Upgrades coming to e-referral

Several new upgrades and changes are coming to the e-referral system. Since its launch in September 2014, users have provided valuable feedback which has driven these changes for an enhanced user experience. The expected go-live date for these enhancements is Aug. 3, 2015. Please watch erefferrals.bcbsm.com for the latest updates and information.

With the upgrade, users will be able to:

- Create a new case for the same patient from the Case Details page which reduces the work effort needed to create multiple cases for one patient.
- Add attachments to a Case Communication with the Attach File button on an initial request.
- Search for referrals and authorizations across all providers in a set when choosing the new Include All Associated Providers option.
- Search for a provider or facility by their NPI within their associated provider list. (Previously a user could only search for a provider.)
- Search by either a code or description in the same field during a Procedure Code search.
- Manually enter a Patient ID during a Referral/Authorization case search (Previously had to search/select a patient to populate this field.)

Please see e-referral upgrades, continued on Page 2
e-referral upgrades, continued from Page 1

Other changes:

• The Add Provider and Add Facility buttons have been replaced by the Add Bookmark button (found in the Bookmarks feature under the Provider tab).

• The From and To dates have been eliminated when searching for a case by Patient.

• The In Focus vertical bar on the left side has been removed to simplify the application.

• The system will now accept ICD-10 codes (as well as ICD-9 codes).

These changes can be found in the updated User Guide online or the User Guide addendum posted on the e-referral Web page. Printed guides were mailed to offices in September 2014. If you have a printed User Guide, please use the addendum along with it to support your use of e-referral.

If you did not receive and would like a User Guide mailed to you, please send an email request to providertraining@bcbsm.com and we will complete those requests as we receive them.

E-referral outage planned before upgrade

In order to upgrade the system, e-referral will not be available starting late Friday, July 31 through early Monday, Aug. 3. Due to this outage, referrals and authorization requests cannot be handled electronically until Monday, Aug. 3. For urgent referral and authorization requests, call BCN Care Management at 1-800-392-2512. Please stay tuned to ereferrals.bcbsm.com for more detailed information about this transition period.
Blue Cross and BCN update policy on concierge medicine

Blue Cross Blue Shield of Michigan and Blue Care Network have updated their policy on concierge medicine to require that concierge or retainer practice models are in line with Blue Cross and BCN affiliation agreements.

In a “concierge” or “retainer” practice, members pay membership fees to a provider or third-party vendor for enhanced services or amenities. As a benefit of paying this fee, members typically receive:

• Immediate appointment access
• Extended office visits
• Extended or enhanced email and telephone communication
• Care coordination between specialists, including referral coordination
• Wellness programs and plans, genetic and nutritional counseling and health assessments

Providers who wish to employ this model in their practices must ensure that the requirements of the model are permitted by their Affiliation Agreements with Blue Cross. Providers may charge a concierge fee so long as:

• Members are not required to pay the concierge fee to become or continue to be a patient in the practice
• Members are not required to pay the concierge fee to obtain access to the provider, and are only permitted access to ancillary providers such as physician assistants or nurse practitioners if they do not pay the concierge fee
• The services or products being offered that are included in the concierge fee are not classified as “covered services” pursuant to the Affiliation Agreements, but instead are not covered under a member’s benefit plan. (Because members’ benefit structures vary significantly, providers are expected to understand a specific member’s benefit structure to ensure that covered services are not included in the concierge fee.)
• Providers maintain the level of access and service to patients who have not paid the concierge fee and continue to meet Blue Cross and BCN access performance standards
• The concierge level of service is clearly over and above usual practice in Michigan. (Complaints from members that they have suffered deterioration in service level may result in BCN concluding that the practice is non-compliant with the non-discrimination clause of the Affiliation Agreements.)

If you have questions related to the concierge medicine policy, please contact your provider consultant.

BCBSM providers must comply with the Affiliation Agreements

As a reminder, the Affiliation Agreements require providers to (1) submit claims for covered services (those services covered under a member’s benefit plan) directly to Blue Cross or Blue Care Network; (2) accept our payment as payment in full; (3) only charge the member the applicable copayment and/or deductible for the covered service; and (4) not discriminate against members based on payment level, benefit or reimbursement policies.
Blue Care Network announces increased rewards for tobacco cessation contest

Blue Care Network will continue its tobacco cessation survey contest in 2015 with monthly Visa gift card rewards for both members and the office staff who provide members with BCN Quit Guides and tobacco-use surveys. In fact, Blue Care Network will double the prize money awarded to the office staff winners for the last six months of the year. Gift cards totaling $1,000 (up from $500) will be split evenly among the winning office staff for the July to December drawings.

In addition, BCN is setting a goal of receiving 5,000 completed surveys during the second half of 2015. If we reach this goal, all the year’s office winners will receive an extra $500. That’s a potential total of $1,500 in gift cards for your office staff!

Watch in the coming weeks for the delivery of more surveys and Quit Guides to your office for you to hand out to BCN commercial members, ages 18 to 65. If you still have surveys on hand from the last distribution, please continue to distribute them along with our Quit Guides and encourage patients to complete our tobacco cessation survey. Paper surveys will continue to be available from your provider consultant. You can also ask your BCN members to complete the survey online at bcbsm.com/bcnsmokingsurvey.

Reminder: Please note that while we encourage you to provide counseling about tobacco use to all members, only BCN commercial members are eligible for incentives as part of our tobacco cessation campaign.

Blue Care Network discontinues CPT-II incentive for smoking cessation program

Blue Care Network has discontinued the $3,000 incentive for providers who bill a certain number of CPT-II codes in a specified quarter related to smoking cessation and counseling.

It will not be replaced at this point, though BCN may pursue a new provider incentive program related to smoking cessation at a later date.
Most providers like **Blues Brief**, find it easy to read

A *Blues Brief* survey was conducted recently to find out how satisfied you are with the monthly (professional) or quarterly (facility) one-page newsletter. Provider consultants drop off the latest copy when they visit you. The newsletter can also be found on web-DENIS under BCBSM Newsletters and Resources or BCN Provider Publications and Resources.

More than 180 providers responded to our survey. Here’s what you told us:

- Fifty-seven percent receive *Blues Brief* regularly.
- Seventy percent read *Blues Brief* often/sometimes.
- Eighty percent strongly agree or agree that the one-page format is easy to read.
- Seventy-five percent strongly agree or agree that *Blues Brief* includes useful information relevant to work you do with Blue Cross and BCN.
- Eighty-six percent strongly agree or agree they are glad *Blues Brief* is available for both Blue Cross and BCN.

Other suggestions included providing hyperlinks to the *BCN Provider News* and *The Record* articles referenced, receiving *Blues Brief* via email, and including specialty-specific articles. Thanks to your suggestions, hyperlink references to the *BCN Provider News* and *The Record* articles are now bold and in color for easier identification. You also asked for more information. There are several other newsletters available via subscription. Visit the [Subscribe to Blues Provider e-Newsletters](http://bcbsm.com/providers) page on bcbsm.com/providers, enter your information and choose from five other electronic newsletters.

Would you like to receive *Blues Brief* regularly? If you would like to receive *Blues Brief* via email, please email your provider consultant. If you do not know who your provider consultant is, see the instructions in the box below to locate your provider consultant.

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**How to find your provider consultant**

Here’s how you can find contact information for your provider consultant:

- Go to [bcbsm.com/providers](http://bcbsm.com/providers).
- Click on *Contact Us* in the upper right corner of the page.
- Under *Physicians and professionals*, click on *Blue Care Network provider contacts*.
- Click on *Provider consultants*.
- Find your provider consultant on the applicable regional list.

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**Congratulations survey winner**

Congratulations to our survey drawing winner! Blue Cross Blue Shield of Michigan and Blue Care Network have chosen the winner of the *Blues Brief* survey drawing. Congratulations to Jo Lunt of the Center for Pulmonary and Sleep Medicine in Petoskey. Jo will receive a $25 gift card for participating in our survey.
Why it’s important to check eligibility and benefits at every visit

It’s very important to check member eligibility and benefits every time you provide services. You can’t rely on the member’s ID card to tell the whole story. Here are some reasons why it’s important:

- **Coverage may not yet be in effect.** With health care reform, more members are purchasing individual or family health care coverage directly from Blue Cross or Blue Care Network or through the Health Insurance Marketplace. These individuals receive ID cards once they enroll, but their coverage isn’t active until they pay their first month’s premium and their effective date occurs. In addition, if the member pays the first payment but doesn’t make subsequent payments, the account becomes delinquent and coverage ceases. Members receiving government subsidized premiums who are in their second or third month of premium delinquency will have their claims held until the premiums are paid in full or until the contract is cancelled at the end of the three-month Advanced Premium Tax Credit grace period. So, even though members may show you an ID card, their coverage may not be in effect. You should check each member’s eligibility and benefits at every visit.

- **Benefits can change.** A member can sign up for coverage but later change that coverage. Members with individual policies can change coverage for any reason during the open enrollment period. After the open enrollment period is over, members with a qualifying event may still be able to change coverage. So a member may present an ID card that no longer accurately represents the coverage he or she has.

**Three ways to check eligibility and benefits**

- Online using web-DENIS or through a 270/271 electronic standard transaction
- By calling our automated phone system, PARS (formerly CAREN)
- By calling Provider Inquiry

**What this means for providers**

Having a Blue Cross or Blue Care Network ID card doesn’t necessarily mean the member has coverage that is currently in effect. You may find more and more situations in which ID cards are presented for coverage that’s not in effect. Be aware that Blue Cross and Blue Care Network won’t reimburse claims for services that are not in effect at the time of service. It’s important to check each member’s eligibility and benefits at every visit.
Chiropractic Update webinars coming in July

An expansion in payable services is coming for chiropractors, effective for dates of service Aug. 1, 2015, or after. To learn more about these changes, chiropractors are invited to our upcoming Chiropractic Update webinars on Tuesday, July 21, and Thursday, July 23. The webinars will be held at 10 a.m. and 1 p.m. both days.

The webinars will include discussion about the expanded payable procedures and more.

To register, please download the invitation, complete the information requested and respond by email or fax by July 17.

Get Continuing Medical Education credits, mobile app for anticoagulation toolkits

Last year, the Michigan Anticoagulation Quality Improvement Initiative created and shared two anticoagulation toolkits: one for providers who administer anticoagulation medication and the other for patients receiving anticoagulation medication. The toolkits are free and available at anticoagulationtoolkit.org.

Recently, the collaborative has taken the toolkits to a new level by offering Continuing Medical Education credits (2 AMA PRA Category 1 credit hours) to individuals who review the toolkit and score 70 percent or better on a 10-question exam. You can find the education activity at the Office of Continuous Professional Development at the University of Michigan.

Additionally, the toolkit now has a free iPhonemobile app. The app includes three different interactive tools, along with the ability to view the entire toolkit. The Michigan Anticoagulation Quality Improvement Initiative plans to add more interactive tools in the future. If you download it, use it and like it, please rate the app so others are encouraged to download it as well.

The toolkits provide practitioners and patients with an up-to-date, reliable, and easy-to-use source of information on anticoagulation.

For additional information about the Michigan Anticoagulation Quality Improvement Initiative, please contact the Blue Cross project lead, Karlie Witbrodt, at kwitbrodt@bcbsm.com.
Members receive out-of-pocket costs cards

Improving our members’ experiences continues to be a focus at Blue Care Network. To help ensure that they understand their cost-sharing responsibilities and have no surprises when they seek health care services, we mailed out-of-pocket costs cards to our commercial, fully-insured group and individual members at a contract level beginning April 16.

Members received two copies of the cards: one for the contract holder member and another for a dependent. BCN group and individual members who already have received a BCN Member Handbook will not receive an out-of-pocket costs card.

The card was developed to address member concerns about how much services will cost. In addition, some of our Health Care Quality and Service Improvement Committee doctors have also asked us to share copayment information with our members to help reduce some of the administrative burden on their office staffs.

The card features helpful information, including:

- A customized tear-out card with a member’s out-of-pocket costs for certain covered medical services
- Definitions of common health care terms related to costs
- A reminder to select an in-network primary care physician to save the most on costs and ensure care is covered
- Instructions on how to request a copy of the recently updated BCN Member Handbook and view a sample handbook at bcbsm.com

Medicare and self-funded group members were not included in the original mailing. Pending approval, these segments will receive their version of the out-of-pocket costs card at a later date.

BCN offices closed for holiday

Blue Care Network offices will be closed on Friday, July 3 for Independence Day.

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
- Expediting 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 emergency admission.

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

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

- When an admission occurs through the emergency room, contact the primary care physician to discuss the member’s medical condition and coordinate care before admitting the member.
Reminder: Keep information up to date with Blue Cross and Blue Care Network

We’d like to remind practitioners, other professional providers and non-hospital facilities that you must notify Blue Cross Blue Shield of Michigan and Blue Care Network within 30 days of changes made in ownership, name, tax identification number, practice location, practice phone number, medical group affiliations and whether your practice is accepting new patients.

Practitioners
To update provider information (name, individual practice address, phone number, or credentialing information), physicians and other professional providers must update information online through the CAQH ProView®. For help, practitioners and professional providers can call the CAQH Support Desk at 1-888-599-1771 or email providerhelp@ProViewCAQH.org. To update your practice location information when under a professional medical group, you must use the change notification process for organizational providers. Changing your practice address in CAQH does not change your practice location information for any medical group affiliations.

To update tax information (tax name, tax ID, mailing or remittance address, accepting new patients) submit the information using the appropriate change form that is available at bcbsm.com/providers by clicking on Enrollment and Changes and following the prompts. Fax the form to Provider Enrollment and Data Management at 1-866-900-0250.

Organizational provider and non-hospital facilities
Professional organizational providers and non-hospital facilities must complete the appropriate change form that is available at bcbsm.com/providers by clicking on Enrollment and Changes and following the prompts. Fax the form to Provider Enrollment and Data Management at 1-866-900-0250.

Hospitals
Hospitals visit bcbsm.com/providers to update existing provider information (name, phone number, tax name, tax ID, remittance address or any other information).

If you’re making an address change and you have questions regarding how it may affect your Blue Care Network or Blue Cross affiliation, please call Provider Enrollment and Data Management at 1-800-822-2761 or call your provider consultant.

Helpful tip: It’s a good idea to periodically review your address information using the Find a Doctor tool on bcbsm.com. Contact your provider consultant if you find any incorrect data. Professional groups should use the enrollment self-service application to change their information.
Where to call for BCN assistance

In the March-April issue, we announced that the Blue Care Network regional toll-free numbers for Provider Outreach were being eliminated. The chart outlined where to call for assistance.

We have updated the chart below to include contact information for behavioral health.

<table>
<thead>
<tr>
<th>For…</th>
<th>Call…</th>
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</thead>
<tbody>
<tr>
<td><strong>General inquiries</strong>, such as:</td>
<td><strong>BCN Provider Inquiry</strong></td>
</tr>
<tr>
<td>• Claim inquiries</td>
<td>• Commercial and BCN Advantage: 1-800-255-1690</td>
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<tr>
<td>• Member benefits</td>
<td></td>
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<tr>
<td>• Primary care physician assignment</td>
<td></td>
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<tr>
<td><strong>Behavioral health inquiries</strong>, such as:</td>
<td><strong>Behavioral health</strong>: 1-800-482-5982</td>
</tr>
<tr>
<td>• Initial authorizations</td>
<td></td>
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<tr>
<td>• Continued treatment reviews</td>
<td></td>
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<tr>
<td>• Authorization issues</td>
<td></td>
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<tr>
<td>• Referrals</td>
<td></td>
</tr>
<tr>
<td><strong>Enrollment inquiries</strong>, such as:</td>
<td><strong>Provider Enrollment and Data Management</strong></td>
</tr>
<tr>
<td>• Enrollment or credentialing</td>
<td>• 1-800-822-2761</td>
</tr>
<tr>
<td>• Demographic updates</td>
<td></td>
</tr>
<tr>
<td>• Issues with information displayed in our online provider search</td>
<td></td>
</tr>
<tr>
<td><strong>Contractual or education inquiries</strong>, such as:</td>
<td><strong>Your provider consultant</strong></td>
</tr>
<tr>
<td>• Contractual issues</td>
<td>• If you don’t know your provider consultant, see Contact Us at bcbsm.com/providers.</td>
</tr>
<tr>
<td>• Recurring problems or unresolved issues</td>
<td></td>
</tr>
<tr>
<td>• Training on BCN policies, procedures and programs</td>
<td></td>
</tr>
<tr>
<td>• Discussion of primary group administration</td>
<td></td>
</tr>
<tr>
<td>• Changes in primary care physician acceptance codes</td>
<td></td>
</tr>
<tr>
<td>• Requests for coverage/on-call providers</td>
<td></td>
</tr>
</tbody>
</table>

For more contact information, go to our Quick Guides at ereferrals.bcbsm.com.
Are you using the right Internet browser to access bcbsm.com?

To access bcbsm.com after June 19, 2015, you must use the latest versions of these Internet browsers:

- Internet Explorer 7.0
- Google Chrome 33.0
- Mozilla Firefox 34.0

How do I update my browser?

- If your computer system can access any website on the Internet, go to the browser’s website (windows.microsoft.com/en-US/internet-explorer/download-ie, firefox.com or chrome.com) and download the most current version.

- If the system is controlled by your Information Technology department, then contact IT to perform the update.

Where can I find version information for my browser?

**Internet Explorer**

1. Click on the wheel/gear in the upper right corner.
2. Click on About Internet Explorer.
3. The version will be displayed right below the words “Internet Explorer”

**Chrome**

1. Click on the three bars in the upper right corner.
2. Click on About Google Chrome.
3. The page will show if your version of Chrome is up to date.

**Firefox**

1. Click on the three bars in the upper right corner.
2. Click on the “?” to open the help menu.
3. Click About Firefox.
4. The page will show if your version of Firefox is up to date.

What will happen if my browser is not up to date?

When accessing bcbsm.com after June 19, 2015, you’ll see a message that the site is not available and your browser needs to be updated.

Why should I update my browser?

Blue Cross is constantly working to improve member data security. Because of our ongoing efforts, we are no longer able to support browser versions with known security issues.

If you have any additional questions, call 877-258-3932.
Remember to refer BCN members only to providers contracted with BCN

Before you refer a BCN HMO℠ or BCN Advantage℠ member to another provider for services, double check to make sure the provider is contracted with BCN or BCN Advantage. In addition, if the member has coverage through a product with a designated local network of providers, check to make sure you’re referring the member to a provider who belongs to that network.

If you feel you need to refer a member to a provider who is not contracted with BCN or who is not part of the designated local network of providers for the member’s plan, you must request clinical review of the proposed service from BCN Care Management before the member has the service.

Referring members to providers who are not contracted with BCN or who do not belong to the local provider network for the member’s plan or failure to obtain clinical review for services from those providers may result in denial of the provider’s payment. The provider cannot balance-bill the member and must write off the billed amount.

Guidelines about clinical review requirements

In addition, the following clinical review requirements apply depending on which provider you send the member to:

- All services provided outside the BCN HMO or BCN Advantage provider network must undergo clinical review from BCN Care Management.
- Services by BCN or BCN Advantage providers who are not in a product’s designated local network typically also require clinical review from BCN Care Management.
- Clinical review must be completed before providing services.

Identifying providers who belong to designated networks

The current method for identifying providers who belong to designated provider networks is outlined in the Finding your Blues plans and networks document, which is available on the web-DENIS BCN Products page. (Refer to the PDF below.) In this document, you’ll see what options to use in the online provider search to locate practitioners and other providers who belong to various provider networks. To access the document, log in to Provider Secured Services, click web-DENIS, click BCN Provider Publications and Resources and click BCN Products. Finally, click the link to the Finding your Blues plans and networks document.

Determining whether the member’s plan has a local provider network

When you check a member’s eligibility and benefits in web-DENIS, you will see special local network messaging on the Member Eligibility page if the member has coverage that includes a local provider network. You’ll also hear this information when you check eligibility and benefits using the PARS phone system.

Please see BCN referrals, continued on Page 13
Here’s a short summary of BCN products that have designated provider networks:

<table>
<thead>
<tr>
<th>Product / Network</th>
<th>Provider network requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross® Select and many other BCN commercial products, including BCN HMO and BCN Healthy Blue Living℠ HMO, use the PCP Focus network.</td>
<td>Most BCN commercial products can be paired with a requirement to use the PCP Focus network, which includes a designated set of primary care physicians and all BCN-contracted specialists and facilities.</td>
</tr>
<tr>
<td>Blue Cross® Metro Detroit HMO</td>
<td>The Blue Cross Metro Detroit HMO provider network is a unique network in metropolitan Detroit that is smaller than the BCN provider network. For care within the statewide BCN provider network, standard BCN referral and clinical review requirements apply. Care rendered outside the statewide BCN provider network requires clinical review by the plan.</td>
</tr>
<tr>
<td>Blue Cross® Partnered</td>
<td>The Blue Cross Partnered provider network consists of physicians primarily associated with Mercy Health. Care by providers outside the Blue Cross Partnered network requires a referral from the primary care physician and clinical review by the plan.</td>
</tr>
<tr>
<td>BCN Advantage℠ HMO-POS</td>
<td>The BCN Advantage HMO-POS provider network is a large network through which BCN Advantage HMO-POS members can get their services in specific areas of the state. Care by providers outside this network requires a referral from the primary care physician and clinical review by the plan.</td>
</tr>
<tr>
<td>BCN Advantage℠ HMO ConnectedCare</td>
<td>The BCN Advantage HMO ConnectedCare provider network is a subset of the BCN Advantage HMO-POS network. Care by providers outside the BCN Advantage HMO ConnectedCare network requires a referral from the primary care physician and clinical review by the plan.</td>
</tr>
<tr>
<td>BCN Advantage℠ HMO MyChoice Wellness</td>
<td>The BCN Advantage HMO MyChoice Wellness provider network consists of physicians primarily associated with Mercy Health. Care by providers outside of this network requires a referral from the primary care physician and clinical review by the plan.</td>
</tr>
</tbody>
</table>

In addition, there are two additional products that increase, rather than limit, the number of providers the members can see:

- Blue Elect Plus Self-Referral Option℠ members can see any provider, whether the provider is inside BCN’s network or outside of it.
- MyBlue Medigap℠ members can see any provider who accepts Medicare.

Identifying providers who belong to specific provider networks will get easier later this year when BCN’s e-referral system is upgraded. Watch for more information later this year at referrals.bcbsm.com. Additional details are available on Page 1 of this issue.
Where to find additional information about BCN’s products and designated provider networks

- Blue Cross and Blue Care Network products and networks for 2015:
  - *BCN products at-a-glance*, available on the web-DENIS BCN Products page. Log in to Provider Secured Services. Click web-DENIS, click BCN Provider Publications and Resources and click *BCN Products*. Finally, click the link to the *BCN products at-a-glance* document.
  - *The Blues to offer a variety of individual products for 2015*, November-December 2014
  - *Blue Care Network continues to offer PCP Focus in 2015*, November-December 2014

- Finding which Blue Cross plans you and other providers participate in:
  - “How to tell if you’re providing services for a BCN or Blue Cross member,” November-December 2014
  - “How to find the Blues health plans you participate in,” March-April 2015
  - “The Marketplace is open — Do you know which Blues products you participate in?,” January-February 2015

- Blue Cross Metro Detroit HMO:
  - “Guidelines for Metro Detroit EPO, HMO networks,” March-April 2015
  - “Referrals and clinical review for Blue Cross Metro Detroit HMO,” March-April 2015
  - “Blue Cross Metro Detroit HMO provides new low-cost coverage to individuals in Southeast Michigan,” November-December 2014

- BCN Advantage HMO ConnectedCare:
  - “BCN Advantage introduces ConnectedCare HMO local network,” November-December 2014

- Blue Elect Plus Self-Referral Option:
  - “Reminder: Members in Blue Elect Plus plan do not need referrals,” November-December 2014
Providers must follow rules to bill non-face-to-face chronic care management services

For BCN Advantage members who have two or more significant chronic conditions, practitioners can provide both face-to-face and non-face-to-face services to help manage these conditions. Non-face-to-face services are activities that would not typically be provided face to face, such as telephone communication, review of medical records and test results, and consultation and exchange of health information with other providers.

Effective Jan. 1, 2015, for eligible BCN Advantage members who meet specific criteria, you can bill for non-face-to-face chronic care management services using a new procedure code finalized by the Centers for Medicare & Medicaid Services. This new CMS initiative is aimed at ensuring continuity of care and care management, including care planning and coordination, member education and communication with the variety of providers involved in the member’s care, as appropriate.

Here’s what you need to know.

**Eligibility.** You may bill for non-face-to-face chronic care management services for a member who meets both of these conditions:

- Has two or more significant chronic conditions expected to last at least 12 months or until the member’s death
- Is at significant risk of death, acute exacerbation or decompensation, or functional decline due to these conditions

Please see Non-face-to-face billing, continued on Page 16
Non-face-to-face billing, continued from Page 15

**Written consent.** You must obtain the member’s consent in writing before non-face-to-face chronic care management services are billed. The member must sign a form documenting that he or she was informed of the following:

- That the member is eligible for chronic care management services and is offered the opportunity to participate in them. This must occur before providing any chronic care management services. The following must also be documented:
  - The member’s decision to accept or decline the offer to participate
  - The member’s permission to share relevant medical information electronically with other providers, if the member is interested in participating
- That the member has the right to discontinue the chronic care management services at any time by giving either oral or written notification. This would revoke the agreement and services would be discontinued at the end of the service period.
- That only one practitioner can furnish and be paid by BCN Advantage for chronic care management services within a service period
- That while there is no copayment or coinsurance for chronic care management services, a deductible may apply and may result in cost-sharing for the member.

The member’s electronic health record must contain evidence of the member’s written consent and the documentation that the items listed above were discussed with the member. If the member gives notification to discontinue services, the notification must be stored in the electronic health record as evidence of ending chronic care management services. The electronic health record must be maintained using technology certified for chronic care management services.

**Services for members.** As a result of the non-face-to-face chronic care management services, members must be able to do the following:

- Reach health care practitioners at any time, 24 hours a day, seven days a week
- Obtain continuous care through successive routine appointments with a designated individual on the health care team
- Receive a systematic assessment of his or her health needs and the appropriate preventive services in a timely way, including review of medication adherence, identification of potential medication interactions, follow-up after emergency department visits, follow-up after the member is discharged from a hospital or other health care facility and oversight of the member’s self-management of medications
- Receive a copy of the patient-centered electronic care plan that is developed
Non-face-to-face billing, continued from Page 16

Responsibilities of practitioners. When providing non-face-to-face chronic care management services, you must do the following:

• Initiate the chronic care management services during a face-to-face visit before billing for them
• Use a certified electronic health care record for specified purposes
• Include the following information in the member’s medical record:
  - Demographic information
  - Problems
  - Medications and medication allergies, consistent with 45 CFR 170.314(a)(3)-(7)
• Provide, upon request, a copy of the member’s structured clinical summary record, consistent with 45 CFR 170.314(e)(2), including:
  - The member’s written consent to receive chronic care management services
  - The member’s written notice or the documentation of the member’s verbal notice to discontinue chronic care management services, as applicable
• Give the member a copy of his or her care plan
• Coordinate and document communication to and from home- and community-based providers
• Access members’ electronic health records 24 hours a day, seven days a week, to address urgent chronic care needs
• Manage the transitions between and among health care providers and settings and community and social services, including referrals, follow-up and providing the member’s electronic health record, as appropriate
• Communicate with members about their care over the phone or through secure messaging

Claims. Non-face-to-face chronic care management services should be billed using procedure code *99490. This is a new code available as of Jan. 1, 2015, for chronic care management services. Here are the guidelines for billing with this code:

• Services may be billed once per calendar month, for a minimum of 20 minutes of qualifying services of the types discussed earlier in this article.
• Services can be billed only by qualifying clinical staff. This includes only physician and nonphysician practitioners directly affiliated with Blue Care Network or billing incident to a supervising physician.
• Only one practitioner can bill per month. The billed services are typically provided by primary care practitioners, although specialists may also bill as long as the requirements are met.

Please see Non-face-to-face billing, continued on Page 18
Non-face-to-face billing, continued from Page 17

- Time spent on various activities may or may not count toward the 20 minutes of chronic care management time, as shown in the table that follows:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Count toward minimum 20 minutes of billable chronic care management time?</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and management services and procedures</td>
<td>No</td>
<td>E&amp;M services should be billed separately.</td>
</tr>
<tr>
<td>Telephone calls between the practitioner and:</td>
<td>Yes</td>
<td>Telephone calls used to schedule appointments cannot be counted toward the 20 minutes of billable chronic care management time. If the time from a phone call leads to scheduling an office visit, that time would be included in the billed office visit, not the chronic care management time.</td>
</tr>
<tr>
<td>• The member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The member’s other health care providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The laboratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General planning or care coordination time that is initiated because of a contact, or does result in a contact with the patient or a contact related to the patient</td>
<td>Yes</td>
<td>General planning or care coordination time that is not initiated because of a contact, and does not result in a contact with the patient or a contact related to the patient, cannot be counted toward the 20 minutes of billable chronic care management time.</td>
</tr>
</tbody>
</table>

- Claims for these services are subject to review and audit. You should ensure that the documentation in the member’s medical record supports the claim.

- Chronic care management services cannot be billed in the same month in which claims are submitted through the following programs, which reimburse for similar services:
  - Blue Cross/BCN High Intensity Care Model program
  - Multi-payer Advanced Primary Care Practice Demonstration
  - Comprehensive Primary Care Initiative
  - Transitional Care Management

Additional information. Additional information about chronic care management services is available through the following resources:

- **Chronic Care Management Services fact sheet**, published by the CMS Medicare Learning Network. In this document, you’ll find examples of the chronic conditions for which chronic care management services can be billed, among other things.
- **Frequently Asked Questions about Billing Medicare for Chronic Care Management Services**, published by CMS
- **Chronic Care Management Tool Kit**, published by the American College of Physicians

Questions? If you have questions about chronic care management services, contact your provider consultant.

*CPT codes, descriptions and two-digit modifiers only are copyright 2014 American Medical Association. All rights reserved.*
Reminder: Submit 2015 service dates for Medicare Advantage Diagnosis Closure Incentive program

The 2015 Diagnosis Closure Incentive program is effective for dates of service Jan. 1, 2015, or later. Please complete diagnoses for your patients, supported by any needed documentation in their medical records following MEAT (manage, evaluate, assess or treat) guidelines.

As part of the Diagnosis Closure Incentive program, you’re required to address 2015 diagnosis gaps with a face-to-face visit by Dec. 31, 2015. You then have until Jan. 31, 2016, to submit results of your 2015 patient visits on Health e-BlueSM.

Your patient’s diagnosis gaps are identified on Health e-Blue’s Diagnosis Evaluation panel. Health care providers may use the monthly reports on Health e-Blue to document that diagnosis gaps have been closed.

Keep in mind that if a prior year date of service is entered for a 2015 diagnosis gap, the diagnosis gap will open with the next refresh and the gap closure will not count toward your 2015 incentive payment.

Physicians who close 100 percent of all identified gaps for each attributed patient will receive $100 per patient. Your incentive payment will be mailed to you by the end of the third quarter 2016.

See the March-April issue of BCN Provider News for details.

For questions about dates of service, diagnosis gap submissions or the Diagnosis Closure Incentive program, please contact provider consultants Tom Rybarczyk at 1-313-225-0445 or Corinne Vignali at 1-313-225-7782.

Need access to Health e-Blue?

If your primary care office does not have access to Health e-Blue, apply today. Go to bcbsm.com/providers. Then:

- Click on Provider Secured Services.
- Under Solutions available through Provider Secured Services, click on Health e-Blue for Blue Care Network patient data and Blue Cross Blue Shield of Michigan Medicare Advantage patient data.
- Complete all fields on both the Health e-Blue Application and the Use and Protection Agreement and return to the address on the form.

Please be sure to sign in to Health e-Blue at least every six months to maintain your access to the system.

Tips for signing up for Health e-Blue

- All applications need to be completed and signed by a primary care physician or PCP manager.
- The practice name has to match across the application.
- Provide state license number (can send additional pages if you are out of space).
- Include any previously created web-DENIS ID to help the Health e-Blue team provide faster service. (Web-DENIS IDs usually start with D or F.)
- Use your full legal name on the application.
Blue Care Network’s Care Transition Program helps patients transition from a hospital stay

Blue Care Network has a Care Transition program offered through the Medical Management department. The program helps BCN Advantage℠ patients transition from hospital to home. It also provides education and support to help your patients get well and stay healthy. The Care Transition program is a free service offered by BCN.

Returning home from the hospital can be overwhelming and stressful. Many times people have questions about their care, and are unsure of how to take care of themselves and manage their illness after they return home. This is where our care coordinator nurses can help. By providing care coordination, education and support, we can help your patients safely transition from hospital to home and help them avoid returning to the hospital or emergency room.

After we’re notified of your patient’s hospitalization, our care coordinators contact the patient during the hospital stay to introduce the program and discuss next steps.

The care coordinator nurses:
- Help coordinate any care and services the patient may need at discharge with the hospital staff and the primary care physician
- Call the patient frequently within the first 30 days after discharge to help offer support in the home and answer any questions or concerns
- Help the patient follow the discharge plan to safely transition from hospital to home

Through follow-up calls upon the patient’s return home, the care coordinator does the following:
- Assists with arranging timely follow-up with the doctor and helps to provide transportation if needed
- Helps the patient understand and manage medications
- Helps patient understand the hospital discharge instructions and what needs to be done to manage any conditions
- Recognizes the signs and symptoms of possible complications and understands what to do next
- Coordinates needed tests, services or equipment, such as home health care after discharge
- Offers other health services and related programs
- Provides available community resources
- Educates about preventive health screenings, lab tests and other services that the patient may need

To learn more about our Care Transition Program, please call 1-800-728-3010, 8 a.m. to 5 p.m. Monday through Friday and one of care coordinator nurses will be happy to assist you.

Please note that this program isn’t intended to take the place of regular follow-up visits with the physician.
BCN Advantage vaccine coverage clarification

It’s important to check BCN Advantage members’ ID cards to determine how to submit claims for immunizations. In certain circumstances, members may receive reimbursement from BCN that is lower than their out-of-pocket costs for the administration of the vaccine. You may want to encourage your patients to get Part D vaccines at retail pharmacies as this is the lowest out-of-pocket option for the member.

Coverage for vaccines under Original Medicare may fall under Part A, Part B or Part D. That means individual vaccines may be administered and billed differently under BCN Advantage, depending on whether the vaccine is considered a Part D benefit.

Coverage for vaccines such as influenza, pneumococcal and hepatitis B for intermediate and high-risk patients is provided under Part B, which means it’s a benefit under BCN Advantage. These services are usually provided in a physician’s office or by mass immunizers.

With the inception of the prescription drug program, Part D plans are required to provide coverage for vaccines that are Medicare benefits and are not covered under Parts A or B, such as the shingles vaccine. For Part D vaccines provided on or after Jan. 1, 2008, Centers for Medicare & Medicaid Services guidelines state that both the vaccine serum and the cost of administering the serum should be billed to the member’s Part D or prescription drug plan.

Certain BCN Advantage individual and group members have Part D coverage through Blue Care Network and may obtain Part D vaccines at the pharmacy or doctor’s office.

<table>
<thead>
<tr>
<th>Obtain Part D vaccine at...</th>
<th>Administered by...</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>Pharmacy</td>
<td>Part D vaccines: Pharmacies collect only one copayment or coinsurance for both dispensing and administering. Part B vaccines: (flu/pneumonia): There is no member copay/coinsurance.</td>
</tr>
<tr>
<td>Doctor</td>
<td>Doctor</td>
<td>Part D vaccines: Members pay for the entire cost of vaccine and administration and are reimbursed by BCN contract rates. Part B vaccines: There is no member copay/coinsurance.</td>
</tr>
</tbody>
</table>
Blue Care Network focuses on blood pressure control in Chronic Care Improvement program

BCN Advantage’s Chronic Care Improvement program, designed to prevent cardiovascular disease in BCN Advantage℠ members is well into its fourth year. The program emphasizes member self-management strategies and partnership with physicians.

Our program focuses on clinical interventions championed by Million Hearts®, a public initiative led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services. The goal is to prevent 1 million heart attacks and strokes in the United States by 2017. The Million Hearts clinical interventions focus on improved management of the ABCs: aspirin for high-risk patients, blood pressure control, cholesterol management and smoking cessation.

We all know that having high blood pressure is a risk factor for heart disease and stroke. Here are a few facts that reinforce our commitment to control blood pressure in our members by working with you and your BCN Advantage patients.

High blood pressure in the United States

- About one in three American adults, or about 70 million people, have high blood pressure.¹
- Only about half (52 percent) of these people have their high blood pressure under control.¹
- Nearly one in three American adults has prehypertension, blood pressure numbers that are higher than normal, but not yet in the high blood pressure range.¹
- More than 360,000 American deaths in 2013 included high blood pressure as a primary or contributing cause.² That’s about 1,000 deaths each day.
- About seven of every 10 people having their first heart attack have high blood pressure.²
- About eight of every 10 people having their first stroke have high blood pressure.²
- About seven of every 10 people with chronic heart failure have high blood pressure.²
- Kidney disease is also a major risk factor for high blood pressure.

One of the goals of BCN’s Million Hearts Incentive program is to support your efforts to control blood pressure in your BCN Advantage patients. The program allows practitioners to earn a payment for BCN Advantage members whose blood pressure is controlled. You can earn payment for patients who meet the eligibility requirements for the incentive and have blood pressure readings within the parameters on the next page.

Please see BP control, continued on Page 23
BP control, continued from Page 22

Controlling blood pressure incentive

- Must meet both a systolic and a diastolic blood pressure reading
- Requirement:
  - Members 18 to 59 years of age whose blood pressure was less than 140/90 mm Hg
  - Members 60 to 85 years of age with a diagnosis of diabetes whose blood pressure was less than 140/90 mm Hg
  - Members 60 to 85 years of age without a diagnosis of diabetes whose blood pressure was less than 150/90 mm Hg
  - Systolic blood pressure value report one of the systolic codes
    » 3074F—Systolic blood pressure less than 130
    » 3075F—Systolic blood pressure 130-139
    » Systolic blood pressure greater than 140 and less than 150 (Needs to be documented in electronic medical record or in Health e-BlueSM. No CPT Cat II codes are available.)
  - Diastolic blood pressure value report one of the diastolic codes
    » 3078F—diastolic blood pressure less than 80
    » 3079F—diastolic blood pressure between 80-89

The 2015 CMS Million Hearts Incentive Program document that explains this program in detail is available in BCN’s Health e-BlueSM. The document is located in the Resources section under Incentive Documents. If you have any questions, please contact your medical care group leadership or your provider consultant. We appreciate your continued support of our physician incentive programs.

References

Providers must use *Notice of Medicare Non-coverage* form when nursing facility or home health care is ending

Medicare regulations require providers to use the Medicare-approved form, *Notice of Medicare Non-coverage* to notify BCN Advantage members in writing that BCN Advantage or the provider has decided to end their covered skilled nursing facility or home health care.

This form also provides notification to the member of the right to an expedited appeal if they disagree with the decision to end covered services. Providers must submit signed copies of all NOMNC forms to Blue Care Network.

BCN is required to provide copies of signed *Notice of Medicare Non-coverage* forms during Medicare audits. As we prepare for the audits, we find that not all providers have a complete understanding of Medicare regulations or BCN’s process to ensure compliance.

Medicare regulations require that providers deliver the form to members at least two days before covered services end at skilled nursing facilities and at least two days before the last services end from home health agencies.

The form should be given to members only when skilled nursing facility criteria are no longer met and no further days are authorized by BCN or two days prior to a scheduled discharge date.

It is important to use the correct NOMNC form (see note below), approved by Medicare that includes:

- The date that covered services are expected to end
- The date that the member’s financial liability begins
- A description of special appeal rights for members that allow a fast-track appeal if the member disagrees with the decision to end covered services
- Detailed instructions about how the member may request an immediate appeal directly to KEPRO (Michigan’s quality improvement organization) including KEPRO’s address and phone number
- Instructions to the member about how to request an expedited review from BCN if he or she misses the deadline to file for review from KEPRO
- The date of the member’s signature

Please see NOMNC, continued on Page 25
NOMNC, continued from Page 24

Please note that BCN may issue a next review date when authorizing skilled nursing services. The next review date doesn’t mean BCN is denying further coverage. Please submit an updated clinical review on the next review date. If upon review of the updated clinical information a denial decision is given, BCN allows for two additional days for the provider to supply the member with the notice.

If there is a change in the member’s condition after the NOMNC is issued, both BCN Advantage and providers should consider the new clinical information. If the effective date of coverage end date changes, providers should inform the member that services will continue. The provider must then inform the member of the new coverage end date either through delivery of a new or amended NOMNC at least two days before services end.

We value our partnership with our contracted providers. We trust that our providers will adhere to the provisions in our contract and continue to provide us with the NOMNC form required by the Centers for Medicare & Medicaid Services.

Note: Contracted facilities should be using the appropriate NOMNC forms. The forms are available in PDF or Word format on the Forms page at ereferrals.bcbsm.com or on BCN’s web-DENIS Forms page.

Providers should insert their name, address and phone number in the spaces provided at the top of the form. Notice of Medicare Non-coverage forms with the BCN Advantage logo at the top should not be used by skilled nursing facilities or home care agency providers.

Important facts about the Notice of Medicare Non-coverage

- BCN is required to ensure compliance with Medicare regulations by BCN Advantage contracted providers.
- Medicare requires that skilled nursing facility and home health agency providers deliver the NOMNC form to all members at least two days before covered services end, whether the member agrees with the plan to end services or not.
- BCN encourages providers to deliver the NOMNC no earlier than four days prior to the day that covered services end.
- Members should be asked to sign and date the form, acknowledging its timely delivery. If members refuse to sign the form, the facility must document the time and date it was delivered to the member.
- Providers are expected to keep a copy of the signed form and fax a copy to BCN Care Management at 1-877-372-1635, Attention: Medical Records.

For more information about the form see the BCN Advantage chapter of the BCN Provider Manual.
Guidelines for clinical review of services

Blue Cross Complete responds to clinical review (utilization management) requests within the following guidelines:

- Clinical review decision-making is based only on the existence of coverage and on the appropriateness of the care and service.
- Practitioners and other individuals are not specifically rewarded for issuing denials of coverage.
- The financial incentives for clinical review decision-makers do not encourage decisions that result in underutilization.

More on the clinical review guidelines and process can be found in the Blue Cross Complete Provider Manual under the Provider Publications section at mibluecrosscomplete.com/providers.

Upgrades made to Jiva provider portal

Recent improvements have been made on the Jiva provider portal user interface. Jiva is the Blue Cross Complete Web-based care management application.

The enhancements improve ease of use as well as reduce keystrokes and the time it will take you to complete a request. The improvements have been made on the New Request functionality of the provider portal. No changes have been made to Extension of Service or the Search functionality.

Enhancements include:
- New flow and display of screen/sections
- Terminology change for request type clinical versus nonclinical
- Improved diagnosis search
- Improved provider search functionality
- Improved request decision display

Peace of Mind Registry for advance directives

The Michigan Department of Community Health provides information about advance directives. An advance directive can be completed and sent to a statewide registry called Peace of Mind. For more information, please go to the Michigan Department for Health and Human Services.

New ID cards for Healthy Michigan Plan members

As of May 1, 2015, Blue Cross Complete ID cards issued for Healthy Michigan Plan members include the Healthy Michigan Plan logo in the upper right hand corner. Current Healthy Michigan Plan members will retain the older cards. The back of both of these cards are identical and show the dental service number, which is only present for members enrolled in the Healthy Michigan Plan.

Member rights and responsibilities outlined in Blue Cross Complete Member Handbook

Blue Cross Complete members have rights, which must be honored by all Blue Cross Complete staff and affiliated providers. Blue Cross Complete members also have responsibilities. Member rights and responsibilities are outlined in the “Member rights and responsibilities” section of the Blue Cross Complete Member Handbook. The entire member handbook can be accessed online at MiBlueCrossComplete.com. Click on Benefits. Then click on Blue Cross Complete Member Handbook.
Health Risk Assessment reminders

Under the Healthy Michigan Plan, primary care physicians must complete a health risk 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 mibluecrosscomplete.com/providers and on NaviNet.

Please follow these guidelines when completing the form:

- **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 will not be eligible for the incentive payment.)
- Fill in the provider NPI and attestation date fields
- A member of the clinical team can complete the HRA form, but the primary care physician 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.

Appointment assistance for Healthy Michigan Plan members

Healthy Michigan members are required to schedule an appointment within 60 days of enrollment and to have an appointment within 150 days of enrollment.

To ensure members meet these requirements, Blue Cross Complete will contact the member and ask if an appointment has been made. If not, Blue Cross Complete conducts a conference with the provider office and member to schedule the appointment.
Blue Cross Complete endorses MQIC guidelines

Blue Cross Complete endorses the clinical preventive care guidelines developed by the Michigan Quality Improvement Consortium. The guidelines help improve the consistent delivery of services to members and to establish a core set of clinical practice guidelines and performance measures.

The guidelines can be accessed at the MQIC Web page.

Pharmacy resources available for Blue Cross Complete

Throughout the year, the Blue Cross Complete Pharmacy and Therapeutics Committee approves formulary changes. These changes are published as a Pharmacy Update document, which can be found under the Pharmacy section at mibluecrosscomplete/providers.

Please visit the site regularly to keep up to date with the latest changes. You can also access the Online Drug Search Tool and prior authorization documents in this section. The drug search lists our guidelines for these drugs, such as any quantity limits, prior authorization requirement and more.

Blue Cross Complete encourages primary care physicians to extend their availability

Primary care physicians should consider increasing their availability to members by extending appointment times into the evening and weekends. By extending hours throughout the week, providers can see patients in a timely manner for preventive health services, chronic conditions, acute illness and other health concerns.
Evidence-based step care of major depression

By William Beecroft, M.D.

Treatment of major depression has improved over the years. The use of medications, psychotherapy, exercise, diet, mindfulness exercises and spiritual resources has improved outcomes.

Remission of the disease, as with any medical disorder, is the desired outcome. Unfortunately the treatments we currently have are less than optimal and nonremission and partial remission are all too common.

The study, Sequenced Treatment Alternatives to Relieve Depression — STAR*D (published in the American Journal of Psychiatry, 2006), found 44 percent full remission and 35 percent partial remission with optimal care.

As with many other areas in medicine, diagnosis is critical when treating major depression. Many medical problems can present with comorbid depressive symptoms. Diabetes, heart disease, chronic pain, endocrine disorders and sleep apnea are only a few of the many medical problems that share similar symptoms with major depression. Unless the underlying issue is treated, the symptoms will not fully respond to medications or psychotherapy interventions.

A careful medical evaluation is critical as a first step. Many times physicians will take a strategy of a presumptive diagnosis and start a trial of medications but then get stuck when the symptoms do not respond, leading to questions of what to do next. The Diagnostic and Statistical Manual (DSM-5) was revised about a year and a half ago and includes other symptoms of major depression that were not included previously, such as bereavement. Therefore, reviewing the more inclusive diagnostic criteria would be a plus in treating these disorders.

The pneumonic “SIG E CAPS” has always been a good screening tool for the initial diagnosis of depression. (The acronym stands for S = suicidal ideation, I = lack of interest or initiative, G = excessive guilt, E = lack of energy, C = change in cognition, A = sad affect or apathy/appetite change, P = psychomotor agitation or retardation, and S = somatization/ sleep disturbance.) This brief review may prompt further objective measure of the symptoms. Use of the PHQ-2 or 9 which is incorporated into many electronic medical record systems gives a clear objective measure of the severity of depression symptoms and is repeatable to measure progress in response to the treatment interventions that have been initiated. Other measures such as the Zung Depression Scale or the Beck Depression Inventory are also well established tools for this purpose.

Please see From the medical director, continued on Page 30
From the medical director, continued from Page 29

STAR-D was a multicenter study done several years ago now. The result of this well done trial to determine the best treatment steps for major depression has been the basis of evidence-based algorithms. The first of these was the Texas Implementation Medication Algorithm. This has generally been the accepted progression of medications standard and interventions to attain the most effective outcomes in the treatment of depressive disorders. Michigan has adopted this and has a protocol, not surprisingly, named the Michigan Implementation Medication Algorithm which is virtually identical to the Texas version.

The basic premise is to do a thorough diagnostic evaluation using an objective measure. Once the diagnosis is made, the provider initiates an antidepressant medication of a selective serotonin reuptake inhibitor, selective serotonin and norepinephrine reuptake inhibitor or an “atypical” (bupropion, mirtazepine) class medication. The provider then titrates the medication to full Food and Drug Administration-approved dose or highest tolerated dose for a full four weeks. For the best likelihood of optimal outcome, initiating a course of cognitive behavioral psychotherapy at the outset of treatment is indicated.

It’s important for the provider to reevaluate the patient at the four-week interval and to re-administer the same objective scale along with clinical interview during this follow-up visit. If there’s no improvement; switch to another class of medication in that group. Another reevaluation would take place at the four-week interval again. If there is still no improvement and the primary care physician is managing the treatment, a request for a psychiatric consultation for diagnostic confirmation and possible use of augmentation agents is recommended. These might include such medications as lithium, thyroid hormone (t3) or a psychostimulant. Each of these has literature to support their use but should be initiated by a specialist or at least in consultation with one. Continuing to reevaluate with objective scales may help identify progress that would be missed using only subjective evaluations even by the most experienced provider.

There are additional steps in the algorithm that the specialist can progress to as indicated. Combinations of medications and somatic treatments, such as electroconvulsive therapy, transcranial magnetic stimulation, vagal nerve stimulation, deep brain stimulation (investigational) each can be done in an objectively measured progression. Since full remission of symptoms is the goal, it is very important to keep working toward that goal until that is achieved. Educating the patient about the importance of staying on medications, diet and psychotherapy, along with the use of spiritual resources and mindfulness is a very important part of the relationship that providers have with their patients.

The following graph shows the courses of illness that can occur with the optimal one being total remission.

Phases of Depression & its Rx


Blue Care Network encourages using step progression in the treatment of depression and the adherence to using objective clinical measures to guide treatments. We know there is no quick fix to this disease, but with adherence to standard clinical practice there are generally moderately good outcomes that can make a world of difference in our members’ lives.

Coordination of care with the primary care physician, psychiatrist, therapist, and encouragement of exercise, diet and mindfulness including spiritual resources all work together better than any one or two resources will on its own.

References:
2) American Journal of Psychiatry; Practice Guidelines for the Treatment of Patients with Major Depressive Disorder, Third Edition, 2010
Adult vaccine recommendations

The Advisory Council on Immunization Practices recently updated its guidelines for the adult population.

Some of the key recommendations include:

- Recommended routine administration of the 13-valent pneumococcal conjugate vaccine (PCV13) in series with the 23-valent pneumococcal polysaccharide vaccine (PPAV23) for adults 65 years of age and older
- Revised footnotes for pneumococcal vaccination, providing algorithmic, patient-based guidance to help derive the appropriate vaccine for the patient
- Expanded the approved ages for the use of the recombinant influenza vaccine (RIV), allowing for patients 18 years of age and older
- Updated the contraindications and precautions for the live attenuated influenza vaccine (LAIV)

Vaccination rates for the adult population in general remain low, though they do vary by vaccine. It is important to remind patients of the importance of the various vaccinations and the associated health benefits.

The link to the Recommended Adult Immunization Schedule, United States, 2015 is on the Centers for Disease Control and Prevention website. The full ACIP recommendations can be found at cdc.gov/vaccines/hcp/acip-recs/index.html.

Human papillomavirus vaccine new product update

Gardasil 9® was recently approved and recommendations published by the Advisory Council on Immunization Practices. These recommendations followed previously published guidelines for the quadrivalent vaccine.
2015 InterQual® criteria take effect August 2015

BCN’s Care Management staff uses McKesson Corporation’s InterQual criteria when reviewing requests for Blue Care Network and BCN Advantage HMO-POS™ members. InterQual criteria have been a nationally recognized industry standard for more than 20 years. Other criteria resources that may be used are BCN medical policies, the member’s specific benefit certificate and clinical review by the BCN medical directors for the most appropriate level of care.

McKesson Corporation’s CareEnhance™ solutions include InterQual clinical decision support tools. McKesson is a leading provider of supply, information and care management products and services designed to manage costs and improve health care quality.

BCN will begin using the following criteria on August 3, 2015:

<table>
<thead>
<tr>
<th>Criteria/Version</th>
<th>Application</th>
</tr>
</thead>
</table>
| InterQual® Acute – Adult and Pediatrics | • Inpatient admissions  
• Continued stay discharge readiness |
| InterQual® Level of Care – Subacute and Skilled Nursing Facility | • Subacute and skilled nursing facility admissions |
| InterQual® Rehabilitation – Adult and Pediatrics | • Inpatient admissions  
• Continued stay and discharge readiness |
| InterQual® Level of Care – Long Term Acute Care | • Long term acute care facility admissions |
| InterQual® Level of Care – Home Care | • Home care requests |
| InterQual® Imaging | • Imaging studies and X-rays |
| InterQual® Procedures – Adult and Pediatrics | • Surgery and invasive procedures |
| Medicare Coverage Guidelines Applies to BCN Advantage only | • Services that require clinical review for medical necessity and benefit determinations |
| BCBSM/BCN medical policies | • Services that require clinical review for medical necessity |
| BCN-developed imaging criteria | • Imaging studies and X-rays |
| BCN-developed local rules | • Exceptions to the application of InterQual criteria that reflect BCN’s accepted practice standards |
| Behavioral health utilization management clinical criteria | • Behavioral health services that require clinical review for medical necessity |

Blue Care Network 2015 Local Rules effective Aug. 3

In applying InterQual® 2015 criteria to different benefit packages, Blue Care Network has adopted local rules. These local rules apply to all BCN commercial and BCN Advantage™ members statewide whose care is coordinated by BCN’s Care Management department. Changes to the Local Rules include:

- Revised the following local rule:
  - Acute coronary syndrome
  - Cellulitis
  - Toxic exposure/ingestion

- Deleted the following local rules:
  - Infection: Systemic or organ

- Added the following local rule:
  - Anemia/bleeding upper and lower GI bleed
Back-to-school tips for children with asthma, diabetes

As kids prepare to return to school, there are important steps primary care physicians and staff can take to help ensure a student begins the school year well-prepared to manage his or her chronic conditions. The following checklists can help you do just that.

For children with asthma
Establish an Asthma Action Plan and provide the school with a copy for the child’s record. The plan can be developed to fit the needs of the child.

• Obtain a copy of the Asthma Action Plan template, available on web-DENIS. Go to BCN Provider Publications and Resources. Click on Forms under Resources. Then scroll down to Chronic condition management and click on Asthma Action Plan.

• Instruct the child and parents on all medications and the importance of having access to them at all times, especially rescue inhalers. Refill prescriptions as needed.

• Discuss asthma condition and triggers that may occur, helping the child and parent learn about asthma.

• Provide the necessary documentation for the school support staff to keep on file in the event of an emergency. Information should be accessible to teachers, coaches and other adults who supervise children at school.

• Talk with the child about how to manage his or her asthma while at school. Sometimes a child can become overwhelmed with managing his or her diabetes and needs to discuss the changes he or she is experiencing.

• Instruct the child to wear a medical alert bracelet, if necessary.

• Provide the necessary documentation for the school support staff to keep on record in the event of an emergency. Information should be accessible to teachers, coaches and adults that interact with the child at school.

Please see Back-to-school tips, continued on Page 34
Back-to-school tips, continued from Page 33

For children with diabetes

- Establish a Diabetes Care Plan and provide the school with a copy for the child’s record. The plan can be developed to fit the child’s needs.
  - To obtain a copy of the plan, please log in to web-DENIS. Go to BCN Provider Publications and Resources. Then click on Forms under Resources. Scroll down to Chronic Condition Management and click on Diabetes care plan for school.
- Instruct the child and parents on diabetes medication, storage and having access to medication and monitoring supplies at all times. Refill prescriptions as needed.
- Ensure the child knows how and when to check blood sugar if he or she is old enough to learn, or advise parent to ensure school is aware of the Diabetes Care Plan.
- Have the child write down his or her blood sugar levels in a diary. A school nurse may be able to assist younger children.
- Ensure the child knows what the symptoms are for low blood sugar and high blood sugar.
- Reinforce that the child should have a rapid sugar-release type of food available such as juice, hard candy or glucose tablets for symptoms of low blood sugar.
- Instruct the child and parents on eating healthy meals and refer to registered dietician as necessary.
- Encourage parents to pack healthy snacks that can be eaten between meals to prevent low blood sugar occurrences.
- Instruct the child to wear a medical alert bracelet, if necessary.
- Provide the necessary documentation for the school support staff to keep on record in the event of an emergency. Information should be accessible to teachers, coaches and adults that interact with the child at school.
- Talk with the child about his or her diabetes. Sometimes a child can become overwhelmed with managing his or her diabetes and needs to discuss the changes he or she is experiencing.

The Michigan Quality Improvement Consortium guidelines include information on assessment and treatment of acute and chronic conditions, and preventive services. To access MQIC guidelines including those for diabetes and asthma, go to mqic.org.
Your patients who have complex medical needs can get personalized support from Blue Care Network’s Case Management department. Registered nurse case managers work with you and your patients to develop a case management plan of care and promote self-management. Our case managers contact members by phone to provide education on disease, nutrition, medication and managed care processes, as well as facilitate access to BCN and community resources as needed.

We identify members for case management through a variety of sources including inpatient admissions, physician and physician group referral, member and caregiver referral, chronic condition management referral and employer group referrals. We may identify BCN Advantage members through completed health assessments. BCN also uses a predictive modeling approach to identify members from both BCN and BCN Advantage who may benefit from case management.

Members enrolled in case management consistently report high satisfaction with the program and a willingness to recommend the program to other members.

We offer case management services as a benefit at no cost to BCN commercial and BCN Advantage members. The following programs are available for adult and pediatric members:

- Asthma (commercial members only)
- Complex conditions
- Chronic obstructive pulmonary disease
- Diabetes
- Heart failure
- High risk pregnancy
- Ischemic heart disease
- Kidney health management (adult only)
- Oncology
- Transplants – bone marrow, stem cell and solid organ

Case managers notify you of any member who is enrolled in our case management program. We encourage our members to be an active participant in managing their health and promote a collaborative relationship with you. Case managers work with you, your staff and your patient to support positive health outcomes.

You can find information about your members enrolled in complex case and chronic condition management on Health e-Blue, your secured clinical support tool. To learn more about BCN’s case management program or refer a member to one of our programs, call us between 8:30 a.m. and 5 p.m., at 1-800-392-4247.

BCN values and recognizes the importance of provider’s rights. We respect your right to:

- Have information about BCN’s case management programs, case management staff and staff qualifications relative to the management of your patient when requested
- Be informed of how BCN coordinates its interventions with treatment plans for individual patients
- Know how to contact the person responsible for managing and communicating with your patients
- Communicate complaints to the organization
- Be supported by the organization to make decisions interactively with patients regarding their health care
- Receive courteous and respectful treatment from the organization’s staff

Note: Case managers may receive requests for services specifically excluded from the member’s benefit package. Member benefits are defined by the limits and exclusions outlined by the individual member’s certificate and riders. BCN doesn’t make benefit exceptions and informs the member of alternative resources for continuing care and how to obtain care, as appropriate, when a service isn’t covered or when coverage ends.
COPD diagnosis should include spirometry

Comprehensive care of people with chronic obstructive pulmonary disease includes diagnosing the condition through spirometry, smoking cessation support if indicated, periodic assessment of the disease and management of stable COPD and exacerbations. Pharmacologic therapy is pivotal as it provides important options for improvement of symptoms and treatment of exacerbations.

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

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

To obtain a copy of BCN’s COPD management plan:
- Log into web-DENIS.
- Click on BCN Provider Publications and Resources.
- Click on COPD Action Plan in Forms (Chronic Condition Management section).

Spirometry as a diagnostic tool

According to BCN’s clinical practice guidelines for the diagnosis and management of COPD, spirometry is needed to establish a diagnosis of COPD and provides a useful diagnostic tool for those patients with symptoms suggestive of COPD. (See table below). A post-bronchodilator FEV1/FVC less than 70 percent confirms the presence of airflow limitation. BCN’s guideline, Guidelines for the Diagnosis and Management of Chronic Obstructive Pulmonary Disease, recommends that you consider COPD in any patient 18 years of age or older with respiratory symptoms and those with a history of exposure (for example, occupational exposure) to risk factors for the disease, especially smoking. Characteristic symptoms include cough, sputum production that can be variable from day to day and chronic and or progressive dyspnea.

<table>
<thead>
<tr>
<th>I: Mild COPD</th>
<th>II: Moderate COPD</th>
<th>III: Severe COPD</th>
<th>IV: Very Severe COPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEV1/FVC &lt;0.70</td>
<td>FEV1/FVC &lt;0.70</td>
<td>FEV1/FVC &lt;0.70</td>
<td>FEV1/FVC &lt;0.70</td>
</tr>
<tr>
<td>FEV1 ≥ 80% predicted</td>
<td>50% ≤ FEV1 &lt; 80% predicted</td>
<td>30% ≤ FEV1 &lt; 50% predicted</td>
<td>FEV1 &lt; 30% predicted or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>FEV1 &lt; 50% predicted plus chronic respiratory failure</td>
</tr>
</tbody>
</table>

The 2015 Healthcare Effectiveness Data Information Set* measures the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis. CPT codes used to identify spirometry testing for this measure include **94010, 94014 - 94016, 94060, 94070, 94375 and 94620.

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

**CPT codes, descriptions and two-digit modifiers only are copyright 2014 American Medical Association. All rights reserved.

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

**Question:**
What is the basis for the four levels of care found in the nursery subsets that began in 2014?

**Answer:**
In 2014, Level IV care was added to the nursery subset. This addition was supported by an updated policy statement outlining the levels of neonatal care from the American Academy of Pediatrics. The AAP designates four levels (I-IV) of neonatal care which encompass the complete spectrum of care from a healthy newborn through the care of a critically ill newborn.

**Newborn Level I**
Description: Routine care of normal full-term or pre-term infants. This level is appropriate for stable neonates who are 35 weeks gestational age or greater, and a weight of 2000 grams that require evaluation and observation for conditions with a low risk for complications. This setting may also be used for an infant that is readmitted. This level requires fewer than three hours of nursing care daily.

**Special Care Level II**
Description: Infants who are moderately ill who may be recovering from an acute illness and no longer require intensive support. These newborns require moderately complex interventions. This level requires nursing care for three hours up to fewer than six hours of care daily. These criteria may be applied to infants located in the nursery unit in facilities that don’t have a designated Special Care Nursery.

**Neonatal Intensive Care Level III**
Description: Seriously ill infants, hemodynamically stable who require intensive observation and frequent interventions. This includes mechanical ventilation and other comprehensive services. This level requires nursing care six to 12 hours daily.

**Neonatal Intensive Care Level IV**
Description: Critically ill infants who aren’t hemodynamically stable with a high probability of life threatening deterioration. This level requires frequent interventions and constant nursing care and continuous cardiopulmonary or other support. This level requires nursing care greater than 12 hours daily.

**Question:**
Are IV fluids at 125 cc/hr or less appropriate to meet the volume expanders criterion. Should the patient have evidence of actual volume loss to meet this criterion?

**Answer:**
IV fluids are given for several reasons: to support adequate fluid intake for a patient who is NPO or due to other issues resulting in inadequate oral intake. These are maintenance or repletion IV fluids rather than IV volume expanders. IV fluids are given to bring fluids and electrolytes to normal levels in situations when patients are hypovolemic but not to a point where they are at risk for circulatory collapse.

Patients who have inadequate circulating blood volume to support their cardiovascular stability or who are at risk of circulatory collapse may be given IV fluids as volume expanders.
Volume expander criteria shouldn’t be applied for situations in which a patient receives IV fluids unless IV fluids are being given as a volume expander. When applying these criteria, documentation should support the need for volume expanders due to issues such as symptomatic fluid loss or a need for IV fluid resuscitation as is seen with diabetic ketoacidosis or sepsis. Volume expanders are given when a patient’s low circulatory volume or disease process requires “expansion” (significant increase) in order to support their circulatory system. Since the intent of volume expanders is to prevent circulatory collapse or to improve hemodynamic stability, IV rates are typically high, 250 cc or greater, or given in an IVF bolus such as 500 ccs or greater.

**Volume Expander is defined as:**
Volume expanders are classified as colloid (for example, albumin, starch preparation, dextran) and crystalloid (for example, normal saline, Ringers lactate) solutions, and may be used to correct fluid deficits (dehydration) for replacement of ongoing fluid losses (for example, treatment of polyuria, emesis or diarrhea), or in resuscitation (for example, treatment of hypovolemic or septic shock).

**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**
- Optical coherence tomography of the breast and/or axillary lymph nodes
- Automated visual evoked potentials for routine vision screening
- Myofascial trigger point injections/dry needling
- Handheld radiofrequency spectroscopy for intraoperative assessment of surgical margins during breast-conserving surgery
- ST2 assay for chronic heart failure

**Covered services**
- Transcatheter mitral valve repair
- Myolysis of uterine fibroids using laparoscopic and percutaneous techniques
Behavioral Health

BCN to discontinue authorization requirement for add-on psychotherapy codes for psychiatrists and nurse practitioners

Psychiatric add-on codes for psychotherapy no longer need prior authorization, effective July 1, 2015. We urge you to familiarize yourself with the correct use of the codes and the associated E&M codes. Documentation of the E&M component of the service and the components of the psychotherapy note should follow Centers for Medicare & Medicaid Services guidelines.

For details, see the full article which appeared in the May-June issue.

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BHIP information and FAQs available on web-DENIS

Blue Care Network’s Behavioral Health Incentive Program compensates behavioral health practitioners for achieving established quality-of-care metrics. Psychiatrists, psychologists and social workers are eligible for these incentive dollars when they provide qualifying outpatient services to BCN commercial members.

If you are not yet familiar with the program, you can learn about it on web-DENIS.

- Log into Provider Secured Services.
- Go to web-DENIS.
- Click on BCN Provider Publications and Resources.
- Under Resources, click on Behavioral Health.
- Scroll down to Behavioral Health Incentive Program to find the documents.

We have created an FAQ document to ensure answers and tips are available to all of our behavioral health providers. It highlights the most commonly asked questions from the provider community, so we hope you use it as a resource. It is available on web-DENIS along with all other BHIP documents. You can also view it from the PDF icon at the right.

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Evidence-based step care of major depression

In this issue’s Medical Director column, BCN Medical Director Dr. William Beecroft discusses treatment of major depression. Please see Page 29 to read the column.
Patient education is key to reducing antibiotics for pharyngitis

Doctors can go a long way toward changing public attitudes about antibiotic use. That’s what Dr. Paul Turke strives for in his Chelsea family practice. He and his partner have maintained a practice culture that eschews antibiotics when unnecessary.

“Our office is successful [in avoiding unnecessary antibiotics] because we set the groundwork early with patients,” says Dr. Turke. “We spend quite a bit of time talking about how antibiotics are great tools, but if they are used when they’re not needed they can be detrimental to a patient and the population at large,” he adds.

Dr. Turke has 100 percent compliance on the HEDIS® measure that focuses on performing strep tests on children with acute pharyngitis. “We do a rapid strep test on nearly every patient who complains of a sore throat,” says Dr. Turke. “If it’s positive, we treat. If not, we don’t. If we’re not certain, we will send out for a culture.”

The doctor starts conversations early with new patients and families considering transferring to his office. “A lot of patients are now tuned into this problem as well,” he says. The conversation happens throughout the patient/doctor relationship, not just during the initial visit so patients know what to expect when they come to the office. “Our patients are already prepared when they come here with symptoms,” says Dr. Turke. “We’ve already discussed with them the importance of good bacteria and of not disrupting the human microbiome.”

Simply letting patients know that you are available after hours can prevent them from getting prescriptions elsewhere, says Dr. Turke. “Sometimes patients come in and have already been prescribed an antibiotic from an urgent care center. Since I wasn’t there when the urgent care doctor was looking at the patient, I don’t challenge the use of the antibiotic,” says Dr. Turke. “What I do tell patients is some things can wait. I remind them we always save office time for sick patients. It’s often just a matter of giving them pain relief and seeing them the next day. By knowing a patient’s history, we can be more judicious,” he says.

Dr. Turke also says he reminds patients to call the office, even when they are closed. “Patients know we are available 24 hours a day with our after-hours service,” he says. “I tell them I can often save them a trip to the emergency room. I’ll never take chances with their children, but I can often get them through the night until they can come into the office,” he adds.

Nurses are also available to answer questions when patients call. Nurses may also encourage patients to come into the office before the end of the day instead of waiting so the patient doesn’t feel the need to go to urgent care if symptoms worsen after hours.

What else can doctors do to help patients understand the role of antibiotics?

“I’m intrigued about some of the new literature about good bacteria and human microbiomes,” says Dr. Turke. “Having physicians read about that gives them some ammunition to tell patients that good bacteria can affect everything from mood to immune function and we’re disrupting those with frequent prescriptions. Physicians may be busy, but if you stop and read the literature, it gives you a better tool for explaining to patients what the downside is.”
Blue Cross and U-M partner to improve emergency care quality

Thanks to a partnership that Blue Cross Blue Shield of Michigan and Blue Care Network have initiated with the University of Michigan Health System, emergency room doctors will get help in making decisions in the fast-paced emergency room.

The Michigan Emergency Department Improvement Collaborative will work with emergency physicians at participating hospitals across the state to develop best practices to improve the experience and outcomes of patients receiving care in emergency departments.

“This is our 21st Collaborative Quality Initiative, and it’s just the latest example of collaboration between Blue Cross Blue Shield of Michigan, hospitals and physicians across the state,” said Dr. David Share, senior vice president, Value Partnerships.

“We’ve already made great strides in improving health care quality and safety, while reducing the cost of care,” he said.

Across Michigan, 75 large and medium size acute care hospitals participate in at least one CQI. Collectively, the CQIs analyze the care given to more than 200,000 Michigan patients annually.

Five of the more established CQIs have saved $597 million in health costs statewide between 2008 and 2012 by reducing and preventing complications and improving patient outcomes.

“We’re interested in collaboratively improving the delivery and outcomes for patients across the entire spectrum of emergency care, from diagnostic testing to treatment and transitions of care into the hospital and back to the community,” said Dr. Keith Kocher, MEDIC project co-director and assistant professor of emergency medicine for the University of Michigan Medical School.

The CQI will have representation from a variety of emergency departments in urban, rural, academic and community settings. Goals include:

- Working together to improve the way emergency care is provided
- Evaluating current patterns of care to guide quality improvement efforts
- Developing tools to help providers help each other get better
- Driving performance by delivering accurate and timely feedback

The CQI is now developing the data infrastructure and reporting system to collect information from participating hospitals. Eight to 10 hospital emergency departments will participate initially, with plans to expand to additional hospitals in subsequent years.

“We are very excited to get this CQI up and running given the important role that emergency department care provides our membership,” said Tom Leyden, director, Value Partnerships. “The MEDIC CQI is the result of a multi-year development between Value Partnerships and the Michigan emergency physician community.”

For more information visit **Emergency Department Improvement Collaborative** to learn more about the new CQI.

For more information on Collaborative Quality Initiatives, visit valuepartnerships.com or uofmhealth.org.
Prenatal and postpartum care are important HEDIS measures

We need your help to increase compliance rates for Healthcare Effectiveness and Data Information Set and to make sure members receive care during the specified timeframes noted below.

- **Prenatal visits**: The first visit should occur within the first trimester of pregnancy or within 42 days of enrollment. Remind patients who are considering pregnancy to make an appointment as soon as pregnancy is suspected.

- **Postpartum visit**: The visit should occur between 21 and 56 days after delivery for both vaginal and cesarean deliveries.

Prenatal visits should include education about nutrition, prenatal vitamins with folic acid, substance abuse, alcohol consumption, tobacco cessation, expectant parent classes and the importance of postpartum care. This education should be documented in the patient’s medical record.

Blue Care Network case management nurses can provide support to members who are identified as high risk for complications during the perinatal period. This support includes:

- Initial assessment and care plan development
- Ongoing telephone support
- Written educational materials about identified risks, condition, medications and other interventions
- Referral to home health care, social worker or behavioral health as indicated

Postpartum visits should be scheduled between 21 and 56 days after delivery. Postpartum visits should include a physical exam including a breast and pelvic exam, measurement of weight, vital signs including blood pressure, contraceptive options, education on sexually transmitted infection prevention, and screening and assessment for postpartum depression. All elements of the exam should be documented in the patient’s medical record.

**Provider and member resources**

- **Postpartum depression**: BCN’s Depression Management Program focuses on member education about depression and the importance of adhering to a prescribed medication regimen. Practitioners and members can speak to registered nurse about the program by calling 1-800-392-4247, weekdays from 8 a.m. to 5 p.m or the 24 hour nurse advice line at 1-855-624-5214.

- **Maternal (or paternal) substance abuse**: BCN’s Behavioral Health department is available 24 hours a day, seven days a week to address substance abuse concerns. BCN members and providers can call 1-800-482-5982.

- **Maternal (or paternal) tobacco use**: BCN’s Quit the Nic tobacco cessation program is available to all BCN members at 1-800-811-1764.

- **Nutrition and weight management after delivery**: BCN members receive than a 20 percent discount on Weight Watchers® program membership in select areas. Call 1-800-651-6000 to find a nearby Weight Watchers location.
Please include national drug codes and the appropriate NDC quantities on professional drug claims for your Blue Care Network patients as soon as possible, but no later than Aug. 30. BCN will begin using this information to price BCN HMO commercial claims for certain drugs as early as Aug. 30, 2015, or soon thereafter. Watch for more information in the Sept.-Oct. BCN Provider News, available Aug. 26.

Once BCN begins processing claims using the NDC codes and quantities, a medical claim for a specialty drug will be paid at the lowest NDC fee for that HCPCS/CPT code billed if the claim does not include the NDC code. If the claim is billed with an invalid NDC and HCPCS/CPT code combination, it will be denied.

You already submit this information for some BCN medical claims — those reporting not-otherwise-classified procedure codes J3490 or J3590, for example. You also already submit this information on Blue Cross Blue Shield of Michigan claims.

Ancillary providers such as home infusion therapy providers, ambulatory infusion centers, Walgreens Specialty Pharmacy and limited distribution drug specialty pharmacies are required to provide the NDC information, as well as the NDC quantity, for claims processing or claims will deny.

BCN is making this change to align with Blue Cross and to ensure the most accurate and up-to-date processing of medical drugs, based on the date of service.

Finding the NDC and unit of measure

The national drug code is found on a medication’s packaging. An asterisk may appear as a placeholder for any leading zeroes. The container label also displays the appropriate unit of measure for that drug. The unit of measure is by weight (grams: GR), volume (milliliter: ML) (milligram: ME) or count (unit: UN). Each dispensed dose must be converted into one of these, following the manufacturer’s unit of measure. International units (F2) must be converted to standard measurements (GR, ML, ME and UN).

- For drugs that come in a vial in powder form that needs to be reconstituted before administration, bill each vial (UN).
- For drugs that come in a vial in liquid form, bill in milliliters (ML).
- For topical forms of medicine (cream, ointment, bulk powder in a jar), bill in grams (GR or ME).

Submitting the NDC on claims

Here are some quick tips and general guidelines to assist you with proper submission of valid NDCs and related information on professional claims:

- The NDC must be submitted along with applicable Healthcare Common Procedure Coding System or Current Procedural Terminology® code.
- The NDC must follow the “5digit4digit2digit” format (11 numeric characters with no spaces or special characters). If the NDC on the package label is fewer than 11 digits, you must adding leading zeroes to total 11 digits.
- The NDC must be active for the date of service.
National drug code, continued from Page 43

- To submit electronic claims (ANSI 837P), report the following information.

<table>
<thead>
<tr>
<th>Field name</th>
<th>Field description</th>
<th>ANSI (Loop 2410) – Ref Desc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product ID Qualifier</td>
<td>Enter “N4” in this field.</td>
<td>LIN02</td>
</tr>
<tr>
<td>National Drug CD</td>
<td>Enter the 11-digit NDC assigned to the drug administered.</td>
<td>LIN03</td>
</tr>
<tr>
<td>NDC Units</td>
<td>Enter the quantity (number of units) for the prescription drug.</td>
<td>CTP04</td>
</tr>
<tr>
<td>NDC Unit / MEAS</td>
<td>Enter the unit of measure of the prescription drug given (GR, UN, ML or ME).</td>
<td>CTP05-1</td>
</tr>
</tbody>
</table>

- To submit paper claims, enter the NDC information in field 24 of the CMS-1500 claim. In the shaded portion of field 24A-24G, enter the qualifier “N4” left-justified, immediately followed by the national drug code. Next, enter the appropriate qualifier for the correct dispensing unit (GR, UN, ML or ME), followed by the quantity and the price per unit, as indicated in the example below.

- The format for billing should be:
  
  **N4 + NDC code + 3 spaces + unit of measure + quantity**

  Example: N4555103026710 ML5.5

- Reimbursement for discarded drugs applies only to single use vials. Discarded amounts of drugs in multiuse vials are not eligible for payment.

- For home infusion therapy and specialty drugs, health care providers must continue to submit claims with national drug code and National Council for Prescription Drug Programs quantities electronically.
Select insulin products moved to generic copay tier

On July 1, 2015, Blue Care Network will move certain insulin products to our generic copayment tier (Tier 1/1a) to make it easier for commercial members to save money and manage their diabetes. Our goal is to increase access to and improve compliance with these drugs by reducing the member’s out-of-pocket costs.

Patients who switch to a generic-tier insulin from preferred brand (Tier 2) insulin product could save an average of $45 per month (based on 2014 BCN claims). Members who take two Tier 2 insulin products may save twice as much by switching.

Members pay the lowest (Tier 1/1a) copay for these insulin products

<table>
<thead>
<tr>
<th>Lantus®</th>
<th>Leveimir®</th>
<th>Novolin 70/30®, Mix 70/30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novolin® N</td>
<td>Novolin® R</td>
<td>Novolog®</td>
</tr>
</tbody>
</table>

Tier 2 (preferred brand copay)

These insulin products remain on Tier 2 and the member’s copay stays the same.

<table>
<thead>
<tr>
<th>Apidra®</th>
<th>Humalog®</th>
<th>Humalog® Mix50/50®, Mix75/25®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humulin 70/30®</td>
<td>Humulin® N</td>
<td>Humulin® R</td>
</tr>
</tbody>
</table>

This change does not apply to BCN AdvantageSM members.

Please help your BCN patients save money by prescribing insulin products that are on BCN’s generic copayment tier. We have written to these members and encouraged them to discuss alternatives with their doctor. If you have questions about our pharmacy programs, call the Pharmacy Services Clinical help desk at 1-800-437-3803.

BCBSM and BCN drug lists and quick guides updated, available online

Please help ensure that our members get the care they need 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](http://bcbsm.com.rxinfo).

For a list of commonly prescribed Tier 1 and Tier 2 drugs on our Custom Drug List, please refer to our 2015 BCBSM and BCN Custom Drug List Quick Guide. Commonly prescribed Tier 1A, 1B and Tier 2 drugs on the Custom Select Drug List are found on the 2014 BCBSM and BCN Custom Select Drug List Quick Guide. The quick guides can be viewed or downloaded by clicking on the PDFs below.
Blue Care Network is expanding our medical drug prior authorization program (also called clinical review) for commercial members to encourage proper utilization of high-cost specialty medications administered by a health care provider. Beginning July 1, 2015, BCN will require prior authorization before these drugs will be covered under members’ medical benefits.

<table>
<thead>
<tr>
<th>J CODE</th>
<th>Medication</th>
<th>Prior authorization / clinical review is required for these members</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0220</td>
<td>Myozyme®</td>
<td>All members except those with BCN AdvantageSM coverage</td>
</tr>
<tr>
<td>J0221</td>
<td>Lumizyme®</td>
<td></td>
</tr>
<tr>
<td>J0775</td>
<td>Xiaflex®</td>
<td></td>
</tr>
<tr>
<td>J1458</td>
<td>Naglазyme®</td>
<td></td>
</tr>
<tr>
<td>J1744</td>
<td>Firazy®</td>
<td></td>
</tr>
<tr>
<td>J1931</td>
<td>Aldurazyme®</td>
<td></td>
</tr>
<tr>
<td>J2504</td>
<td>Adagen®</td>
<td></td>
</tr>
<tr>
<td>J9043</td>
<td>Jevtana®</td>
<td></td>
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<tr>
<td>J9047</td>
<td>Kyprolis®</td>
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</tr>
<tr>
<td>J9228</td>
<td>Yervoy®</td>
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</tr>
<tr>
<td>J9354</td>
<td>Kadcyla®</td>
<td></td>
</tr>
<tr>
<td>J9999</td>
<td>All medications</td>
<td>All members</td>
</tr>
</tbody>
</table>

Criteria include, but aren’t limited to diagnosis, lab results, dosing and frequency of administration. We may also require documentation regarding medications previously used to treat the member’s condition, including dosage, regimens, dates of therapy and response, as well as additional pertinent clinical information.

This requirement will apply only to BCN commercial members who start the medication on or after July 1, 2015. Members who have a paid claim for one of these medications by the end of June 2015 will not be required to seek initial prior authorization or clinical review.

This requirement won’t apply to the BCN Advantage members.

To request approval for one of these medications, please submit the request through BCN’s e-referral system or fax the request to BCN Care Management at 1-800-675-7278. You can also call Care Management at 1-800-392-2512.

For a full 2015 list of all medications and procedure codes subject to the BCN Referral and Clinical Review Program please visit ereferrals.bcbsm.com and click on Clinical Review & Criteria Charts. Details on medical necessity criteria are posted on the same page. Just scroll down to the Medical necessity criteria / benefit review requirements section. The updated criteria charts will be posted to the website by July 1, 2015.
New edit codes, effective Oct. 1, to support ICD-10

As you know, the federal government is requiring the health care industry to use ICD-10 codes in place of ICD-9 codes beginning with dates of service on or after Oct. 1, 2015. To comply with this mandate, Blue Cross Blue Shield of Michigan will use new front-end edit codes for electronic claims that:

- Have invalid ICD-10 codes and qualifiers
- Contain ICD-9 codes for dates of service on or after Oct. 1
- Contain ICD-10 codes for dates of service prior to Oct. 1
- Contain both ICD-9 and ICD-10 codes in the same claim

The edits listed below are effective Oct. 1. Claims receiving any of these edits on 277CA reports or transactions must be corrected and resubmitted.

<table>
<thead>
<tr>
<th>Edit code</th>
<th>FACILITY – Edit description</th>
<th>Logic</th>
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<tbody>
<tr>
<td>MF20</td>
<td>INVALID ICD-10 PRINCIPAL DIAGNOSIS</td>
<td>If qualifier ABK is reported, the principal diagnosis code reported in Loop 2300 HI01-2 must be a valid ICD-10 code.</td>
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<tr>
<td>MF21</td>
<td>INVALID ICD-10 OTHER DIAGNOSIS CODE</td>
<td>If qualifier ABF is reported, the other diagnosis code reported in Loop 2300 HI01-2 through HI12-2 must be a valid ICD-10 code.</td>
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<tr>
<td>MF22</td>
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<td>MF23</td>
<td>INVALID ICD-10 OTHER PROCEDURE CODE</td>
<td>If qualifier BBQ is reported, the other procedure code reported in Loop 2300 HI01-2 through HI12-2 must be a valid ICD-10 code.</td>
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<td>MF24</td>
<td>INVALID ICD-10 ADMITTING DIAGNOSIS CODE</td>
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<tr>
<td>MF25</td>
<td>INVALID ICD-10 EXTERNAL CAUSE OF INJURY DIAGNOSIS CODE</td>
<td>If qualifier ABN is reported, the diagnosis code reported in Loop 2300 HI01-2 through HI12-2 must be a valid ICD-10 code.</td>
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<tr>
<td>MF26</td>
<td>INVALID ICD-10 PATIENT REASON FOR VISIT DIAGNOSIS CODE</td>
<td>If qualifier APR is reported, the diagnosis code reported in Loop 2300 HI01-2 through HI03-2 must be a valid ICD-10 code.</td>
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<tr>
<td>F720</td>
<td>BK PRINCIPAL DIAGNOSIS QUALIFIER INVALID AFTER 10/1/2015</td>
<td>BK qualifier not valid on or after Oct. 1, 2015. For inpatient claims, use Statement Through date.</td>
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<tr>
<td>F721</td>
<td>BK PRINCIPAL DIAGNOSIS QUALIFIER INVALID AFTER 10/1/2015</td>
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<tr>
<td>F722</td>
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<td>F723</td>
<td>BF OTHER DIAGNOSIS QUALIFIER INVALID AFTER 10/1/2015</td>
<td>BF qualifier not valid on or after Oct. 1, 2015. For outpatient claims, use Statement From date.</td>
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Please see New edit codes, continued on Page 48
New edit codes, continued from Page 47

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<td>F725</td>
<td>BQ OTHER PROCEDURE QUALIFIER INVALID AFTER 10/1/2015</td>
<td>BQ qualifier not valid on or after Oct. 1, 2015. For inpatient claims, use Statement Through date.</td>
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<tr>
<td>F726</td>
<td>BJ ADMIT DIAGNOSIS QUALIFIER INVALID AFTER 10/1/2015</td>
<td>BJ qualifier not valid on or after Oct. 1, 2015. For inpatient claims, use Statement Through date.</td>
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<tr>
<td>F727</td>
<td>BN EXTERNAL CAUSE OF INJURY QUALIFIER INVALID AFTER 10/1/2015</td>
<td>BN qualifier not valid on or after Oct. 1, 2015. For inpatient claims, use Statement Through date.</td>
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<tr>
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<td>BN EXTERNAL CAUSE OF INJURY QUALIFIER INVALID AFTER 10/1/2015</td>
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<td>ABK PRINCIPAL DIAGNOSIS QUALIFIER INVALID PRIOR TO 10/1/2015</td>
<td>ABK qualifier not valid on or prior to Sept. 30, 2015. For inpatient claims, use Statement Through date.</td>
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<td>F731</td>
<td>ABK PRINCIPAL DIAGNOSIS QUALIFIER INVALID PRIOR TO 10/1/2015</td>
<td>ABK qualifier not valid on or prior to Sept. 30, 2015. For outpatient claims, use Statement From date.</td>
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<tr>
<td>F732</td>
<td>ABF OTHER DIAGNOSIS QUALIFIER INVALID PRIOR TO 10/1/2015</td>
<td>ABF qualifier not valid on or prior to Sept. 30, 2015. For inpatient claims, use Statement Through date.</td>
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<tr>
<td>F733</td>
<td>ABF OTHER DIAGNOSIS QUALIFIER INVALID PRIOR TO 10/1/2015</td>
<td>ABF qualifier not valid on or prior to Sept. 30, 2015. For outpatient claims, use Statement From date.</td>
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<td>F734</td>
<td>BBR PRINCIPAL PROCEDURE QUALIFIER INVALID PRIOR TO 10/1/2015</td>
<td>BBR qualifier not valid on or prior to Sept. 30, 2015. For inpatient claims, use Statement Through date.</td>
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<tr>
<td>F735</td>
<td>BBQ OTHER PROCEDURE QUALIFIER INVALID PRIOR TO 10/1/2015</td>
<td>BBQ qualifier not valid on or prior to Sept. 30, 2015. For inpatient claims, use Statement Through date.</td>
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<td>ABJ ADMIT DIAGNOSIS QUALIFIER INVALID PRIOR TO 10/1/2015</td>
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<tr>
<td>F737</td>
<td>ABN EXTERNAL CAUSE OF INJURY QUALIFIER INVALID PRIOR TO 10/1/2015</td>
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<td>F738</td>
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<tr>
<td>F739</td>
<td>APR PATIENT REASON FOR VISIT QUALIFIER INVALID PRIOR TO 10/1/2015</td>
<td>APR qualifier not valid on or prior to Sept. 30, 2015. For inpatient claims, use Statement Through date.</td>
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</table>

Please see New edit codes, continued on Page 49
## New edit codes, continued from Page 48

<table>
<thead>
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<tr>
<td>F740</td>
<td>APR PATIENT REASON FOR VISIT QUALIFIER INVALID PRIOR 10/1/2015</td>
<td>APR qualifier not valid on or prior to Sept. 30, 2015. For outpatient claims, use Statement From date.</td>
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<tr>
<td>F741</td>
<td>CLAIM CANNOT HAVE BOTH ICD-9 &amp; ICD-10 QUALIFIERS</td>
<td>Claims can only contain ICD-9 or ICD-10 qualifiers, not both.</td>
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<tr>
<td>F742</td>
<td>SPLIT CLAIM - DATES OF SVC EQUAL TO OR LESS THAN 9/30/15 AND EQUAL TO 10/1/15 OR GREATER</td>
<td>Submit separate claims if Statement From date is prior or equal to Sept. 30, 2015, and Statement Through date is equal to or greater than Oct. 1, 2015.</td>
</tr>
<tr>
<td>F743</td>
<td>PRIN PROC-BBR/OTHER PROC-BBQ NOT VALID ON AN OUTPATIENT CLAIM</td>
<td>BBR and BBQ procedure code qualifiers are not valid for outpatient claims.</td>
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<td>MP09</td>
<td>INVALID ICD-10 PRINCIPAL DIAGNOSIS</td>
<td>If qualifier ABK is reported, the principal diagnosis code reported in Loop 2300 HI01-2 must be a valid ICD-10 code.</td>
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<tr>
<td>MP10</td>
<td>INVALID ICD-10 ADDITIONAL DIAGNOSIS</td>
<td>If qualifier ABF is reported, the diagnosis code reported in Loop 2300 HI01-2 through HI12-2 must be a valid ICD-10 code.</td>
</tr>
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<td>P943</td>
<td>SPLIT CLAIM - DATES OF SVC EQUAL TO OR LESS THAN 9/30/15 AND EQUAL TO 10/1/15 OR GREATER</td>
<td>Submit separate claims if service dates are prior or equal to Sept. 30, 2015 and equal to or greater than Oct. 1, 2015.</td>
</tr>
<tr>
<td>P944</td>
<td>BK PRINCIPAL DIAGNOSIS QUALIFIER INVALID AFTER 10/1/2015</td>
<td>BK qualifier is invalid if date of service is equal to or greater than Oct. 1, 2015.</td>
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<tr>
<td>P945</td>
<td>BF OTHER DIAGNOSIS QUALIFIER INVALID AFTER 10/1/2015</td>
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<tr>
<td>P946</td>
<td>ABK PRINCIPAL DIAGNOSIS QUALIFIER INVALID PRIOR TO 10/1/2015</td>
<td>ABK qualifier is invalid if date of service is prior to Oct. 1, 2015.</td>
</tr>
<tr>
<td>P947</td>
<td>ABF OTHER DIAGNOSIS QUALIFIER INVALID PRIOR TO 10/1/2015</td>
<td>ABF qualifier is invalid if date of service is prior to Oct. 1, 2015.</td>
</tr>
</tbody>
</table>

For questions regarding ICD-10, visit our [ICD-10 website](#). For questions about electronic HIPAA transactions or front-end edits, contact the Blue Cross EDI Helpdesk at 1-800-542-0945.

Contact your software vendor or clearinghouse with questions about ICD-10 code reporting using your practice management claim system.
Blue Cross following CMS guidelines for ICD-10 billing information

By now, everyone knows that the federal government is requiring the health care industry to begin using ICD-10 codes in place of ICD-9 codes, beginning with dates of service Oct. 1, 2015.

For months now, Blue Cross Blue Shield of Michigan has been offering health care providers information about the transition through seminars, conference calls and many other avenues to spread the word about this extremely important initiative.

One of the most common questions we receive about billing for ICD-10 codes is: How will our billing guidelines compare to those from the Centers for Medicare and Medicaid Services?

Blue Cross will follow guidelines from CMS when it comes to billing ICD-10 codes. Those guidelines are found on the CMS website.

Below we’ve listed other common questions from health care providers about ICD-10 codes.

Common ICD-10 questions

Q: When is implementation?
   A: Oct. 1, 2015

Q: When should I begin to use ICD-10 codes?
   A: ICD-10 is based on the date of service.
   - For dates of service before Oct. 1, 2015, use ICD-9 codes and qualifiers.
   - For dates of service on or after Oct. 1, 2015, use ICD-10 codes and qualifiers.

Q: What are the major changes for ICD-10?
   A: Some of the major changes are:
   - The ICD-10 implementation affects diagnosis and inpatient procedure codes. (It does not affect CPT and HCPCS codes used for outpatient procedures and physician services.)
   - ICD-10 codes differ in length and structure from ICD-9 codes. (The maximum number of digits in ICD-10 is seven as opposed to five for ICD-9.)
   - The code set contains more details about conditions, injuries and illnesses.

Q: What happens if a provider does not switch to ICD-10?
   A: Claims with dates of service on or after the Oct. 1, 2015, implementation date that do not use the appropriate ICD-10 code will be rejected in EDI front-end edits. Remember that claims for services provided before Oct. 1, 2015, must use ICD-9 diagnosis and inpatient procedure codes.

Q: Can a submitter send ICD-10 codes prior to Oct. 1, 2015?
   A: No

Q: Can a submitter send both ICD-9 and ICD-10 codes on the same claim?
   A: No

For more information, refer to previous issues of The Record or go to cms.gov/icd10 and bcbsm.com/icd10.
Question: How do we submit claims for P-Stim services?

Answer: P-Stim is not a covered service for any BCN member. It is addressed in our medical policy titled, “Cranial Electrotherapy Stimulation (CES) and Auricular Electrostimulation.” The link to this medical policy can be found in web-DENIS. Go to BCN Provider Publications and Resources. Click on Medical Policy Manual under Resources. You can search alphabetically for “Cranial Electrotherapy Stimulation and Auricular Electrostimulation.”

The procedure codes contained in this policy include *97139, *97813, *97814, S8930 and E1399. This service should not be reported under procedure code *64555 as it does not represent the P-Stim therapy. Reporting P-Stim under this code could be subject to audit. Additionally, *64999 should not be used to report this service as there is a more appropriate code.

Question: Why do my radiology codes with professional component deny as inclusive when another physician billed for that service with a different tax ID?

Answer: It is BCN’s policy to only reimburse for one read on a radiology procedure. If additional reads or professional components are submitted for an individual radiology procedure, edits will be generated on those claim lines.

It is important to note that BCN does not reimburse for wet reads. Therefore, a professional component, noting a radiology interpretation and report, should not be submitted for a wet read. A complete report should be maintained in the patient’s medical record when a radiology code for a report and interpretation is submitted. At a minimum, the report should contain:

- Patient demographics
- Diagnosis (clinical information)
- Body of report
- Impression (diagnosis)

* CPT codes, descriptions and two-digit modifiers only are copyright 2014 American Medical Association. All rights reserved.
Providers must follow rules to bill non-face-to-face chronic care management services

For BCN Advantage™ members who have two or more significant chronic conditions, practitioners can bill for both face-to-face and non face-to-face services to help manage these conditions.

Please see full article on Page 15.

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 the following:
• Do not submit duplicate appeals
• Submitting a Clinical Editing Appeal

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.

Coding Corner

Documentation is key when coding morbid obesity

The Record is running a series of revised "Coding corner" articles that include updated codes to align with the transition to ICD-10-CM.

See The Record June 2015 issue for the complete article.
Updated information on billing and medical necessity guidelines for observation stays

Hospitals and professional providers may bill for observation stays only when observation care is the medically appropriate level of care for the member. Currently, a maximum of 48 hours of observation care may be reimbursed, for all members. For BCN Advantage℠ members only, a minimum of eight hours of observation care must be billed.

When a member is admitted for inpatient care but the admission is denied, the following guidelines apply:

- If the member was actually in observation and observation care was the appropriate level of care for the member’s condition at the time, the services the member received may be billed as observation.
- If the member did not spend time in observation, the services rendered during the member’s stay should be billed as outpatient services. This applies to BCN HMO (commercial) members only.

Refer to the Blue Care Network Referral and Clinical Review Program to determine what referral and clinical review requirements apply.

Currently, neither referral nor clinical review is required for the observation stay itself. In the future, however, clinical review may be required for observation stays, to ensure the member’s situation meets medical necessity criteria for that level of care.

More information about observation stays is available as follows:

- In the BCN Provider Manual:
  - Care Management chapter – “Guidelines for observations and inpatient hospital admissions” section
  - BCN Advantage chapter – “BCN Advantage Care Management program” section
  - Claims chapter – “Billing guidelines for observation stays” section

To access the BCN Provider Manual, log in to web-DENIS, click BCN Provider Publications and Resources and, finally, click Provider Manual.

- On BCN’s billing instructions:
  - Observation: instructions for professional services
  - Observation stay: instructions for facilities

To access the billing instructions, log in to Provider Secured Services. Click on web-DENIS, click BCN Provider Publications and Resources and, finally, click Billing.

- In the January-February 2014 issue of BCN Provider News – article on page 15 titled Determining medical necessity for BCN Advantage members: inpatient vs. observation stay

This article updates the information in an earlier article about observation stays that was published in the March-April 2015 issue of BCN Provider News.
Blue Care Network partnered with CareCore National, LLC (now called eviCore healthcare) for clinical review for certain radiology services on July 1, 2014.

Beginning September 2015, CareCore will perform clinical review for additional high tech radiology services, cardiology services and radiation therapy. Clinical review is required prior to services provided for select procedures including but not limited to MRI, MRA, CT, nuclear medicine, nuclear cardiology, PET scans and radiation care. This applies to nonemergent outpatient procedures for commercial HMO and BCN Advantage members. See below for a more comprehensive list of services that will require clinical review.

A full list of procedures that will require clinical review if performed on or after September 2015 will be available at a future date at the Radiology Management Program page on e-referral.

The clinical criteria utilized by CareCore medical directors are vetted by an expert review board with relevant medical specialties to validate that the criteria are in keeping with published research, including guidelines from the appropriate specialty societies. This coverage criterion is available at the Care Core National website. Below is a list of new services that will now require clinical review. This is not an exhaustive list.

### Additional high tech radiology services
- Positron emission tomography
- Magnetic resonance angiography
- Additional MRI and CT procedures
- MRI breast
- Bone/joint imaging
- Pulmonary ventilation imaging
- Brain imaging
- Kidney imaging
- Thyroid imaging
- Bone marrow Imaging

### Cardiology services
- Insertion, replacement or upgrade of permanent pacemaker
- Insertion or removal of implantable defibrillator
- Cardiac MRI
- CT heart
- CT angiography heart
- Cardiac radionuclide angiography
- PET myocardial imaging
- Myocardioperfusion imaging PET
- Echocardiography (transthoracic and doppler)
- Catheter placement in coronary artery for coronary angiography

### Radiation care services
- Radiation treatment
- Brachytherapy of coronary arteries
- Hyperthermia
- Image guided radiation therapy
- Neutron radiotherapy
- Proton beam therapy
- Radioimmunotherapy
- Radioactive Yttrium-90 microspheres
Guidelines for bundling admissions

Blue Care Network reviews inpatient readmissions that occur within 14 days of discharge from a facility that is reimbursed by diagnoses-related groups, or DRGs, when commercial HMO and BCN AdvantageSM members have the same or a similar diagnosis.

Please refer to the attached PDF to read the guidelines we use to determine when to combine two admissions into one for purposes of DRG reimbursement. Guidelines are subject to change.

BCN expanding specialty medical drug approval program on July 1

Blue Care Network is expanding our medical drug prior authorization program (also called clinical review) for commercial members to encourage proper utilization of high-cost specialty medications administered by a health care provider. Beginning July 1, 2015, BCN will require prior authorization before these drugs will be covered under members’ medical benefits. Please see article on Page 46 for details.

CoreCore changes name to eviCore

CoreCore/Med Solutions Inc. have become eviCore healthcare. The website will change to eviCore.com in early July.
Important information about home sleep studies

The Sleep Management Program information at erreferrals.bcbsm.com and in the BCN Provider Manual has been updated with the following information:

In accordance with BCN’s revised medical policy for home sleep testing, which was implemented in August 2013, home sleep testing must be authorized and submitted globally on a CMS-1500 claim form. Only providers who have signed a specific sleep testing agreement may provide services for BCN members. Hospitals billing for services related to home sleep studies must also execute a specific sleep testing agreement and bill in accordance with BCN requirements. Claims are payable only if they are billed globally and the services are authorized. Claims submitted on a UB-04 claim form are not payable.

You can find the names of home sleep study providers contracted with BCN at bcbsm.com/find-a-doctor by typing “home sleep testing” in the What are you looking for? field.

For more specific instructions for finding BCN-contracted home sleep study providers, refer to the document Finding home sleep study providers.

Blue Care Network policies typically cover home sleep studies for adult patients with symptoms of obstructive sleep apnea without other comorbid conditions. A nondiagnostic home sleep study is required for adult members to be considered for approval of a sleep study in an outpatient facility or clinic.

Sleep study candidates include habitual snorers with daytime sleepiness or observed apnea (cessation of breathing lasting 10 seconds or more). Daytime sleepiness can be determined by using a common assessment tool available to health care providers.

Home sleep studies are covered to diagnose obstructive sleep apnea for patients who fit the following description:

- Are 18 years of age or older
- Have a high pretest probability of moderate to severe obstructive sleep apnea
- Have no comorbid conditions

Home sleep studies allow for testing in the comfort of the patient’s own bed and are particularly useful in rural areas where the nearest sleep center may be hours away.

Outpatient facility or clinic-based sleep studies are also covered by BCN for the following members:

- Pediatric members (17 years of age or younger) with symptoms of obstructive sleep apnea
- Adult members with symptoms of obstructive sleep apnea who completed a nondiagnostic home sleep study or who have comorbid conditions that preclude them from being a candidate for a home sleep study

When you submit a clinical review request for a sleep study on BCN’s e-referral system, the system prompts you to complete a questionnaire to determine the appropriateness of the request. The questionnaire that opens is specific to the treatment setting you have selected.

Examples of the different questionnaires are provided on the Sleep Management Program page at erreferrals.bcbsm.com. You can use these examples to organize your responses in preparation for completing the questionnaire in the e-referral system.
Remember to refer BCN members only to providers contracted with BCN

Before you refer a BCN HMOSM or BCN AdvantageSM member to another provider for services, double-check to make sure the provider is contracted with BCN or BCN Advantage. In addition, if the member has coverage through a product with a designated local network of providers, check to make sure you’re referring the member to a provider who belongs to that network.

For more information and a summary of BCN products that have designated provider networks, see the article on Page 12.

Updated information on billing and medical necessity guidelines for observation stays

Hospitals and professional providers may bill for observation stays only when observation care is the medically appropriate level of care for the member. For updated information on billing guidelines, please see Page 53.

Use specialty group NPI for University of Michigan, Henry Ford referrals

When issuing referrals to the University of Michigan or Henry Ford Health System specialty providers, referring providers should use the specialty group NPI. Please do not issue referrals to the individual specialty providers.

Likewise, when submitting plan notifications and clinical review requests to BCN, requesting provider should use the UMHS or Henry Ford System specialty group NPI instead of the individual specialty provider’s NPI.

For the University of Michigan, some specialty groups have a Pay Loc 1 and Pay Loc 2 group NPI number. When a specialty has two group numbers, referring physicians should use the Pay Loc 1 number when referring to locations in Washtenaw County (Ann Arbor, Chelsea, Dexter, Saline, Ypsilanti); Oakland County (Milford, West Bloomfield) and Wayne County (Canton, Livonia). The Pay Local 2 number should only be used when referring to UM specialists’ offices in Livingston County (Brighton).

The Specialty Group NPI document is available at ereferrals.bcbsm.com. Click Provider Search. Information on the BCN referral process is found in the Care Management chapter of the BCN Provider Manual.
**BCN Advantage**

Providers must follow rules to bill non-face-to-face chronic care management services ................................ Page 15

Reminder: Submit 2015 service dates for Medicare Advantage Diagnosis Closure Incentive program .......... Page 19

Need access to Health e-Blue? ........................................ Page 19

Tips for signing up for Health e-Blue .................................. Page 19

Blue Care Network’s Care Transition Program helps patients transition from a hospital stay ............... Page 20

BCN Advantage vaccine coverage clarification ........................................... Page 21

Blue Care Network focuses on blood pressure control in Chronic Care Improvement program ............. Page 22

Providers must use Notice of Medicare Non-coverage form when nursing facility or home care is ending ... Page 24

Important facts about the Notice of Medicare Non-coverage ............................................. Page 25

**Behavioral health**

BCN to discontinue authorization requirement for add-on psychotherapy codes for psychiatrists and nurse practitioners ........................................ Page 39

BHIP information and FAQs available on web-DENIS ............................................. Page 39

Evidence-based step care of major depression ............................................. Page 39

**Billing Bulletin**

New edit codes, effective Oct. 1, to support ICD-10 ............................................. Page 47

Blue Cross following CMS guidelines for ICD-10 billing information ...................... Page 50

Billing Q&A ............................................. Page 51

Providers must follow rules to bill non-face-to-face chronic care management services .......... Page 52

Clinical editing billing tips ............................................. Page 52

Updated information on billing and medical necessity guidelines for observation stays .......... Page 53

**Blue Cross Complete**

Guidelines for clinical review of services ............................................. Page 26

Upgrades made to Jiva provider portal ............................................. Page 26

Peace of Mind Registry for advance directives ............................................. Page 26

New ID cards for Healthy Michigan Plan members ............................................. Page 26

Member rights and responsibilities outlined in Blue Cross Complete Member Handbook .......... Page 26

Health Risk Assessment reminders ............................................. Page 27

Appointment assistance for Healthy Michigan Plan members ............................................. Page 27

Blue Cross Complete endorses MQIC guidelines ............................................. Page 28

Pharmacy resources available for Blue Cross Complete ............................................. Page 28

Blue Cross Complete encourages primary care physicians to extend their availability .......... Page 28

**Network operations**

Upgrades coming to e-referral ............................................. Page 1

E-referral outage planned before updated ............................................. Page 2

Blue Cross and BCN update policy on concierge medicine ............................................. Page 3

BCBSM providers must comply with Affiliation Agreements ............................................. Page 3

Blue Care Network announces increased rewards for tobacco cessation contest ............. Page 4

Blue Care Network discontinues CPT-II incentive for smoking cessation program .......... Page 4

Most providers like Blues Brief, find it easy to read ............................................. Page 5

How to find your provider consultant ............................................. Page 5

Why it’s important to check eligibility and benefits at every visit ............................................. Page 6

Chiropractic Update webinars coming in July ............................................. Page 7

Get Continuing Medical Education credits, mobile app for anticoagulation toolkits .......... Page 7

Members receive out-of-pocket costs cards ............................................. Page 8

BCN officers closed for holiday ............................................. Page 8

Reminder: Keep information up to date with Blue Cross and Blue Care Network ............. Page 9

Where to call for BCN assistance ............................................. Page 10

Are you using the right Internet browser to access BlueCrossComplete.com? ............. Page 11

Remember to refer BCN members only to providers contracted with BCN ............. Page 12

**Patient care**

From the medical director: Evidence-based step care of major depression ............................................. Page 29

Adult vaccine recommendations ............................................. Page 31

2015 InterQual criteria take effect August 2015 ............................................. Page 32

Blue Care Network 2015 Local Rules effective Aug. 3 ............................................. Page 33

Back-to-school tips for children with asthma, diabetes ............................................. Page 33

BCN’s Case Management Program helps you care for patients ............................................. Page 35

COPD diagnosis should include spirometry ............................................. Page 36

Criteria corner ............................................. Page 37

Medical policy updates ............................................. Page 38

**Pharmacy news**

Report national drug code number on professional drug claims for accurate processing .......... Page 43

Select insulin products moved to generic copay tier ............................................. Page 45

BCBSM and BCN drug lists and quickspaves updated ............................................. Page 45

BCN expanding specialty medical drug approval program on July 1 ............................................. Page 46

**Quality Counts**

Best Practices: Patient education is key to reducing antibiotics for pharyngitis ............................................. Page 40

Blue Cross and U-M partner to improve emergency care quality ............................................. Page 41

Prenatal and postpartum care are important HEDIS measures ............................................. Page 42

**Referral Roundup**

Procedures requiring clinical review beginning September 2015 ............................................. Page 54

Guidelines for bundling admissions ............................................. Page 55

BCN expanding specialty medical drug approval program on July 1 ............................................. Page 55

Important information about home sleep studies ............................................. Page 56

Remember to refer BCN members only to providers contracted with BCN ............................................. Page 57

Updated information on billing and medical necessity guidelines for observation stays .......... Page 57

Use specialty group NPI for University of Michigan, Henry Ford referrals ............................................. Page 57