respond to a short survey in *Good Health* magazine will be eligible for a one-time drawing for a \$250 gift card. Members can either mail the card or go online to answer the questions.
- Members who respond to the second mailing (a letter with smoking cessation resources) will be entered into a drawing for a separate \$250 gift card. Again, the member can mail back the form or respond to the questions online.
- Members will also be eligible for a drawing to win a \$250 gift card if they join the Quit the Nic program within a specified timeframe and complete the first counseling session.

Member/office staff incentive

BCN will provide our *Quit Guide* for office staff to hand out during patient visits. Offices will also receive a flier describing a special incentive for office staff. The flier will include an attestation for the member to complete, verifying that he or she has received information about quitting smoking. The member can complete and mail the attestation, give it to the office staff to return to us, or complete the attestation online.

Every month, Blue Care Network will choose a member from the completed attestations to receive the \$250 gift card. When the member verifies the PCP office they visited through the attestation, the staff members at that office will be entered into a drawing to win \$500 to share at the provider's discretion.

Provider incentive

Providers who billed at least five eligible CPT II codes in a specified quarter will be entered into a drawing to win a \$3,000 check each quarter at BCN's discretion. The CPT II codes billed on claims help BCN verify that doctors are asking about smoking habits and providing counseling and support for those members who want to quit.

The eligible CPT II codes are outlined below. Some of the codes are payable; others are informational.

Eligible CPT II* codes

Counseling codes

1000F	1034F
1031F	1035F
1032F	1036F
1033F	G8751

Intervention codes

4000F	99407
4001F	G0436
99406	G0437

We hope you and your office staffs will work with us to provide advice to their patients and make this a successful smoking cessation campaign. (Please also see *Medical Director* column, **Page 17**.)

Watch for future web-DENIS messages and additional communications about the program. If you have questions about this initiative, call your provider consultant.

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Blues provider website gets a new Web address

This fall, Blue Cross Blue Shield of Michigan and Blue Care Network are upgrading our internal systems supporting all of the Blues' Provider Secured Web Services which includes access for web-DENIS features.

This update will not change the look and feel of the system and all navigation will remain the same.

However, the Web address, or URL, will change.

The best way to log in to Provider Secured Services is to follow these steps:

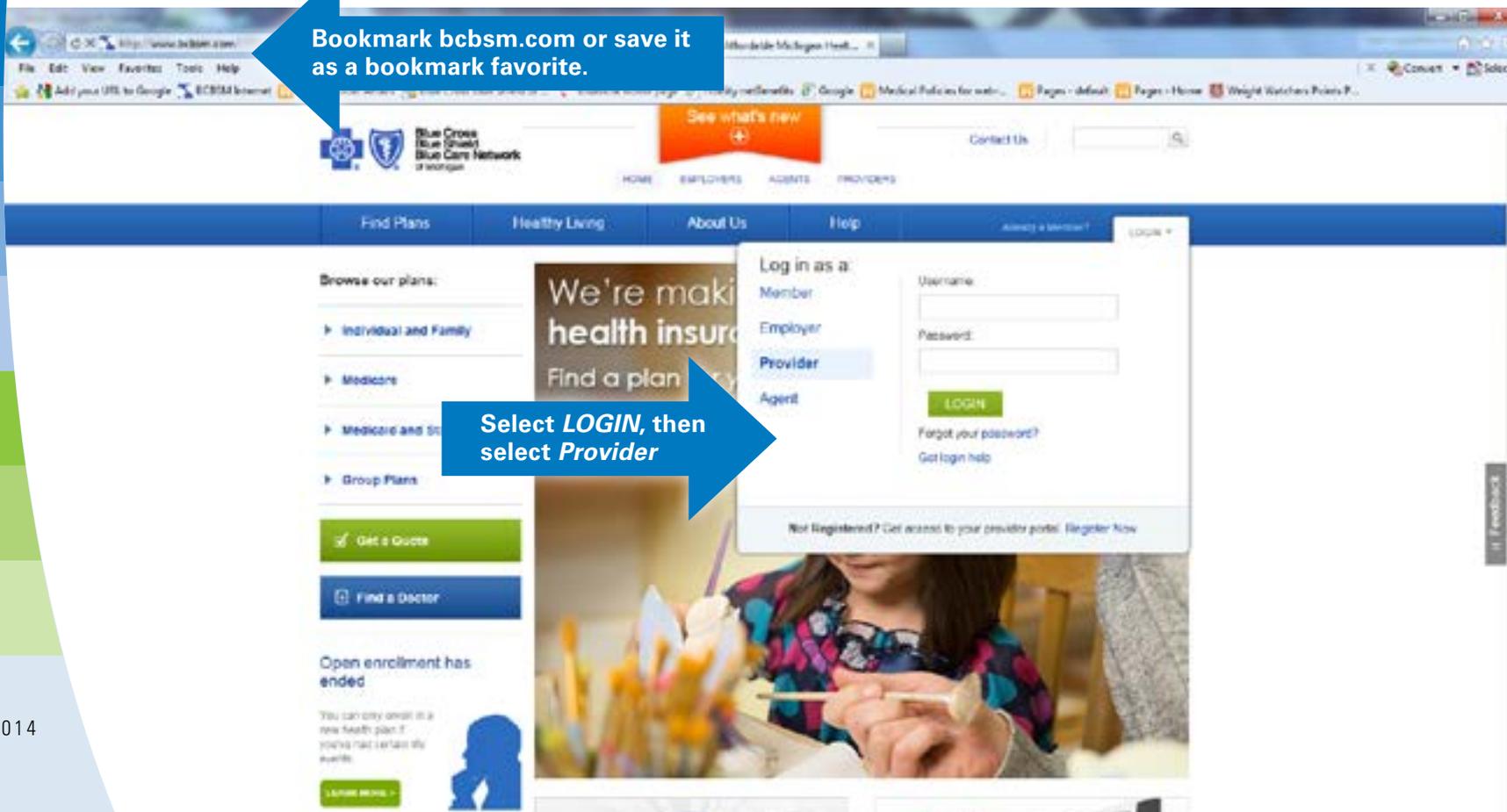
- Visit **bcbsm.com**.
- Select *LOGIN*.
- Select *Provider*.
- Enter your user ID and password.

For a smooth transition, eliminate former bookmarks and save **bcbsm.com** as your favorite.

If you continue to try and use an existing favorite or bookmark, you will receive an error and not be able to log in. This can be avoided by visiting bcbsm.com and following the instructions at left.

We'll let you know through an alert on web-DENIS when the update is complete and it is time to log in directly as illustrated here.

For questions about this change, please contact the BCBSM Web Support Help Desk at 1-877-258-3932.



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Blues to offer new health plans for 2015 individual market

Blue Cross Blue Shield of Michigan and Blue Care Network plan to more than double their product offerings in the 2015 individual market this November. Blue Cross and its HMO subsidiary, Blue Care Network, filed 41 total product options with the Department of Insurance and Financial Services, with the intent to offer these plan options to Michigan consumers during the 2015 open enrollment period that begins Nov. 15, 2014. The new products and their prices require regulatory approval.

During 2015 open enrollment, the Blues intend to continue to offer its products to residents of all 83 Michigan counties – something only the Blues did during 2014 open enrollment. Highlights of the 2015 offerings include:

- Two new affordable product lines available in Southeast Michigan, allowing cost-conscious consumers to select from additional affordable health plan options
 - *Metro Detroit Exclusive Provider Organization (EPO) offers a lower-cost option with more than 5,000 physicians in-network. Coverage will include Wayne, Oakland, Macomb, Livingston, St. Clair and Washtenaw counties and 25 hospitals in eight hospital systems.*
 - *Metro Detroit HMO offers coverage in Wayne, Oakland and Macomb counties and includes at least 12 hospitals in four hospital systems.*

- New plans with a designation of “extra,” which pays for unlimited primary care physician visits before deductible, unlimited specialist office visits with up to four visits before deductible, and generic prescription drugs before deductible. Copays will apply.
- A new platinum-level plan offering both a low deductible and out-of-pocket maximum, that also includes comprehensive dental and vision coverage

Both Blue Cross and Blue Care Network will offer plans at the gold, silver, bronze and catastrophic levels. The new Blue Cross platinum-level plan will be an option for consumers seeking richer benefits.

“Products like our new Southeast Michigan EPO will expand choice for consumers shopping for a low-cost health insurance plan backed by quality local doctors and hospitals,” said Terry Burke, vice president for individual business at BCBSM. “Our platinum plan is designed for people who want broad access and can pay a higher premium to obtain it. The bottom line is choice. We are aiming to give people enough choices to select the right health plan for their needs.”

Products will be available through independent Blue-certified insurance agents and also directly through BCBSM and BCN.



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Health e-Blue site now allows you to manage patient care for Individual and Group patients

The new BCBSM Health e-BlueSM site for individual and group patients is operational and accessible through our **Provider Secured Services** portal.

Health e-Blue is an online tool designed to make the process of managing diagnosis gaps and treatment opportunities easy and efficient for providers.

Previously available for Medicare Advantage PPO and Blue Care Network patients, Health e-Blue has expanded to include individual and group patients.

Existing Medicare Advantage PPO and BCN Health e-Blue users will receive automatic access to commercial BCBSM Health e-Blue once it is live. If you don't have current access to Health e-Blue, **sign up today**, or contact your provider consultant for more information.

The following provider types can get access to Health e-Blue:

- BCN primary care physicians and medical care group administrators
- BCBSM physicians and physician organizations from the following specialties:
 - Adult medicine
 - Family medicine
 - Family practice
 - General practice
 - Geriatric medicine
 - Health clinic practice
 - Internal medicine
 - Nurse practitioner
 - Osteopathy
 - Pediatrics
 - Physician assistant

There are a few things to keep in mind regarding BCBSM Health e-Blue:

- There is a user's guide available in the *Resources and Training* section of Health e-Blue.
- Diagnosis gaps will be updated every 30 days and treatment opportunities will be updated every 60 days. Alerts will be posted when these updates take place. In the future, we'll post the updates monthly.
- BCBSM Health e-Blue allows users to enter a 2013 date of service for a 2014 diagnosis gap. Please make sure that you are entering a 2014 date of service to properly close a 2014 diagnosis gap. If a prior year date of service is entered for a 2014 diagnosis gap, the diagnosis gap will not be closed.
- Please use the **Feedback** button found in the upper right of each screen to send comments or ask questions related to BCBSM Health e-Blue functionality. Before you click the Feedback button, verify that the product line (BCBSM, BCN or MAPPO) listed near the upper left of each page in small, blue font is the correct product line associated with your comment or question. If needed, we'll contact you within 72 hours if we have questions. Our response will be returned as a secure email. Click "Yes" to open the secure email. Questions that require investigation and corrective action could take longer.

Provider training webinars were offered in August. If you were unable to attend one of these webinars, but would still like to learn about BCBSM Health e-Blue, contact your provider consultant who can assist you with training.

Health e-Blue was designed with you in mind to make the process of closing diagnosis gaps and treatment opportunities as simple and efficient as possible. If you have further questions about Health e-Blue, please see the FAQ document found in the *Resources* section of BCBSM Health e-Blue, or contact your provider consultant.

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What's the latest on health reform?

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Look on BCN's Health Care Reform Web page for information about health reform that's updated regularly.

The Health Reform page contains information that your office should know so you can code and bill correctly. This includes information about essential health services covered by all BCN plans, including preventive services and immunizations covered with no member cost sharing.

To get to BCN's Health Reform page, complete the following steps:

1. Visit bcbsm.com.
2. Log in to Provider Secured Services. Remember to log in as a provider!
3. Click *web-DENIS*.
4. Click *BCN Provider Publications and Resources*.
5. Click *Health Reform* under *Resources*.



The screenshot shows the 'BCN Provider Publications and Resources' page. It features a navigation menu on the left with categories like Home, Products, Publications, Resources, BCN Provider Publications & Resources, and Contact us. The main content area is titled 'Health Reform' and includes sections for 'Health Reform', 'Fact sheets', 'Preventive services and immunization codes', 'Risk adjustment', and 'CMS Risk adjustment models'. The 'Health Reform' section states that many changes have already taken place since the 2010 Patient Protection and Affordable Care Act became law, with more sweeping changes taking effect in 2014. The 'Fact sheets' section lists several topics such as 'What are essential health benefits?' and 'What is the Health Insurance Marketplace?'. The 'Preventive services and immunization codes' section explains that the ACA requires insurers to cover preventive services with no member cost-sharing. The 'Risk adjustment' section notes that the ACA extends risk adjustment activities beyond Medicare Advantage products. The 'CMS Risk adjustment models' section lists links for 'Commercial' (Instruction sheet, Technical details) and 'Medicare Advantage' (2014 model software/ICD-9-CM).

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BCN drug list name now displays on web-DENIS eligibility screen

When you check member eligibility in web-DENIS for a Blue Care Network or BCN AdvantageSM member, you can now see which drug list applies to the member. This will help you determine the most cost-effective drug choice for your patient.

When you open the Member Eligibility/Coverage screen, look under *Current Product Summary*. If the member has drug coverage, you will see the name of the drug list listed rather than the generic "Drugs" indicator. The name will appear as an active link. The link will take you to **a list of BCN drug lists** where you can click on the member's drug list and review the member's drug coverage. When you click on the drug list link, it will take you to a general BCN formulary page where you can review any BCN drug list.

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Clarification: Blue Elect Plus Self-Referral OptionSM has higher in-network benefit

Members of the Blue Elect Plus Self-Referral Option product must select a primary care physician from BCN's provider network, but then may choose to self-refer to any in-network or out-of-network provider.

Members pay the lowest costs when their care is provided by their primary care physician or by another provider in the BCN network. Certain services are covered only when provided by a BCN provider.

Requirements for plan notification and benefit and clinical review apply whether services are performed by BCN or non-BCN providers. Providers do not need to give referrals to Blue Elect Plus Self-Referral Option members.

Additional information on Blue Elect Plus Self-Referral Option can be found in the *BCN Provider Manual*, specifically in Chapter 8: Care Management.

BCN videos continue to help improve member experience

In our continued efforts to respond to member feedback, Blue Care Network has created two more informative short videos to help improve members' experiences. Earlier in the year, we produced *Getting Started and About Your Primary Care Physician* which we highlighted in the **May-June issue**.

The newest videos, *Healthy Blue LivingSM* and *Provider Networks*, star BCN employees and provide important information about understanding how the Healthy Blue Living plan works and what members need to know about our provider networks.

The videos are located on **bcbsm.com** and will also be available on the BCBSM YouTube channel. We will be sharing these videos on BCN's Facebook page and through email alerts to members.

Feel free to share the links with your BCN patients.

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BCN Advantage begins third year of Chronic Care Improvement Program

As we begin the third year of our **Chronic Care Improvement program**, we're focused on preventing cardiovascular disease in our BCN AdvantageSM members. If we achieve that goal, we'll also meet our other important goals to decrease heart attacks, strokes and related deaths in BCN Advantage members aged 40 and over, who have a history of cardiovascular disease or diabetes.

For this program, we've adopted the clinical interventions championed by Million HeartsTM, a public initiative led by the Centers for Disease Control and Prevention and the Center for Medicare & Medicaid Services, to prevent one million heart attacks and strokes in the United States over the next five years by focusing on evidence-based community and clinical prevention actions. The Million Hearts clinical interventions focus on improved management of the "ABCs" – **A**spirin for high-risk patients, **B**lood pressure control, **C**holesterol management and **S**moking cessation.

Are we making progress?

A report published May 30, 2014 in the CDC's *Morbidity and Mortality Weekly Report* looked at the early effects of the Million Hearts initiative. According to the report, more Americans are working to control blood pressure and cholesterol, but rates for these and other heart healthy habits still fall short of goals.

According to the report:

- There was no significant change in the use of aspirin to prevent a second heart attack or stroke since 2009-2010. It stayed steady at just under 54 percent of heart attack patients.
- There was some improvement in terms of blood pressure control; medications were prescribed for about 43 percent of patients in 2009-2010 and nearly 52 percent of patients in 2011-2012.

How you can help

You can help us reach our goal of preventing heart attacks and strokes in our BCN AdvantageSM members by focusing on these Million Hearts clinical interventions:

- Prescribe appropriate aspirin therapy for those who would benefit from it.
- Emphasize that controlling blood pressure and managing cholesterol reduces your patients' risk of heart attack and stroke.
- Ask your patients about their smoking habits and provide smoking cessation counseling and tools to help current smokers quit.
- Recommend our free smoking cessation program to help BCN Advantage members quit smoking. Members can receive reimbursement for over-the-counter, nicotine replacement products and telephone counseling. To enroll in Quit the Nic, members can call 1-800-811-1724, 24 hours a day, seven days a week.

More information about the **Million Hearts** initiative is available on the website.

Chronic care, continued from Page 9

- Similar increases in use of cholesterol medications was achieved, with 33 percent of patients getting prescriptions in 2009-2010 and just under 43 percent of patients getting prescriptions in 2011-2012.
- There was only a small increase in the number of patients advised by their doctors to quit smoking, which rose from about 22 percent in 2009-2010 to 25 percent in 2011-2012
- The most current data also showed a minimal decrease in salt intake overall, from 3,619 milligrams a day to 3,594 milligrams a day, the study authors noted.¹

Similarly, the data we gathered during our first Million Hearts audit last year revealed opportunities for improvement for all measures. Another Million Hearts audit is underway for 2014. We'll share the results of the first full year of our Chronic Care Improvement Program in the next issue of the *BCN Provider News*.

Sources

¹Million Hearts: Prevalence of Leading Cardiovascular Disease Risk Factors – United States, 2005 -2012. CDC Morbidity and Mortality Weekly Report (MMWR), May 30, 2014

<http://consumer.healthday.com/general-health-information-16/aspirin-news-46/more-efforts-needed-to-prevent-1-million-heart-attacks-strokes-cdc-688321.html>

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6321a3.htm?s_cid=mm6321a3_w

Matthew Ritchey, division for heart disease and stroke prevention, U.S. Centers for Disease Control and Prevention; Gregg Fonarow, M.D., professor, cardiology, preventative cardiology program, University of California, Los Angeles, and spokesman, American Heart Association; May 30, 2014, *Morbidity and Mortality Weekly Report*

Last Updated: May 29, 2014

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The Blues Medicare Advantage member website is redesigned to improve servicing

The Blues recently launched its redesigned Medicare website – www.bcbsm.com/medicare – to better its customer experience for those shopping for Medicare and BCN AdvantageSM plans.

Key improvements include:

- Combined BCBSM MA PPO and BCN Advantage site
- Simplified site navigation to find information about our Medicare plans
- Faster and more effective search tools
- A new Medicare 101 and Help Center that provides answers to the most common questions consumers and members ask

Members who cannot access the site can call 1-877-258-3932.

Additional features will be added to help members compare plans and shop for insurance as the site evolves.

As you continue to provide high quality care for our members – your patients – we hope these updates are valuable.

For BCN, members the redesign includes a URL change. Please tell your patients to bookmark the new URL. bcbsm.com/medicare

New quality improvement organization effective for BCN Advantage

The Quality Improvement Organization for BCN AdvantageSM has changed to KEPRO, effective Aug. 1, 2014. A QIO consists of groups of doctors who are paid by the federal government to review the medical necessity, appropriateness and quality of hospital treatment provided to Medicare patients, including those enrolled in a managed care plan like BCN Advantage.

Members may request a QIO review from KEPRO if they disagree with the decision of an inpatient facility, skilled nursing facility, comprehensive outpatient rehabilitation facility or home health agency to discharge them.

Revised *Notice of Medicare Non-Coverage* forms are available on web-DENIS. The NOMNC forms include detailed instructions about how the member may request an immediate appeal directly to KEPRO, including KEPRO's address and phone number.

Note: Starting Aug. 1, 2014 contracted facilities should use the revised **NOMNC forms**. Please discard any forms printed prior to Aug. 1, 2014. The forms are available in PDF or Word format on BCN's **e-referral** home page or web-DENIS.

For more information about the form go to *BCN Provider Publications and Resources* on web-DENIS. Go to *Forms* in the Resources section. Then scroll down to the BCN Advantage page.

Preventing falls in older adults

Osteoporosis is responsible for 1.5 million fractures each year at the cost of \$1.8 billion. For Michigan alone, costs are predicted to increase to \$560 million by 2025. One in three older adults falls every year and these falls threaten the lives, independence and health of these adults. Of those adults who suffer moderate to severe injuries from a fall, 20 to 30 percent find it harder to get around or live independently. In addition, falls increase the risk of an early death.

The annual direct and indirect cost of fall injuries is expected to reach \$67.7 billion by 2020. One in two women and one in four men will have an osteoporosis related fracture sometime in their lifetime. In Michigan alone 50 percent of those hospitalized with a hip fracture are discharged to a long term care facility and 24 percent of hip fracture patients aged 50 or older dies within the year following the fracture.

We know the risk for disease and disability increases with age, but poor health isn't a necessary part of aging. People who fall but don't experience an injury may develop a fear of falling which may cause many to limit their activities which can lead to reduced mobility and loss of physical fitness, thereby increasing their actual risk of falling.



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How to help older adults prevent falls

Physicians can help older patients by counseling them about exercise and fall prevention strategies. Some of the following advice may be helpful:

- Exercise is a great way to reduce the risk of a fracture after sustaining a fall.
- Tai chi and Yoga programs are especially good for helping to improve balance and strength.
- Encourage your patients to have a yearly eye exam and their ears tested because even small changes in vision or hearing can cause someone to fall. Hearing aids should be properly fitted and worn.
- If a cane or a walker is recommended for use, make sure it's the right size and the wheels roll smoothly.
- Wear non-skid, rubber-soled, low-heeled shoes, or lace-up shoes with non-skid soles that fit and support feet. Don't walk around the home or use the stairs in stockings or in shoes or slippers with smooth soles.
- Be careful when walking on wet or icy surfaces. Be safe by having sand or salt spread on the icy areas around the front and back doors of the home.
- Have handrails on both sides of the stairs and make sure they are securely fastened. Be careful if carrying an item that it doesn't block the view of the steps.
- Have good lighting and use the lights for long hallways and stairs. Use night lights to illuminate dark hallways and rooms.
- Don't clutter walk areas. Keep the floor clear from books, magazines, papers, clothes, shoes and pets. Know where your pet is to avoid being tripped and possibly sustaining a fall.
- Reduce tripping hazards and make the home safer by removing throw rugs and having all carpets firmly fixed to the floor so they don't slip or turn up at the corners.

- Keep all electrical cords, telephone wires, computer cords or other electronic device cords near walls and away from walking pathways.
- Sofas and chairs should be the right height for getting in and out of easily.
- Keep items within easy reach and use an assist device such as a step stool with a hand rail or a "reach-stick" for things too high.
- Mount grab bars inside and outside of tubs, showers and near toilets.
- Have emergency numbers in large print next to the telephone.
- Have the telephone close to the bed and within reach to avoid falling out of bed.
- Consider getting a home-monitoring system which can call for help. Medicare and most medical insurance companies don't pay for these systems.
- Eat a healthy diet and get adequate calcium and vitamin D daily requirements to help with bone strength and health.
- Get screened for osteoporosis and treatment if needed.

Additional information is available from the **Centers for Disease Control and Prevention** and the **National Institutes of Health**.

Blue Cross Complete encourages providers to check patients for chronic conditions

Blue Cross Complete is sending notices to members with chronic conditions who have not been seen in 2014, encouraging them to schedule an appointment with you by the end of February 2015. Chronic disease reporting is important to identify gaps in disease and comorbidity assessment.

When you see your patients, please take that opportunity to:

- Complete a comprehensive examination checking for all chronic conditions.
- Submit a claim form to report all confirmed chronic diagnoses billed to the highest level of specificity.

The Provider Services Department is available to assist you with this project. Please feel free to contact your designated representative.

Developmental screenings are important for young children

In the past year, Blue Cross Complete providers have consistently performed developmental screenings at a higher rate than the state average for members in all Medicaid plans.

Please continue to remind members about the importance of bringing their children in for a screening at the first, second, and third year of life. When a developmental screening is performed, please remember to bill for these services. We appreciate the quality care and service you provide to Blue Cross Complete members.

Blue Cross Complete offers incentives for preventive health services

Blue Cross Complete encourages primary care providers to identify gaps in care for their patients. It is important to identify patients with chronic conditions and to provide them with preventive health care services.

Blue Cross Complete offers quality incentive payments for providing and reporting a number of preventive health services. Please visit the provider site at [Navinet](#) to access Care Gap reports. Please call your provider consultant for more information or if you have questions.



Healthy Michigan Plan reminders and updates

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Feedback

Thank you for your partnership during the Healthy Michigan implementation and providing a new population of members with quality care. Going forward, we will continue to provide updates that affect providers.

Health risk assessment required

Under the Healthy Michigan Plan, primary care physicians must complete a health risk assessment form at the time of the appointment. Blue Cross Complete members receive a copy of the HRA form in their welcome packet and should bring it to their appointment. The form is also available on mibluccrosscomplete.com/providers and on **NaviNet**. Please follow these guidelines:

- Complete the HRA form legibly and in its entirety. *Please Note: When completing Section 4 Member Results, be sure to include all required information. If a diagnosis is checked 'yes' (for example, blood sugar test results for diabetes. Incomplete HRAs not be eligible for the incentive payment.)*
- A member of the clinical team can complete the HRA form, but the PCP will need to sign it.
- Fax the entire form to 1-855-287-7886 within five business days of the appointment.
- Submit a claim with CPT code *99420 with modifier 25 to indicate that an HRA was completed.
- Direct any questions about the status of the HRA to 1-888-312-5713.

Blue Cross Complete will pay a \$15 incentive upon receipt of the claim.

Copayments

While there are beneficiary cost-sharing requirements for this population, primary care physician offices are not required to collect copayments. The collection of a Healthy Michigan Plan member's cost-sharing amounts is handled through the member's MIHealth account. Primary care physician offices should not collect copayments from these members.

Dental services

The Healthy Michigan Plan covers some dental care, including dental exams, cleanings and extractions through Healthy Michigan Dental. For more information, call 1-800-320-8465 or visit us online at MiBlueCrossComplete.com.

***CPT codes, descriptions and two-digit modifiers only are copyright 2013 American Medical Association. All rights reserved.**

Please report National Drug Codes on Blue Cross Complete claims for certain pharmaceuticals

Providers should continue to report the National Drug Code on all Blue Cross Complete claims for physician-administered pharmaceutical products.

The NDC is a unique, 11-digit identifier assigned to a drug product by the manufacturer under U.S. Food and Drug Administration regulations. Claims will be rejected if the NDC is not reported or if the NDC reported is not valid.

For more information, please refer to the *Blue Cross Complete Provider Manual* on mibluccrosscomplete.com/provider.

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NaviNet enhancements completed in July

Several enhancements to NaviNet were made recently.

Claim Status Inquiry

There is an option in the Claim Status Inquiry menu for “Select all Providers” in the dropdown menu. This new option allows the user to search for claims for all providers and groups associated with the office. Results will display only the first 50 claims. Please note that details will be returned only on the groups or providers loaded into that office, so if you are missing providers and need to update this information, contact NaviNet Customer Support using the “My Account” option.

Eligibility and Benefits

Enhanced Primary Care Physician Group details appear in the Eligibility and Benefits details screen to provide your office with more information.

The screen displays the member’s assigned primary care provider and their NPI number, as well as the associated primary care group name and NPI number.

Claims status summary reports

A new Claims Status Summary report that provides the status – pended, accepted or finalized – of all claims submitted can be found under “Report Inquiry” in the left navigation dropdown menu.

If you have any questions about any of these changes, please call your provider consultant.

Blue Cross Complete encourages providers to accommodate new members

Due to membership increases as a result of the Healthy Michigan Plan, we encourage providers to accommodate new members. We want to ensure that all members are able to receive care in a timely manner.



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Personal care plan letters sent to members

Blue Cross Complete is mailing letters to select Blue Cross Complete members by early September to remind them about important screenings and tests. Each member letter is customized with a list of services our records indicate are needed by the member this year. We are encouraging these members to work closely with their primary care physician to get and stay healthy through a personal plan that includes preventive screenings.

Support and intervention from our provider partners can make a difference in whether our members receive the appropriate screenings. Addressing these treatment opportunities can also help us raise our HEDIS® rates. HEDIS® is required for National Committee for Quality Assurance accreditation of health plans and is part of an integrated system to establish accountability in managed care. Members can use Michigan Department of Community Health star ratings to compare Medicaid plans against quality measures when choosing coverage.

Our recommended screenings include those identified at right. You can determine which screenings your members need and submit test results electronically using Health e-BlueSM.

Thank you for encouraging your patients to receive appropriate preventive tests and screenings.

Preventive tests for adult members

- Cervical cancer screening
- Chlamydia screening
- A1C test
- LDL cholesterol screening
- Retinal eye exam
- Breast cancer screening
- Kidney function test

Preventive tests/immunizations for children

- Hepatitis B
- DTaP
- Pneumococcal (PCV 13)
- Hib
- Polio (IPV)
- Rotavirus (RV)
- Hepatitis A
- MMR
- Chickenpox (VZV)
- Lead screening



Let us help you help your patients to quit smoking

By Dr. Duane DiFranco



The negative health effects of tobacco use are so tremendous that even a small change is worthy of a very large effort. That's why we're introducing a new suite of wellness interventions aimed at helping our members and you, their primary care physicians, achieve higher rates of tobacco cessation. The program will begin this fall.

You know the statistics well. According to the Centers for Disease

Control, cigarette smoking is responsible for one in five deaths within the United States – more than from HIV, illegal drug use, alcohol use, motor vehicle accidents and firearms related fatalities *combined*. Ten times as many Americans have died from cigarette smoking than have died in all of the wars the U.S. has ever fought. What is even more astounding is that each of these many deaths is entirely *preventable*.

Preventable, yes, but it does not always seem that way, does it? Nicotine addiction is, we must admit, powerful. Our experience as health care providers who are diligently

attempting to motivate our patients to quit may tempt us towards nihilism. We know that we must not succumb to that temptation, however, because even a slight improvement in such a horrific problem is so very worthwhile.

Even impossibly simple interventions can have a powerful effect. Research has shown, for example, that just asking about a patient's smoking status can increase quit rates. (See references on the next page for more information.) Blue Care Network has made a significant commitment to improving the rates with which our members are offered advice and information related to tobacco cessation and, thereby, to reducing the tobacco use rates among our members.

As your partners in this all-important wellness program, we hope that you will take advantage of the program and help educate your BCN member patients as to what is available to them. (Please also see related article on **Page 1**.)

- **BCN's Quit Guide for members.** Filled with information and resources, a supply of these guides will be delivered to your office sometime this fall. Please distribute them liberally to BCN members.
- **A reward contest for PCPs.** You and all primary care physicians have been entered into quarterly drawings for a \$3,000 personal reward. If your name is the one drawn and you have submitted five or more smoking-related CPT-II codes in the preceding quarter, you will be able to claim your reward. Do not miss the chance. Ask all your patients about their smoking habits, counsel them to quit, give them information on medications and other strategies that can help and simply submit the appropriate CPT-II codes.

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

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

From the medical director, continued from Page 17

- **Monthly reward contest for your office staff.** If you choose to participate, the check-in staff in your clinic can be eligible for this drawing by simply handing out our *Quit Guides* to BCN members as they check in.
- **Member incentives.** BCN members will also maintain eligibility for monthly reward drawings by simply acknowledging that they received advice about quitting and information about how to quit. Details for them will be posted to the BCN website in the early fall.
- **Quit the Nic incentive.** BCN members who have joined Quit the Nic by the end of November, National Lung Cancer Awareness Month, will be eligible for yet another reward drawing.

Given the magnitude of negative health effects caused by tobacco use, if these measures and wellness incentives push even a few members “off the fence” toward a successful quit attempt, their improved health will have been well worth our efforts and yours.

References

*Lancaster T, Stead L. “Physician advice for smoking cessation,” *Cochrane Database Syst Rev* 2004.

Robinson MD, Laurent SL, Little JM Jr. “Including smoking status as a new vital sign: it works! *Journal of Family Practice* 1995; 40:556.

Okuyemi KS, Ahluwalia JS, Wadland WC. The evaluation and treatment of tobacco use disorder. *Journal of Family Practice* 2001; 50:981.)

Promoting good health with preventive health guidelines

Blue Care Network supports the Michigan Quality Improvement Consortium recommended preventive health clinical guidelines that promote positive health outcomes for our members. These guidelines are developed using the most current medical and scientific literature. Some of these guidelines cover many of the Healthcare Effectiveness Data and Information Set® measures. HEDIS® is a quality measurement program of the National Committee for Quality Assurance®. NCQA is recognized nationally and by Medicare as a reliable indicator of quality health care.

MQIC provides the following preventive health guidelines:

- Adult Preventive Services Ages 18 to 49
- Adult Preventive Services Ages 50 to 65+
- Routine Preventive Services for Infants and Children Birth to 24 Months
- Routine Preventive Services for Children and Adolescents Ages 2 to 21

These one-page guidelines are located at the **MQIC** website along with update alerts. MQIC has additional clinical guidelines. The guidelines updated in 2014 include:

- Advance Care Planning
- Primary Care Diagnosis and Management of Adults with Depression
- General Principles for the Diagnosis and Management of Asthma
- Management of Acute Low Back Pain in Adults
- Management of Uncomplicated Acute Bronchitis in Adults
- Medical Management of Adults with Osteoarthritis
- Prevention of Pregnancy in Adolescents 12-17 years.

Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Physicians can promote patient understanding of osteoporosis

The *Journal of Bone and Mineral Research* recently published findings from a study that revealed that 10.2 million adults have osteoporosis and another 43.4 million have low bone mass. Approximately 2 million fractures every year occur due to osteoporosis, yet only 25 percent of older women who experience a fracture are tested or treated for osteoporosis.

Approximately half of all women over the age of 50 will experience fracture of the hip, wrist or spine due to osteoporosis. Bone is a living, growing tissue composed mostly of collagen and calcium phosphate and the existing bone is constantly being replaced by new bone. When the body fails to form enough new bone, or when too much existing bone is reabsorbed by the body, osteoporosis can occur.

The leading cause of bone loss in women occurs due to a drop in estrogen at the time of menopause. Other causes of bone loss include certain medical conditions and certain prescription drugs.

Other risk factors may include:

- Amenorrhea
- Family history of osteoporosis
- Consuming a large amount of alcohol
- Low body weight
- Smoking

There are no symptoms in the early stage of osteoporosis and often a person isn't aware they have the disease until they learn they have a fracture. Pain anywhere in the spine can be caused by a fracture and can often occur without an injury. The pain usually occurs suddenly or slowly over time. There can also be a loss of height and stooped posture, or kyphosis may develop. A bone mineral density test can diagnose bone loss and osteoporosis, predict risk of future bone fractures and help evaluate the effectiveness of osteoporosis medication. Medicare usually covers the cost of the test with a follow up test every two years for female beneficiaries as well as for male recipients who have significant risk factors for osteoporosis.

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



Osteoporosis, continued from Page 19

Treatment

Lifestyle changes such as diet and exercise are often recommended. Low calcium levels or intake appears to be associated with low bone mass, rapid bone loss and high fracture rates. Good sources of calcium include low-fat dairy products such as milk, yogurt, cheese and ice cream; dark green, leafy vegetables such as broccoli, collard greens, bok choy and spinach; sardines and salmon; tofu; almonds; and foods fortified with calcium such as orange juice, cereals and bread.

Women over the age of 50 should consume 1,200 mg of calcium daily and men between the ages of 51 and 70 should consume 1,000 mg daily. The dose should be increased to 1,200 mg for patients 70 and older.

Vitamin D helps the body to absorb calcium. Those who are indoors most of the time or live in the northern areas may have trouble getting enough vitamin D, especially during the winter months. As people age, their needs for vitamin D increase. People 51 to 70 should consume at least 600 international units of vitamin D daily. After age 70, people should consume 800 IUs per day. A few good sources for obtaining vitamin D in the diet are certain kinds of fish (herring, salmon and tuna) and low-fat milk fortified with vitamin D.

Regular physical activity has long been identified as having a positive affect on health, and exercise definitely plays a key role in preserving bone density in older adults.

Adults should engage in at least 30 minutes of moderate physical activity most days of the week. Children should engage in at least 60 minutes most if not all days of the week. Although exercise is a positive way to help prevent osteoporosis, any exercise that presents a risk of falling or is high-impact and could cause fractures in older adults should be avoided.

Smoking causes the body to absorb less calcium from diet; women who smoke have lower levels of estrogen in their bodies. Excessive consumption of alcohol and the use of certain medications, such as glucocorticoids and anticonvulsants, can increase the risk of bone loss and fractures.

It's important for physicians to discuss family history because heredity can be a factor in developing osteoporosis.

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

Improve the health of Michigan children

Fall is a popular time for well care visits. The required components of a well care visit include:

- Height and weight measurements for all age groups
 - Children 16 years and younger need their vital statistics noted on a growth chart or in percentile form.
 - Children 17 years and older meet the adult BMI requirement.
- Counseling that includes maintaining a healthy weight through nutritional advice and encouraging physical activity
- Immunization updates

All these components of the well care visit need to be documented in the patient's medical record. Including these components in the patient's medical record will help improve Healthcare Effectiveness and Data Information Set® scores. This annual HEDIS® data may also help show improvement in the health of Michigan's children.

Resources

For the latest on immunization recommendations, Vaccination Information Statements form and catch-up schedules go to the **Centers for Disease Control and Prevention** website page for providers.

For information on the **Michigan Health and Wellness 4x4 Plan**, visit **Michigan.gov**.



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Blue Care Network helps providers manage patients' asthma

Asthma is on the rise in the United States. More than 40 million Americans suffer from asthma, including 6.2 million children under 18, according to the National Institute of Environmental Health Sciences

BCN's Asthma Management program provides members with the information they need to make informed health choices. Members learn about their condition, how it affects their lives and how to manage symptoms. The program is available for BCN members age 2 and older. The program is consistent with the Michigan Quality Improvement Consortium guidelines for the **Management of Asthma** in both children and adults.

Our chronic condition management team offers information about the importance of working with the health care team as well as the primary care physician. We send members materials about recommended tests and how to recognize and control triggers. We also include information about medications that may be prescribed and how to self administer. BCN also educates members about the purpose and use of a peak flow meter as well as how to maintain an exercise program. Children who are asthmatic receive age-appropriate information about how to manage the disease while at school or away from parents' supervision.

We provide both adults and children with a management action plan so you and your patient can work together to control the disease process and prevent attacks and hospitalizations.

BCN offers enrollment in our asthma case management program to members with severe disease. In conjunction with the member's physician, we help develop an individualized plan of care and monitor outcomes.

The Asthma Management program is a part of Blue Care Network's Blue Health Connection benefit. Encourage members to use this program when appropriate. Current referral requirements apply. Registered nurses are available from 8:30 a.m. to 5 p.m., Monday through Friday and can be reached by calling-1-800-392-4247 or-1-800-257-9980 for TTY users.



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Criteria corner

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

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Question:

On pages 530 and 531 Adult General Medical Acute Day 1, electrolyte or mineral imbalance: What does "hospital acquired" mean in the IQ criteria subset under each of the electrolyte sections?

Answer:

This criterion was added to enhance workflow for patients who developed an alteration in their electrolytes during their hospital stay. The electrolyte imbalance may be as a result of treatment or the patient's disease process and is applied (Episode Day 1) on the day that this "hospital acquired" electrolyte imbalance becomes a predominant issue for the patient.

Medical policy updates

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

Noncovered services

- Genetic testing – molecular markers in fine needle aspirates (FNA) of the thyroid
- Antigen leukocyte antibody test
- Selective HDL delipidation and plasma reinfusion
- Endothelial function assessment

Covered services

- Cryosurgical ablation of renal and bone tumors
- Ocular photoscreening in the primary care physician's office as a screening tool to detect amblyogenic factors



[Medical Policy Updates PDF](#)

Question:

On page 162 Adult Deep Vein Thrombosis, Acute Day 1: Regarding the criteria point "major surgery" within one month in the DVT criteria subset, would an umbilical hernia repair qualify as a major procedure?

Answer:

McKesson uses standard medical terminology. A "major surgery" is defined as one which involves opening one of the major body cavities, the abdomen (laparotomy), the chest (thoracotomy), or the skull (craniotomy). A major procedure is usually done using general anesthesia in a hospital operating room by a team of doctors. An inpatient stay of at least one night in the hospital usually is needed after major surgery.

An umbilical hernia repair wouldn't normally be considered to be a "major surgery". An umbilical hernia repair is recommended for the outpatient setting and usually described as a "simple" procedure. However, there are variations in how extensive a herniorrhaphy may be based on factors such as the size of the hernia (greater than 4 cm is considered "large"), whether or not the hernia was recurrent and the approach for the surgery (laparotomy vs. laparoscopy). Careful review of the medical record might show a particular umbilical hernia repair to be a "major" surgery if there is strong documentation which shows that this particular herniorrhaphy was extensive and that the involved clinicians felt that the patient was at high risk for serious bleeding when anticoagulated to treat their DVT. This type of documentation could push the procedure over the line into "major" for the purposes of applying this particular criteria point, the intent of which is to identify patients at risk for bleeding.

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BCN's Depression Management Program supports members and providers

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

The goals of the program include:

- Provide education about basic pathophysiology of depression and current treatment modalities with emphasis on acute and continuation phases of treatment, self-management techniques and the importance of medication compliance
- Decrease absenteeism in the workplace
- Decrease inappropriate inpatient admissions and emergency room visits
- Address comorbid medical conditions
- Assist practitioners to track and monitor services for members with depression

The Depression Management program is available to all commercial HMO members 18 years and older and BCN AdvantageSM members. We identify members for the program through claims for outpatient, inpatient and emergency room visits for depression, pharmacy claims for antidepressants, referrals from physicians, data collected from members' completions of health assessments, referrals from BCN's utilization and case management departments and member self-referral. Once identified, the member is automatically enrolled in the program. The member may choose to opt out of the program by contacting BCN.

Enrolled members are placed into two levels.

Level one members receive:

- A program booklet and introductory letter
- A depression self-management booklet
- Medication refill reminder letters if necessary
- Ongoing telephone support from a chronic condition management registered nurse
- Web-based chronic condition management information and tools at bcbsm.com

BCN places the member in level two if admitted to the hospital with a primary diagnosis of major depression. In addition to the above materials, level two members receive the opportunity to enroll in a behavioral health case management program provided by BCN's Behavioral Health department. The behavioral health case manager makes sure that a follow-up visit is scheduled within seven days of discharge and monitors appointment compliance. The case manager calls noncompliant members to provide support and education. We provide additional support to members with readmissions including a member-specific plan of care.

We also offer support to providers through patient-specific case management reports, clinical guidelines, articles and program assistance from a registered nurse chronic condition management specialist.

To learn more about BCN's Depression Management program or to refer a member, contact a chronic condition management specialist at 1-800-392-4247 or 1-800-257-9980 for TTY users, Monday through Friday, 8:30 a.m. to 5 p.m.

Addressing intimate partner violence as a public health concern

Each year more than 12 million women and men are victims of rape, physical violence, or stalking by an intimate partner.¹ As a result of increasing incidence rates and the associated health problems, this very serious and preventable issue has become a public health concern.

Research reveals that although physicians generally believe identification and management of intimate partner violence is imperative, routine screening is infrequent. In addition, most physicians believe that domestic violence isn't a common problem with their patients and that screening questions will harm the patient-physician relationship.² The contrary is, in fact, true. Research shows that patients who are victims of intimate partner violence want routine screening, support, respect for autonomy and assistance in the form of safety planning and referrals. Of patients who aren't abused, 78 to 99 percent view routine screening as a positive and preventive measure.²

Physician-reported barriers to screening include:

- Lack of time and training
- Limited local resources for victims
- Personal and patient safety concerns
- Complexity of the issue
- Personal discomfort and concern for patient discomfort
- Inability to be of assistance
- A belief that the patient's situation won't be affected²⁻³

The following information is meant to assist physicians during patient interactions and interventions relating to intimate partner violence.

Please see [Violence](#), continued on Page 25



Violence, continued from Page 24

Identifying an abuser

There is no sure way to identify an abuser, but there are warning signs that may help identify potentially abusive behavior. If an individual expresses that his or her partner exhibits any of the following traits or behaviors, then an intervention may be necessary.

- Jealousy
- Overbearing and controlling
- Cruelty to animals
- Drives away partner's friends and family
- Emotional highs and lows
- Sees partner as an object
- Extreme anger/temper
- Violent family history
- History of former abuse

Finding help

The good news is help is always available. Michigan has over 40 free intimate partner violence programs available throughout the state. These programs help individuals and families affected by intimate partner violence, provide education and training, and work with local authorities, legal, medical, public and mental health and social services agencies.⁴ To find program information in your area visit the Health and Human Services Web page on **domestic violence**.

Resources

1. *The National Intimate Partner and Sexual Violence Survey* (2010). Centers for Disease Control and Prevention. Retrieved from <http://www.cdc.gov/violenceprevention/nisvs/>
2. Burge, S.K., Schneider, F.D., Ivy, L., Catala, S. Patients' Advice to Physicians About Intervening in Family Conflict. *Annals of Family Medicine*. 2005;3(3):248-254.
3. Gerbert, B., Gansky, S.a., Tang, J.W., McPhee, S.J., Carlton, R., Herzig, K., Danley, D., Caspers, N. Domestic Violence Compares to Other Health Risks: A Survey of Physicians' Beliefs and Behaviors. *American Journal of Preventive Medicine*. 2002;23(2):82-90.
4. *Domestic Violence* (n.d.). Michigan Department of Community Health. Retrieved from http://www.michigan.gov/documents/mdch/Domestic_Violence_brochure_2_175593_7.pdf

Please encourage victims of intimate partner violence to:

- Contact the police or 911 if in immediate danger.
- Maintain open communication with close family, friends or community.
- Call a domestic violence program for assistance.
- Make a safety plan that includes:
 - Gathering important documents such as ID cards, custody papers, Department of Human Services identification, pictures of bruises or other injuries and any other important documentation
 - Identifying someone to call in the event of a crisis such as a neighbor, family member, friend or local police
 - Identifying the quickest escape route
 - Sharing the safety plan with children or any others that may be involved⁴

The National Domestic Violence Hotline is another resource that is available 24 hours a day, seven days a week. It is confidential and free. The phone number is 1-800-799-(SAFE) or 1-800-787-3224 (TTY).

Prevention

Regular screenings for intimate partner violence are crucial in the prevention of abuse or further abuse. Physicians and physician offices should be aware of the resources available and refer their patients as necessary. Intimate partner violence screening alone is a powerful tool and positive intervention, and physicians play a crucial role in the prevention of this public health concern.

Flu season is the time to vaccinate

Approximately 36,000 Americans die from the flu each year and more than 200,000 are hospitalized from flu-related complications, according to the Centers for Disease Control and Prevention. Flu severity can vary widely from one season to the next. The 2012-2013 flu season was moderately severe compared with the 2011-2012 season, with a higher percentage of outpatient visits for flu-like illnesses, higher hospitalization rates and more deaths from pneumonia and influenza.

The American Academy of Pediatrics strongly recommends immunization for everyone 6 months and older. Therefore, as soon as the vaccine is available, immunization should be started especially for children at high risk of complications from influenza.

2014-2015 Influenza Vaccine

The 2014-2015 trivalent influenza vaccine contains the following virus strains:

- A/California/7/2009 (H1N1)-like virus
- An A(H3N2) virus antigenically like the cell-propagated prototype virus A/Victoria/361/2011
- B/Massachusetts/2/2012-like virus

Quadrivalent vaccines will also contain:

- B/Brisbane/60/2008-like virus

Who should get vaccinated

The Advisory Committee on Immunization Practices recommends that everyone from 6 months of age and older get vaccinated every year. Even healthy people are at risk for contracting the flu.

Those at high-risk of developing serious complications include:

- Children 6 months through 4 years of age
- Adults 50 years of age and older
- People with chronic pulmonary disease (asthma, even if well controlled), cardiovascular disease (except hypertension), renal, hepatic, neurologic, hematologic or metabolic disorders including diabetes

- Immunosuppressed individuals including those whose immunosuppression is caused by medications or any of the human immunodeficiency viruses
- Pregnant women or those women who may become pregnant during the influenza season
- Children 6 months through 18 year of age who are on long-term aspirin therapy
- Those living in nursing homes or other long-term extended care facilities
- American Indians/Alaskan natives
- People with a body mass index of 40 or greater
- Health care personnel
- Household contacts and out-of-home caregivers of children younger than 6 months and adults 50 years and older
- Household contacts and out-of-home caregivers of people with medical conditions that places them in a high risk category for complications from influenza

Infants are very susceptible and vulnerable to complications from the flu and pertussis. Therefore, it's very important to protect them by vaccinating the people around them against the flu and pertussis. This includes parents, grandparents, siblings, babysitters, daycare workers, caregivers/takers and health care personnel.

Certain medications can be taken to relieve the symptoms of the flu. Amantadine, Rimantadine, Zanamivir and Oseltamivir are antiviral drugs that can be used to treat influenza, but must be prescribed by a doctor. The medications can last for five days but must be started within the first two days of illness. They aren't a cure, but can help alleviate symptoms. Antibiotics are not effective against influenza.

Members can get flu shots at participating pharmacies with no member cost sharing.

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National Lead Poisoning Prevention Week is October 19-25

This year’s National Lead Poisoning Prevention Week theme, “Lead-Free Kids for a Healthy Future”, focuses on the importance of the many ways parents and doctors can reduce a child’s exposure to lead and prevent its serious health effects.

The U.S Centers for Disease Control and Prevention’s National Center for Health Statistics monitors blood lead levels in the United States. Providers can get information on the number of children with elevated blood lead levels and the percentage of children tested for lead in your area.

According to the CDC, the most important step parents, doctors and others can take is to prevent lead exposure before it occurs. Until recently, children were identified as having a blood lead level of concern if the test result was 10 or more micrograms per deciliter of lead in blood.

Experts now use a new level based on the U.S. population of children ages 1 to 5 years old who are in the top 2.5 percent of children when tested for lead in their blood (when compared to children who are exposed to more lead than most children). Currently that is 5 micrograms per deciliter of lead in blood. The new lower value means that more children likely will be identified as having lead exposure allowing parents, doctors, public health officials and communities to take action earlier to reduce the child’s future exposure to lead.

For more information visit the **Environmental Protection Agency** and **Michigan Department of Community Health** websites.

October is National Breast Cancer Awareness Month

Please remind your patients about the importance of routine breast cancer screening. Early detection saves lives.

Blue Care Network follows these screening guidelines:

Recommendation	18 – 49	50 – 74
Mammography	Ask your doctor	Every two years

For additional screening information, refer to the Michigan Quality Improvement Consortium Adult Preventive Services Guidelines **ages 18 to 49** and for ages **50 to 65+**.

Discuss pneumonia vaccine benefits with patients

About 175,000 cases of pneumococcal pneumonia occur each year in the United States, according to the Centers for Disease Control and Prevention. The symptoms of pneumococcal pneumonia include an abrupt onset of fever, shaking chills or rigors, chest pain, cough, shortness of breath, rapid breathing and heart rate, and weakness. The fatality rate is approximately 5 to 7 percent and can be even higher in the elderly.

Protection against pneumococcal disease can be accomplished by administering the pneumococcal conjugate vaccine. PCV can protect against 13 of the more than 90 strains of S pneumonia. These 13 types of S pneumonia cause the most severe illnesses.

Who should get this vaccine?

All infants aged 2, 4 and 6 months should be given a primary series of PCV13 and a booster at 12 to 15 months of age. If a child falls behind on this recommendation, a “catch-up” vaccination should be given through age 59 months if healthy or through 71 months if the child has certain underlying conditions.

PCV13 isn't the same vaccine as PCV23 (pneumococcal polysaccharide vaccine) which is the vaccine of choice for children over 2 and adults.

Who should get the PCV23 vaccine:

- Cigarette smokers age 19-64
- Everyone age 65 or older
- People age 2 or older with a high risk of infection:
- People with heart disease, lung disease, kidney disease, alcoholism, diabetes, cirrhosis, cochlear implants and leaks of cerebrospinal fluid
- People with sickle cell disease
- People who have had their spleen removed or whose spleens aren't working well

- People living in nursing homes or extended care facilities
- People living in any institution where there are other people with long-term health problems
- People with weakened immune systems from cancer, HIV or organ transplant
- People with a history of long-term medicines that suppress the immune system, including steroids
- Certain groups of Alaskan natives and Native American populations 2 to 5 years old or over age 50

One dose of the vaccine usually works for most people but some may need a second dose again in five years if the patient:

- Had the shot before the age of 65
- Has a weakened immune system
- Has chronic kidney failure or nephritic syndrome
- Has sickle cell disease
- Has had his or her spleen removed

Risks and side effects

There are typically only minor side effects, if any, from the pneumococcal vaccine. There may be some pain or redness at the site of the injection. Serious effects are rare and are due to an allergic reaction to part of the vaccine. PCV23 is an inactivated-bacteria vaccine; therefore an infection can't occur from the administration of this vaccine.

Assistance programs are available to cover vaccine expenses for patients who are uninsured or whose health plans don't cover vaccination.

Eligible members can get the PCV23 vaccine at participating pharmacies with no member cost sharing.

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September is Prostate Cancer Awareness Month

Blue Care Network encourages primary care physicians to educate their male patients about prostate health and encourage those at risk to be screened for prostate cancer.

Prostate cancer is the most common form of cancer in men. According to the Centers for Disease Control and Prevention, more than 200,000 men in the United States are diagnosed with prostate cancer each year, and about 30,000 men die from the disease.

1. New Cases of Prostate Cancer by Race and Ethnicity (2011, August 13). Centers for Disease Control and Prevention.

Physicians should discuss the benefits and potential risks of prostate cancer screening with their patients so they can make informed decisions about their health. Discussions with their physicians can help men understand the nature and risk of prostate cancer, the risk and benefits of screening and alternatives to screening.¹

For additional information contact the BCN Quality Management department by emailing BCNQIQuestion@bcbsm.com or by calling 248-350-6263.

Safe to Sleep campaign reduces SIDS deaths

The Safe to Sleep Campaign, formerly known as the “Back to Sleep” campaign, has helped educate millions of caregivers, parents, grandparents, babysitters and health care providers about ways to reduce the risk of Sudden Infant Death Syndrome and other sleep-related causes of infant death.

Since the start of the campaign, SIDS rates in the United States have decreased by almost by 50 percent, both overall and within various racial and ethnic groups. However, SIDS remains the leading cause of death for infants in the United States from one month to one year of age. Some populations, such as African Americans, are also at high risk for SIDS.

Today, the Safe to Sleep campaign builds on the success of “Back to Sleep” to address SIDS and other sleep related causes of infant death and to continue spreading safe sleep messages to members of all communities.

For additional information and to order materials visit the National Institutes of Health [Safe to Sleep](#) Web page.





BCN adds residential psychiatric treatment benefits, effective July 1

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Blue Care Network has begun covering residential psychiatric treatment, effective July 1, 2014.

Residential psychiatric treatment takes place in a state licensed facility with a multidisciplinary treatment team. The following is available to assist with medical issues, administration of medication and crisis intervention as needed:

- Nursing care is on-site (preferably), or on call, and no more than 15 minutes away 24/7.
- A psychiatrist is on-call 24/7.
- A psychiatrist is on site a minimum of two days per week.

Providers treating patients who may benefit from residential psychiatric treatment should call Behavioral Health Services at 1-800-482-5982 for information about facilities and authorization for benefits.

Please note that this new coverage does apply to self-funded groups on their renewal date on or after July 1, 2014; coverage may not necessarily apply on July 1. Coverage also does not currently apply to government programs, including BCN AdvantageSM and Blue Cross Complete and to retiree-only groups. Check web-DENIS and future issues of *BCN Provider News* for updates.

Limits removed for applied behavior analysis for autism

Effective Jan.1, 2015, Blue Care Network will remove the hourly limit for the treatment of autism using applied behavior analysis, but will continue to apply medical necessity criteria when authorizing these services.

Psychiatric and psychological services are already without limits but are managed using medical necessity criteria. Prescription medications will continue to be managed using the BCN drug list.

Physical, occupational and speech therapy services are available based on need and do not need authorization if there has been an autism diagnosis.

This change applies to all individual and fully insured employer group plans.

Reminder: Blue Care Network's Behavioral Health Incentive Program documents are on web-DENIS

Blue Care Network's Behavioral Health Incentive Program launched in January of 2014 and is created exclusively for behavioral health providers. This program is specifically designed for psychiatrists, fully licensed psychologists and clinically licensed certified social workers.

If you are unfamiliar with the program, we strongly encourage you to access it on web-DENIS.

- Go to *BCN Provider Publications and Resources*
- Click the link for *Behavioral Health* in Resources
- Documents are located in the *Behavioral Health Incentive Program* section

Please see full details in the **March-April** issue.

Additionally, BCN would like your help in responding to a **survey** which addresses familiarity with the program, feedback and any barrier to participating. Please add your voice to that of your colleagues by completing this survey. We look forward to receiving your input and partnering with you in designing 2015 BHIP.

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Best Practices

Spirometry test helps patients improve lung function

Doing spirometry testing on patients who have respiratory symptoms helps Dr. James Kohlenberg plan follow-up treatment, provide patient education on smoking cessation and increases patients' medication compliance.

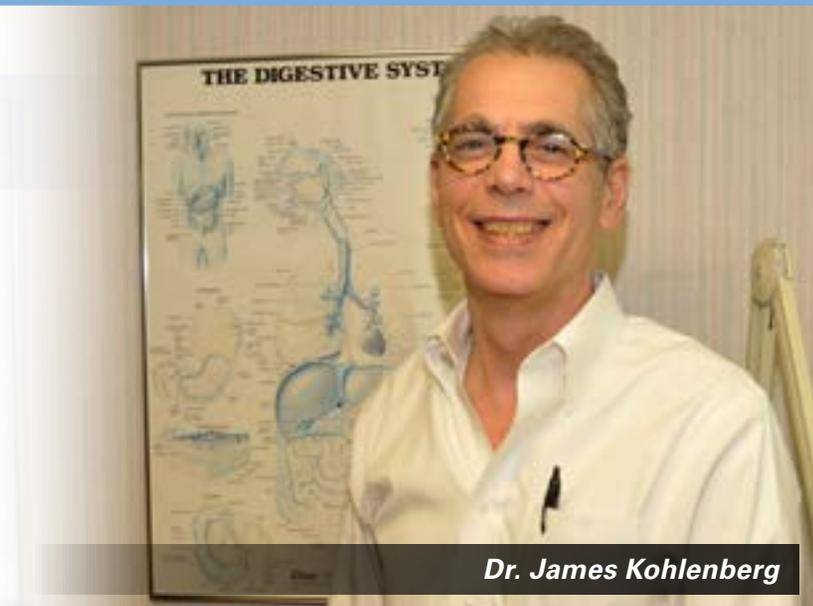
Spirometry is beneficial when determining the extent of pulmonary diseases for patients with symptoms such as shortness of breath, wheezing and persistent coughing, says Dr. Kohlenberg. The test is important because many doctors have patients with asthma as well as older patients who have smoked or continue to do so, he said.

Medical assistants in his office have received basic training and can administer the spirometry test. "The test is easy, the machines are inexpensive and the computer readouts are readily available," he says. The readouts help Dr. Kohlenberg show his patients their lung function and how it can improve over time with subsequent testing. "Spirometry is accurate and gives reproducible results so the physician can diagnose and monitor pulmonary disease."

Frequently, people use the pulmonary function testing as feedback. And they've based their actions on this feedback, Dr. Kohlenberg says. "By knowing their own function, they're able to own their disease and make decisions to help self manage their disease, whether it's asthma or pulmonary disease."

Discussing smoking cessation with patients

The main cause of COPD is smoking, acknowledges Dr. Kohlenberg. He says a component of COPD is reversible with medication. "Smoking cessation will improve the reversible component and slow down the



Dr. James Kohlenberg

progression of loss of function," he says. Therefore, "it's important to show patients who smoke their loss of function compared to normal and to also demonstrate the reversible proportion of their loss that could be eliminated."

The doctor inquires about smoking at every patient encounter and documents it on the medical record. Dr. Kohlenberg counsels patients about smoking cessation and sometimes prescribes medication. (See **Page 1** to read about BCN's smoking cessation initiative.)

Follow up is also critical. Patients with severe respiratory disease are seen as often as monthly. Those with moderate disease can be seen every three or four months. With minimal disease, yearly visits are sufficient, says Dr. Kohlenberg. Spirometry is usually measured once or twice a year.

Dr. Kohlenberg and his medical assistants actively counsel patients. "We give them action plans for health. The patient is involved in developing a strategy to achieve specific goals that are timely and achievable," he says. "And both patient and caregiver work together to generate ideas to overcome barriers," he said.

The added benefit of spirometry testing, Dr. Kohlenberg says, is medication compliance "because patients know they improve when they take their medications regularly."

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Resources for appropriate antibiotic use

Blue Care Network wants to remind providers of available resources to help educate patients about inappropriate antibiotic use. The use of antibiotics is addressed in two Healthcare Effectiveness Data and Information Set® measures for children with symptoms of upper respiratory infections and pharyngitis.

- Appropriate Testing for Children with Pharyngitis
 - Children 2 to 18 years old who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
- Appropriate Treatment for Children with Upper Respiratory Infection
 - Children 3 months to 18 years old who were diagnosed with an upper respiratory infection and weren't dispensed an antibiotic prescription.

Some parents believe antibiotics are necessary to treat these types of infections, so providers are challenged to prevent the inappropriate use of antibiotics. Listed below are some practices that can assist you:

- Discuss the risks of antibiotics and make the topic part of staff meetings.
- Don't offer a prescription for antibiotics by phone.
- Discuss with parents at the initial meeting that antibiotics aren't prescribed by phone.
- Keep same-day appointment slots open for sick children.
- Perform rapid strep test.
- Teach parents how to care for children with colds without giving them a prescription.
- Use posters, your practice website, on-hold phone messages and fliers to educate patients that antibiotics don't work for certain types of infections.

There are several internet resources available to support appropriate use of antibiotics:

- The Michigan Quality Improvement Consortium clinical guideline for **Acute Pharyngitis in Children 2 to 18 years old** is available on their website. This is a one-page guideline with levels of evidence for the most significant recommendations. MQIC health guidelines are a tool to support practitioners and aren't intended to be a substitute for medical judgment. Individual patient considerations and advances in medical science may supersede or modify these recommendations
- The Centers for Disease Control and Prevention **Get Smart** Web page features brochures, posters and a one-page Q&A sheet in English and Spanish that provides answers to commonly asked questions about using antibiotics for upper respiratory symptoms.
- The **Michigan Antibiotic Resistance Reduction Coalition** promotes proper use of antibiotics in Michigan. The organization provides educational materials and information.

MQIC updates guidelines

Updates have been made to two Michigan Quality Improvement Consortium guidelines.

- *Management of Diabetes Mellitus*
- *Routine Prenatal and Postnatal Care*

Visit the **MQIC website** to view the updated guidelines and update alerts.

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BCN partners with Walgreens Infusion to provide outpatient immunoglobulin therapy to members

Blue Care Network is joining with Walgreens Infusion, the nation’s largest infusion provider, to bring an innovative immunoglobulin management program to our members and their providers. This new program provides additional clinical management, cost effective care and outcome reporting.

Beginning Oct. 1, 2014, BCN members who use immunoglobulin therapy will receive their subcutaneous and intravenous IG therapy through Walgreens Infusion, which has been designated as BCN’s preferred provider of outpatient IG services.

This arrangement applies to BCN commercial members and BCN Advantage HMO-POSSM members. Members who receive IG therapy in a contracted hospital, contracted hospital-owned infusion center or their physician’s office can continue to receive IG therapy in these settings.

Members who currently receive IG therapy through a home infusion provider or at an infusion center other than

Walgreens will receive services from Walgreens Infusion beginning October 1. To ensure a smooth transition, BCN will notify affected members, their physicians and current IG providers about this initiative by mail. Walgreens will contact affected members to arrange an appointment at the member’s home or a Walgreens Infusion center.

Walgreens will contact the member’s current IG provider to transition the member’s prescription. Walgreens will also contact the member’s physician for additional information if needed.

Nurses specially trained in IG therapy will provide a full assessment of the member at every visit. Walgreens’ highly trained pharmacists will work with BCN clinicians to review the assessments and contact the physician with any concerns regarding the member’s progress.

BCBSM and BCN drug lists updated, available online

The Blue Cross Blue Shield of Michigan and Blue Care Network Pharmacy and Therapeutics Committee reviewed the pharmaceutical products listed in the PDF below for inclusion in the *BCBSM/BCN Custom Drug List 2014, Custom Select Drug List 2014* and the *BCN AdvantageSM HMO-POS Formulary*.

Please help our members by talking with them about their drug copayment or coinsurance. Note that many members with a commercial drug benefit do not have coverage for Tier 3 drugs.

Blue Cross Blue Shield of Michigan and Blue Care Network regularly update their drug lists. For the most recent updates, go to bcbsm.com.rxinfo.



[Drug Lists PDF](#)



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FDA recommends lower dose of Lunesta

Following the recommendation in January 2013 that doses of the sedative-hypnotic Ambien® (zolpidem) be reduced, the U.S. Food and Drug Administration has continued to evaluate the risk of impaired mental alertness with the use of insomnia medications. As a result, on May 15, 2014, the FDA released a safety announcement warning of next-day impairment with Lunesta® (eszopiclone).

The warning stems from a double-blind study assessing Lunesta's effects on psychomotor function the morning following a 3 mg dose. The study found 3 mg of Lunesta can impair driving, memory and coordination which can last more than 11 hours after taking the medication. The study found individuals were often unaware of their decreased abilities and felt comfortable going on with normal daily activities, such as driving. Therefore, it is recommended patients taking the 3 mg dose should be cautioned against next-day driving or engaging in other activities that require complete mental alertness.

References:

1. United States Food and Drug Administration. FDA drug safety communication: FDA warns of next-day impairment with sleep aid Lunesta (eszopiclone) and lowers recommended dose [Internet]. Silver Spring (MD): U.S. Food and Drug Administration (FDA). [cited 2014 Jul 1]. Available from: <http://www.fda.gov/Drugs/DrugSafety/ucm397260.htm>
2. American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society updated beers criteria for potentially inappropriate medication use in older adults. *J Am Geriatrics Society* 2012 Apr; 60 (4): 616-31.
3. Wolters Kluwer Health. Lexicomp database. © 1978 – 2014. Available at www.lexi.com. Accessed: July 2014.

The drug manufacturer recommends a starting dose of 1 mg for both men and women, who are equally susceptible to impairment. The dose may be increased to 2 mg or 3 mg only if clinically necessary, because higher doses increase the risk of next-day impairment. Please caution patients who take the 3 mg dose against next-day driving or engaging in other activities that require complete mental alertness.

While the FDA continues to evaluate the risk of impaired mental alertness with the entire class of sleep aids, including over-the-counter agents, health care professionals are encouraged to prescribe the lowest dose capable of treating a patient's insomnia to decrease the potential risk of impairment and facilitate patient safety.



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Why do some generic drugs need prior authorization?

There are times patients may go to the pharmacy to fill their generic drug prescription, but the medication is blocked at the pharmacy because prior authorization is needed. A call from the pharmacist to notify the physician of the requirement may prompt the doctor to ask why a health plan would restrict access to a generic therapy when the plan consistently emphasizes the importance of prescribing generic agents.

Some generic medications have prior authorization to ensure appropriate use of the drug. For example, Blue Care Network requires that members meet certain body mass index and comorbidity criteria before we'll cover weight loss drugs. This helps ensure that users are in the patient population specified in the drug's package insert. It also limits off-label prescribing, which could be detrimental to individuals with borderline BMI and no other underlying health conditions.

Indication plays a role in generic prior authorization requirements, and another driver is cost. Recent price spikes among previously cost-efficient generic therapies are prompting insurance providers to closely evaluate the use of these drugs.

Prices for generics have jumped, mainly due to supply and demand. Unlike other countries that set national wholesale pricing for each drug that comes to market, the United States relies on market competition to set the going rate. If a branded drug goes generic and has very few new manufacturers approved to make the medication, the cost stays relatively high. Cymbalta® is one example. Only one

pharmaceutical company currently markets the generic version of the product and the cost has held steady at more than \$7 per capsule.

If one manufacturer has an issue with production, there's a drop in the availability of a key raw material, or a company decides they no longer want to market a generic therapy, the supply will decrease. If demand has remained the same, prices will jump. This was the case with doxycycline, which experienced a 6,000 percent cost jump in 2013 due to a manufacturing issue. The Food and Drug Administration removed doxycycline from its shortage list in March of 2014, but the price remains at an average of \$3 per tablet.

There has also been consolidation within the generic industry and fewer companies are making generic drugs. Mylan, Teva, and Actavis generate 44 percent of generic drug revenue worldwide. As more generic drug manufacturers are swallowed up in mergers and acquisitions, we will likely see a decrease in supply with a steady demand for generic therapies, resulting in higher costs to consumers.

Even though we have seen a steady increase in cost of generic medication, BCN strongly encourages providers to use these agents where appropriate to help control prescription drug costs.

Generics that require prior authorization are noted in BCN's drug lists. The drug lists, prior authorization and step therapy guidelines can be found at bcbsm.com/Rxinfo.

References:

1. Rosenthal E. The soaring cost of a simple breath. *The New York Times* [Internet] October 12, 2013 [cited 7 July 2014]. Available from: www.nytimes.com/2013/10/13/us/the-soaring-cost-of-a-simple-breath.html.
2. Fuquay J. Some generic drugs have had eye-popping price spikes. *Star-Telegram* [Internet] April 19, 2014 [cited 7 July 2014]. Available from: www.star-telegram.com/2014/04/19/v-print/5748846/some-generic-drugs-have-had-eyepopping-price-spikes.html.
3. Graedon J & Graedon T. The people's pharmacy: beware stratospheric increases in generic-drug prices. [Internet] January 7, 2014 [cited 7 July 2014]. Available from: www.roanoke.com/life/health/the-people-s-pharmacy-beware-stratospheric-increases-in-generic-drug-prices.html.
4. Colliver V. Prices soar for some generic drugs [Internet] January 1, 2014 [cited 7 July 2014]. Available from: www.sfgate.com/health/article/prices-soar-for-some-generic-drugs-5105538.php.



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Tamoxifen, raloxifene added to PPACA preventive drug coverage list

Beginning September 30, 2014, generic tamoxifen and raloxifene will be eligible for coverage with no cost-sharing when prescribed for primary prevention of breast cancer in women at high risk. This change affects our commercial health plan members with BCBSM or BCN prescription coverage.

These additions are recommended by the U.S. Preventive Services Task Force under the Affordable Care Act.

Members must meet plan requirements and a prescription is required for coverage.

Plan requirements for \$0 copay:

- Women ≥ 35 years of age
- No prior history of breast cancer
- Documentation of risk factors demonstrating the member is at high risk for developing breast cancer
- Low risk for thromboembolic events
- Post-menopausal (raloxifene only)

To request approval for a patient to receive these drugs at \$0 copay, prescribers can contact the Pharmacy Clinical Help Desk at 1-800-437-3803. Members can call the Customer Service number on the back of their Blues member ID card.

Cost sharing will apply when these drugs are prescribed as a treatment for breast cancer.

The PPACA **preventive drug coverage list** is on our website.

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Blue Care Network is making changes to its electronic claims system

Beginning October 2014, the criteria we use in our electronic claims system process will align more closely with our paper submission criteria.

Please keep the following changes in mind for member match criteria:

- We will no longer look for the subscriber if the contract number submitted is not found. Claims without a contract number or with an invalid contract number, will be rejected as contract number not found.
- We will no longer match If a social security number is submitted as the contract number. These claims will be rejected as contract number not found.
- An exact match on the date of birth is no longer required. A match on six characters will be considered a match for the date of birth.

Example: If the date of birth is 09141954 and is submitted as 09141954:

09151953 – Matches on 6: Accepted
 08151954 – Matches on 6: Accepted
 10141954 – Matches on 6: Accepted
 10141964 – Does not match 6: Rejected

- We have implemented a new hierarchy for matching:
 - Date of birth (6), last name (first 4 characters) and first name (first 3 characters)
 - Date of birth (6) and last name (first 4 characters)
 - Date of birth (6) and first name (first 3 characters)
 - Date of service will be used when there is more than one group that matches on a member.

- We have implemented enhanced logic if there is more than one match (twin logic). The full first name will be used. If there are still two matches, the relationship code will be used.

- Spaces and hyphens (and other special characters) will be ignored when matching on name.

Example: First name: JO ANN or JO-ANN = JOANN (first three logic will be applied).

Example: Last name: MC DONALD or MC-DONALD = MCDONALD (first four logic will be applied).

Changes will also be made to the 277CA. Today we don't distinguish between "member not found" and "contract not found" and return only A3:26:QC (see below). The following codes will be returned with the new changes:

- Member not found
 - A3 – Acknowledgement / returned as claim not able to process – The claim/encounter has been rejected and has not been entered into the adjudication system.
 - 26 – Entity not found. **Note:** this code requires use of an entity code.
 - QC – Patient.
- Contract not found
 - A3 – Acknowledgement/returned as claim not able to process – The claim/encounter has been rejected and has not been entered into the adjudication system.
 - 164 – Entity's contract/member number. Note: This code requires use of an entity code
 - HK – Subscriber

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Question:

We now have a practitioner making home visits. Is it a requirement to have vital signs when billing an E&M code?

Answer:

It is not a requirement to document vital signs when reporting or billing an evaluation & management service. If, however, the patient's condition indicated a need for vital signs to be taken during the E&M service, we would expect they would be part of the evaluation and documented accordingly. The level of care reported by the E&M code must be supported in the documentation.

Question:

When doing a status using the new CMS-1500 form to correct a procedure code, I would use the ORN and bill frequency code 7. Can I send this claim electronically? Also, if there were originally three codes billed and I only want to correct one of them, do I only send the one corrected code back as a status or all three even though two of the three were paid?

Answer:

Corrected claims can be submitted electronically. When submitting a corrected or status claim, it must include the claim number being corrected, the codes submitted on the original claim, with the corrections noted. If three codes were billed originally and only one was submitted on the corrected claim, you would likely end up being paid just for the one code reported on the status claim.

Please refer to Claims section in the *Provider Manual*, "Resubmitting a claim for inquiry," for additional information about submitting status claims.

Question:

Can I send in a second appeal that has been upheld when I forgot to include some key information?

Answer:

No. BCN has only one level for clinical editing appeals. Please make sure you submit all pertinent information on the initial request and that the appeal form is complete and accurate. Information on the appeal process is available in the *BCN Provider Manual* on web-DENIS in *BCN Publications and Resources*.

Some key items to remember with submitting a clinical editing appeal:

- Fill out the clinical editing form completely and accurately.
- Submit the appeal within 180 days of the original clinical editing denial.
- Include all pertinent clinical information relevant to the appeal. This may include office notes, surgical reports, radiology reports or duplicate reports. What you include depends on the denial received. If in doubt, include it.
- Include a contact person and phone number so we can call you if we have questions.

Have a billing question?



If you have a general billing question, we want to hear from you. Click on the envelope icon to open an email, then type your question. It will be submitted to *BCN Provider News* and we will answer your question in an upcoming column, or have the appropriate person contact you directly. Please do not include any personal health information, such as patient names or contract numbers, in your question to us.



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The Blues to implement diagnosis-specific pricing

New technology in medical care often results in better treatment, improved care and more effective outcomes. But sometimes the new technology is not superior to the previously existing approaches. And when the cost of the newer technology is significantly higher than other equally effective approaches, the cost of care can be unnecessarily inflated.

In order to match the cost of a service with its effectiveness, Blue Care Network and Blue Cross Blue Shield of Michigan plan to take into account not only the procedure performed but also the patient's diagnosis or condition. When the performance of a procedure for a particular diagnosis is indicated as "established" by BCBSM/BCN medical policy, then the fee will be in line with the given procedure. If the procedure performed is not medically necessary, then the fee will be in line with the alternative, equally effective and less costly treatment approach.

BCN has already implemented this capability for future Proton Beam Therapy procedures performed in Michigan. Effective February 1, 2015, we will begin applying this diagnosis-specific pricing process for selected Intensity Modulated Radiation Therapy procedures.

The specific procedure codes that will be affected for PBT are *77520, *77522, *77523 and *77525. For IMRT, the procedure codes are *0073T, *77301, *77338, *77418. Information on established diagnosis codes will be provided in the near future.

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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 we receive reporting of the performed procedure. To view the full content of the tips, click on the *Clinical editing billing tips* below.

This issue's billing tips include:

- Billing for cancelled or discontinued surgeries
- Submitting documentation for review of claims with denied unlisted codes
- Reporting antepartum services for four or more visits
- Reporting nuclear medicine procedures
- Special treatment procedure – radiation oncology



[Clinical editing
billing tips PDF](#)

Facilities should use accurate coding when billing for RhoGAM

Rho(D) immune globulin (for example, RhoGAM™) may be a required treatment for pregnant or postpartum women. This is determined by a blood test the physician orders during pregnancy to determine the Rh and ABO blood typing. The risk for the condition, known as mother-fetus incompatibility, increases with each pregnancy when a mother is Rh negative and the fetus is Rh positive.

Therefore, it is important to diagnose and treat this condition. To facilitate reimbursement of this important treatment, Blue Care Network does not require a referral for the Rho(D) immune globulin injection when performed by contracted providers.

To facilitate reimbursement, follow the few simple steps below:

- Identify the correct CPT or HCPCS code for the Rho(D) immune globulin being provided to the member.
- Report this CPT or HCPCS code under revenue code 0250.
- For the administration of the injection, use CPT code *96372.
- Report the administration CPT code under revenue code 0940.
- To identify the member as requiring the injection related to pregnancy, please report the diagnosis codes of 656.10, 656.11, or 656.13.

Reporting the services in any other manner may result in a delay or possible denial of services, such as for an authorization or referral.

Below is a sample of a claim processing with the appropriate codes submitted:

Total Charge		\$400.00		Patient Paid		\$0.00		Submitted DRG	
	From	To	Rev	TOS	Procedure	Units	Charges	Diagnosis	
-->	06/01/2014	06/01/2014	0250	ASQL	J2790	1	\$300.00	65613	
2	06/01/2014	06/01/2014	0940	FOML	96372	1	\$100.00	65613	

Billing instructions for services associated with Rho(D) immune globulin are available on the web-DENIS *BCN Provider Publications and Resources* page under Billing.

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Keep in mind these coding tips to improve medical record documentation

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According to the Centers for Disease Control and Prevention, one in every three adults has hypertension and only half of those adults have it under control. If left uncontrolled for too long, hypertension can damage the heart, kidneys and other organs.

The hypertension table in the *Index to Diseases* is the first point of reference when coding hypertension. It classifies hypertension by type (primary or secondary) and by nature (benign, malignant or unspecified). There are codes which are used for reporting hypertension in its simple vascular state, without manifestations, and combination codes that illustrate the affect of hypertension on other organs. This allows providers to communicate the complexity of their patient's condition to the greatest specificity – whether the condition exists alone or with other diseases.

Coding tips for hypertension

Here are common codes for hypertension:

- Primary, or essential, hypertension is considered idiopathic – occurring without apparent cause. Code categories 401 to 404 are used for primary hypertension.
- Secondary hypertension is due to an underlying cause and is reported with codes from category 405.
- Documentation of hypertension should also specify if it's benign or malignant:
 - According to the National Institutes of Health, malignant hypertension is defined as high blood pressure that comes on suddenly and quickly. Malignant hypertension often causes organ damage. Other terms for malignant hypertension include accelerating or necrotizing.
 - Benign hypertension is mild to moderate elevation in blood pressure of prolonged or chronic duration without target organ damage.
 - If hypertension is not documented as benign or malignant, it's reported as unspecified hypertension (401.9). Coders can't determine if hypertension is benign or malignant; it must be documented in the progress note by the provider.

- Documentation should indicate *hypertension, benign*, or *hypertension, malignant*. Documentation that states only *elevated* or *high blood pressure* could be misinterpreted as transient or incidental hypertension.
- Use of the words *controlled* or *uncontrolled* to describe hypertension refers to the status of the condition, not whether it's benign or malignant. Status indicates if it's responding to medication, diet or other therapy, not if it's benign or malignant. For example, documentation that states *hypertension, controlled* should be coded as 401.9 (hypertension, unspecified), not 401.1 (malignant hypertension).
- Documentation that indicates *elevated* or *high blood pressure*, or *borderline hypertension*, but doesn't state a diagnosis of hypertension, is reported with 796.2 (elevated blood pressure reading with no mention of hypertension).

Hypertension and correct coding

There are three codes for primary (essential) hypertension in its most simple vascular state:

Code	Title
401.0	Malignant hypertension
401.1	Benign hypertension
401.9	Unspecified hypertension

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Coding tips, *continued from Page 41*

Hypertensive heart disease

Hypertension may increase the workload of the left ventricle of the heart due to the higher systemic vascular resistance. This can result in hypertrophy of the heart or combined hypertrophy and dilation, also known as heart disease.

When documentation indicates a cardiac condition is due to hypertension, caused by hypertension or hypertensive, report a combination code from category 402. Providers must establish causality in the documentation. Causality can't be assumed.

Code	Title
402.00	Malignant hypertensive heart disease, without heart failure
402.01	Malignant hypertensive heart disease, with heart failure
402.10	Benign hypertensive heart disease, without heart failure
402.11	Benign hypertensive heart disease, with heart failure
402.90	Unspecified hypertensive heart disease, without heart failure
402.91	Unspecified hypertensive heart disease, with heart failure

Conditions in category 402 are indicated in the subterms and include cardiomyopathy, myocarditis, myocardial degeneration, cardiovascular disease, cardiomegaly, heart disease and conditions from 429.81 to 420.89 (other ill-defined heart diseases).

Additional codes from category 428 may also be documented and reported for the type of heart failure. Hypertensive heart disease doesn't include conditions classifiable to ischemic heart disease (410 to 414); however, these might also be documented in the medical record and should be coded separately.

Hypertensive chronic kidney disease

According to the National Kidney Foundation, hypertension is the leading cause of chronic kidney disease. It can also be a complication of CKD, and the association between hypertension and CKD is so strong that ICD-9-CM presumes a cause-and-effect relationship between the two conditions.

Code	Title
403.0x	Malignant hypertensive CKD
403.1x	Benign hypertensive CKD
403.9x	Unspecified hypertensive CKD
Fifth digit: 0 – CKD stage I through IV, or unspecified. 1 – CKD stage V or end-stage renal disease.	

A code from category 585 should also be used to document the stage of CKD.

Only chronic kidney conditions classified to category 585 or 587 can be reported with the hypertensive CKD codes. There isn't an assumed causal relationship between hypertension and acute renal failure, which usually develops as the result of an event such as dehydration, major blood loss or the effect of medicine, and it's often reversible. In contrast, chronic kidney disease is caused by the effects of hypertension or other diseases over a long period of time.

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Coding tips, continued from Page 42

Hypertensive heart and chronic kidney disease

The kidneys play an important role in regulating blood pressure. But when they develop disease, blood pressure increases and the likelihood of heart problems increases, too. Due to their interactive nature, category 404 combines three conditions: heart disease, hypertension and CKD. As previously indicated, a relationship between CKD and hypertension can be assumed, but documentation must indicate a causal relationship between hypertension and heart disease.

Code	Title
404.0x	Hypertensive heart and chronic kidney disease, malignant
404.1x	Hypertensive heart and chronic kidney disease, benign
404.9x	Hypertensive heart and chronic kidney disease, unspecified
Fifth digit: 0 – without heart failure and with CKD stage I – IV, or unspecified	
1 – with heart failure and with CKD stage I – IV, or unspecified	
2 – without heart failure and with CKD stage V or end stage renal disease	
3 – with heart failure and chronic kidney disease stage V or end stage renal disease	

Additional codes should be added to indicate the type of heart failure and stage of CKD.

Secondary hypertension

Secondary hypertension is coded using category 405. It's defined as high arterial blood pressure due to another underlying cause or primary disease, such as renal disorder, central nervous system disorders, endocrine or vascular diseases. A code should be reported for the type of secondary hypertension and also a code for the underlying etiology.

Hypertension may contribute or accelerate the development of many other conditions. Because ICD-9-CM doesn't provide combination codes for every condition, assign a code for each individual condition to communicate the complexity of a patient's condition.



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New e-referral tool coming Sept. 29

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Feedback

BCN's new e-referral tool is expected to launch Sept. 29. In order to maintain access to e-referral without disruption, please make sure your Provider Secured Services user ID and password (web-DENIS ID) are operational for the sign-on process.

All e-referral users in your office must have their own Provider Secured Services ID and password. Your Provider Secured Services user ID and password should not be shared with others.



Test your user ID

The new e-referral tool is part of the Blues' Provider Secured Services. Check that you can get into Provider Secured Services. Go to **bcbsm.com/providers** and click *LOGIN*. Make sure Provider is selected and type your username and password.

- If you can get into Provider Secured Services, congratulations — you are ready for the new e-referral tool.
- If your account is not active, call the Web Support Help Desk at 1-877-258-3932 to get it reactivated.
- If you do not have a Provider Secured Services username and password, sign up now at **bcbsm.com/providers** and click on *Provider Secured Services*.
- Use your Provider Secured Services user ID within 14 days of receipt. After that, we encourage you to log in to Provider Secured Services monthly, but you must log in at least once every six months to keep your account active.
- Providers may also transfer e-referral access from a former employee to a new employee. Visit **bcbsm.com/providers**:
 - Click on *Help*
 - *FAQs*
 - *How to sign up for Provider Secured Services*
 - *Reassign old user IDs*
 - Download the *Provider Secured Services ID Reassignment* PDF and fax it to 1-800-495-0812

Make sure your computer system is compatible with the new e-referral tool

To ensure that the new e-referral tool works with your computer system, check these minimum requirements:

- Computer processor: computer with a 3.3 GHz Intel Core i3 processor or higher (or comparable)
- 4 GB memory (RAM)
- 10 GB hard drive space
- Monitor able to display 1024x768 pixels or higher
- Browser requirements Microsoft Internet Explorer 8.0 or 9.0, and the latest versions of Firefox, Google Chrome and Safari

For more instructions on e-referral sign-on please visit **ereferrals.bcbsm.com** and click on *Sign Up or Change a User*. Watch for upcoming training opportunities on **ereferrals.bcbsm.com**.

Watch for BCN Alert announcing new e-referral tool

We will give you the details about BCN's new e-referral tool in early September, including training and transition information. Watch for a BCN Alert email or for news posted on **ereferrals.bcbsm.com**.



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[Feedback](#)

Reminder: Refer patients to JVHL for laboratory services

To help members save on out-of-pocket costs, the Blues have created partnerships to provide lab services.

Blue Care Network contracts with Joint Venture Hospital Laboratories to provide clinical laboratory services to BCN HMO commercial and BCN AdvantageSM members. This partnership offers statewide access to more than 130 hospitals and 450 service centers that provide 24-hour access and a full range of laboratory services.

We encourage you to refer your patients to JVHL for laboratory services to ensure payment coverage. To locate patient services center locations visit the [JVHL website](#) or call 1-800-445-4979.



Facilities should use accurate coding when billing for RhoGAM

Blue Care Network does not require a referral for the Rho(D) immune globulin injection when performed by contracted providers. Please see [Page 40](#) for the full article, including tips for facilitating reimbursement.

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