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Doctor in Fruitport provides education and support to patients with high blood pressure

One of the challenges with helping patients control their high blood pressure is convincing them of the importance of maintaining a healthy blood pressure, says Dr. Darrell Roelandt, who practices in a residency clinic in Fruitport. The doctor says his clinic helps patients by providing education about blood pressure and offering resources to alleviate barriers to getting care or medications.

Dr. Roelandt says he takes the time to educate patients and answer questions about their condition. He first approaches patients by explaining why it's important to keep their blood pressure under control. "If patients need further education or support, then I set an appointment with the staff pharmacist to discuss blood pressure, lifestyle changes and possible medications," he says.

The office also has nurses that help educate patients. Nurses also answer patients' questions and return calls within 24 hours.

For patients with high blood pressure, Dr. Roelandt requires follow-up visits once or twice a year, especially if they're on medication.

"If a patient has isolated hypertension, we try lifestyle modifications before putting them on medication. That's sometimes difficult for patients," he says. "You're asking them to make lifestyle changes, especially with diet and exercise. Even with lifestyle modifications, many patients end up with medication," adds Dr. Roelandt. Patients with underlying conditions, such as diabetes, are usually put on medications sooner than those without other conditions.



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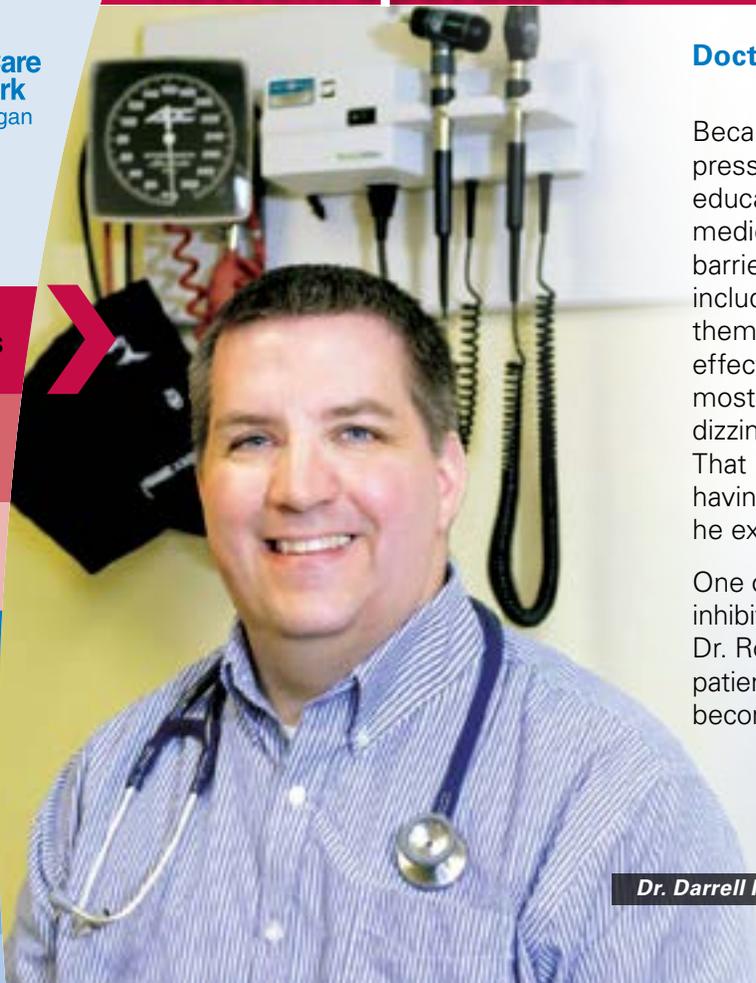
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Dr. Darrell Roelandt

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Because many patients are on blood pressure medications, part of the education process also addresses medication compliance. One of the barriers to staying on medications includes the side effects. “I warn them ahead of time about side effects,” says Dr. Roelandt. “The most common one is fatigue or dizziness for the first couple of weeks. That is the body getting used to having a more normal blood pressure,” he explains.

One of the side effects with ACE inhibitors is a persistent cough. Dr. Roelandt will sometimes switch patients to other drugs if the cough becomes problematic.

If Dr. Roelandt is concerned about side effects with medications, sometimes he will ask patients to take blood pressure readings at home. Patients will then call the office with the readings or bring logs to their follow-up appointments.

Costs and transportation can also be barriers to some of Dr. Roelandt’s patients. Many of the clinic’s patients are uninsured or underinsured. “We have a social worker on staff available to talk to patients who have cost barriers. The social worker helps patients obtain resources to help alleviate the cost of medications,” he says. The social worker also helps patients explore insurance options through the Health Insurance Marketplace as part of the Affordable Care Act and helps patients arrange transportation to the office for follow-up visits.

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Provider Recognition Program materials posted on Health e-Blue

Blue Cross Blue Shield of Michigan and Blue Care Network are pleased to provide you with details of our 2015 Provider Recognition Program for the following products:

- BCN Commercial
- BCN AdvantageSM
- BCBSM Medicare Advantage PPOSM

To simplify the program we created one booklet that outlines the requirements for all three products.

The 2015 PRP material can be found on the home page of Health e-BlueSM under Incentive Documents. The material contains a one-page summary document that outlines the program. Please use this as a reference tool to help give quality care to our members.

Our goal is to make meaningful payments to encourage appropriate clinical outcomes as well as increase HEDIS[®] and Centers for Medicare and Medicaid Services Star ratings.

Please remember that all data entered into Health e-Blue must be for services completed, not just ordered or reminders sent.

Please visit the home page on BCN Health e-Blue or MAPPO Health e-Blue for all 2015 recognition program information.

If you have any questions, please contact your **Blues provider consultant**. We appreciate your continued support of our physician recognition programs.

CAQH updates to Universal Provider Datasource

The Council for Affordable Quality Healthcare, or CAQH[®] updated its Universal Provider Datasource[®] in February. New features were added and the name was changed to CAQH ProView[™]. Please make note of the following changes.

- **Incomplete applications will not migrate:** Completed Universal Provider Datasource applications with current attestations automatically migrate into CAQH ProView. Providers with incomplete applications need to have completed and attested to any outstanding applications **prior** to the transition to ProView. Unattested data does not convert into CAQH ProView.
- **Email is required:** CAQH ProView requires an email address for all providers as a primary method of contact. Providers should enter an email address in the UPD now.
- **Paper applications discontinued in February 2015:** Providers must enter and complete their information online. Paper versions of the credentialing application are longer accepted.
- **Questions:** If you have questions, contact the CAQH ProView Provider Transition Support Center. Providers can email proview@caqh.org or call 1-844-259-5347.

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Reminder: Some Blue Care Network members have separate contraceptive coverage

Some Blue Care Network members have contraceptive coverage through BCN only (and not through their employer) in addition to the health coverage they have through their employer. These members carry a separate ID card, called RA Limited Choice, for contraceptive services. This applies to both group and self-funded members.

The RA Limited Choice coverage — RA stands for “religious accommodation” — is for members of certain nonprofit organizations. Under the Affordable Care Act, these organizations are not required to offer contraceptive coverage if they certify they are an “eligible” organization as defined by the Act. The contraceptive coverage is provided through BCN instead.

BCN covers women’s medical contraceptive services at 100 percent for these group members when they receive the services from a BCN-participating provider. Generic contraceptives are also covered at 100 percent; brand-name drugs are covered only when medically necessary.

If a member presents the RA Limited Choice card when obtaining contraceptive services from an in-network provider, the provider should bill BCN for payment of the claim using information on the ID card. The member does not have to do anything further or make any kind of payment.

If a patient visits your office for contraceptive services before she has the RA Limited Choice card, you can look up the member on web-DENIS. The contract number will be the same as the one under which the patient is covered by her employer, although the group number will be different. If she has opted in for the benefit, it will show up on the system.

Subscribers who opt-in will have dual coverage on our internal systems with their regular employer group and with the women’s contraceptive coverage group. The employer group coverage will show as primary and women’s contraceptive coverage as secondary.

If the benefit does not show up or the patient doesn’t have a card, you can tell the patient that she can pay for services and apply for reimbursement. If the member opts in for contraceptive coverage later in the year, BCN will pay claims retroactive to the beginning of the year.

Please keep in mind the following guidelines regarding billing for contraceptive services.

- Office visit for contraceptive counseling is covered under the women’s contraceptive group coverage.
- Contraceptive services billed with a medical diagnosis (endometriosis, dysmenorrhea) will process as any other medical service under the member’s employer group coverage.
- Services billed as contraceptive in nature will be paid pay under the member’s RA group coverage.

Guidelines for Metro Detroit EPO, HMO networks

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As a reminder, the Blue Cross® Metro Detroit EPO network covers six counties in southeast Michigan (Livingston, Oakland, Macomb, St. Clair, Wayne, and Washtenaw), while the Blue Cross® Metro Detroit HMO covers three counties (Macomb, Oakland and Wayne).

Other than eligible emergency services and accidental injuries, members who have enrolled in a **Metro Detroit EPO** do not have coverage if they visit a doctor or hospital that is outside the network. Be sure to always refer members to health care providers that are in the network.

For care outside the local **Metro Detroit HMO** network, keep the following guidelines in mind:

- If the service is in the statewide BCN provider network, standard BCN referral and clinical review requirements apply.
- If the service is outside the BCN provider network, BCN out-of-network rules apply. (Providers submit a request to BCN, and BCN conducts a clinical review before making a decision.)

The following hospitals participate in the Metro Detroit EPO network:

- Detroit Medical Center
 - DMC – Children’s Hospital – Wayne County
 - DMC – Detroit Receiving – Wayne County
 - DMC – Harper – Hutzel – Wayne County
 - DMC – Huron Valley – Sinai – Oakland County
 - DMC – Sinai Grace – Wayne County
 - DMC – Rehabilitation Institute of Michigan – Wayne County
- Oakwood Healthcare, now part of Beaumont Health**
 - Oakwood Hospital and Medical Center, Dearborn – Wayne County
 - Oakwood Hospital Southshore – Wayne County
 - Oakwood Hospital Taylor – Wayne County
 - Oakwood Hospital Wayne – Wayne County
- St. John Providence Health System
 - Providence Hospital Oakland County
 - Providence Park Hospital – Oakland County
 - St. John Hospital and Medical Center – Wayne County
 - St. John Macomb – Oakland Hospital Macomb Center – Macomb County
 - St. John Macomb – Oakland Hospital Oakland Center Oakland County
 - St. John River District Hospital
- Saint Joseph Mercy Health System/CHE Trinity Health
 - St. Joseph Mercy – Ann Arbor – Washtenaw County
 - St. Joseph Mercy – Chelsea – Washtenaw County
 - St. Joseph Mercy – Livingston – Livingston County
 - St. Joseph Mercy – Oakland – Oakland County
 - St. Joseph Mercy – Port Huron
 - St. Mary Mercy Hospital – Livonia – Wayne County

Metro Detroit EPO, HMO networks,

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- Botsford Hospital, now part of Beaumont Health** – Oakland County
- Garden City Hospital – Wayne County
- Stonecrest Center for Behavioral Health – Wayne County
- Straith Hospital for Special Surgery – Oakland County

These hospitals participate in the Metro Detroit HMO network:

- Botsford Hospital, now part of Beaumont Health**
- Detroit Medical Center
 - DMC Children’s Hospital of Michigan
 - DMC Detroit Receiving Hospital
 - DMC Huron Valley-Sinai Hospital
 - DMC Harper University/Hutzel Women’s Hospital
 - DMC Sinai-Grace Hospital
 - DMC Rehabilitation Institute of Michigan
- Oakwood Healthcare System
 - Oakwood Hospital Dearborn
 - Oakwood Hospital Southshore
 - Oakwood Hospital Taylor
 - Oakwood Hospital Wayne
- St. John Providence Health/Ascension
 - Providence Hospital
 - St. John Hospital & Medical Center
 - St. John Macomb – Oakland Hospital, Macomb Center
 - St. John Macomb – Oakland Hospital, Oakland Center
 - St. John River District Hospital
- Saint Joseph Mercy Health System
 - St. Joseph Mercy Ann Arbor
 - St. Joseph Mercy Livingston
 - St. Joseph Mercy Oakland
 - St. Mary Mercy Livonia

****Note:** Beaumont Health campuses in Royal Oak, Troy and Grosse Pointe are not part of the EPO network.

Online tutorial

If you would like to learn more, please view our **online tutorial** located on web-DENIS. The tutorial walks you through our Metro Detroit EPO and Metro Detroit HMO networks and individual plans. Here’s how to find the tutorial:

- Log in to *Provider Secured Services*.
- Click on *web-DENIS*.
- Click on *BCBSM Provider Publications and Resources*.
- Click on *Newsletters & Resources*.
- Scroll down to Blue Cross® Metro Detroit EPO and HMO local networks resources.
- Click on *Training presentation: Blue Cross® Metro Detroit EPO and HMO local networks*.

Find a doctor

You can search for a participating doctor in the local networks using the Find a Doctor tool:

- Go to **bcbsm.com/find-a-doctor**.
- Click on *Get Started*.
- Click on *Advanced Search*.
- Select ZIP code, street address or city, state or county and type in the information.
- Go to “Please select your plan.” In the drop-down menu, click on *Individual and Family plans (under 65)*.
- Go to “Please select your sub plan. In the drop-down menu, click on *Blue Cross Metro Detroit (EPO) or Blue Cross Metro Detroit (HMO)*.
- Choose the provider type.
- Add additional search criteria (optional) or click *Go*.



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How to find the Blue health plans you participate in

Please make sure your front office personnel know which Blue health plans you participate in so they can accurately answer questions from patients.

Here are the local network products and where to find more information.

- **Blue Cross® Metro Detroit EPO** – New exclusive provider organization in Southeast Michigan
- **Blue Cross® Metro Detroit HMO** – New local HMO in Southeast Michigan
- **Blue Cross® Partnered** – Local HMO in West Michigan introduced last year (see PDF below)
- **Blue Cross® Select or PCP Focus** – Special HMO PCP network
- **BCN AdvantageSM HMO ConnectedCare** – New local Medicare Advantage HMO in Southeast Michigan and Kalamazoo
- **BCN AdvantageSM HMO MyChoice Wellness** – Local Medicare Advantage HMO in West Michigan introduced last year

Not sure which of these plans you participate in? Here are some ways to check.

1. Check your listing on the **BCBSM online provider search**. You need to look up the Blue Cross products separately from the Blue Care Network products. *Finding your Blues plans and networks* is a step-by-step guide we've put together to help providers find the networks they participate in. (See PDF *Finding your Blues plans and networks* below)
2. Check with your practice administrator.
3. Contact your Blues provider consultant.

All Blue individual commercial products all have names that begin with "Blue Cross", but some of them are BCN plans. Here's **how to know which plans are Blue Cross vs. BCN**.



[Blue Cross Partnered fact sheet \(Mercy\) PDF](#)



[Finding your Blues plans and networks PDF](#)



[Blue Cross Metro HMO Info PDF](#)

BCN offers online provider training

Blue Care Network offers online training and resources for providers to help you work more efficiently with us.

- Go to web-DENIS
- Click on *BCN Provider Publications and Resources*
- Click on *Learning opportunities*

Some of the training available on web-DENIS includes:

- Blue Cross® Metro Detroit EPO and HMO local networks
- BCN AdvantageSM HMO ConnectedCare
- Frequently asked questions on freestanding radiology clinics
- E-referral online training

We'll keep you updated about training opportunities in future issues.



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Earn cash prize for billing codes related to smoking cessation

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

The incentive is part of our year-long tobacco cessation campaign. We hope you and your office staffs will work with us to provide advice to your patients and make this a successful smoking cessation campaign. We plan to conduct quarterly drawings throughout 2015.

The eligible codes are outlined at right. Some of the codes are payable; others are informational. We have provided descriptions along with some of the codes.

Eligible* codes

Counseling codes

- 1000F
- 1034F Current tobacco smoker: CAD1, CAP1, COPD1, DM4, (PV1)
- 1031F
- 1035F Current smokeless tobacco user: EG, CHEW, (SNUFF), (PV1)
- 1032F
- 1036F Current tobacco non-user: CAD, CAP, COPD, PV1, (DM)4, (IBD)10
- 1033F
- G8751

Intervention codes

- 4000F Tobacco use cessation intervention, counseling
- 4001F Tobacco use cessation intervention, pharmacologic therapy
- 99406
- 99407
- G0436
- G0437

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

Blue Care Network announces tobacco incentive office winners

Blue Care Network has chosen the winners of the tobacco office staff contest for October.

Congratulations to the office staff at Bellaire Family Health Center. The office won \$500 in gift cards in the October drawing as part of Blue Care Network's tobacco cessation initiative. The BCN commercial member who won our recent member drawing was from that office.

Office staffs are still eligible for our ongoing incentive. Please continue to distribute our Quit Guides and encourage patients to complete our tobacco cessation survey. Paper surveys are available from your provider consultant. You can also ask your BCN members to complete the survey online at bcbsm.com/bcnsmoking_survey.

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 the tobacco cessation campaign.

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Referrals and clinical review for Blue Cross® Metro Detroit HMO

Blue Care Network introduced a new plan on Jan. 1, 2015 with a local network. Blue Cross® Metro Detroit HMO is available for purchase by residents of Wayne, Oakland and Macomb counties through the Health Insurance Marketplace or at bcbsm.com.

Referrals and clinical review requests for patients with Metro Detroit HMO coverage follow BCN's standard referral and clinical review process:

- Members must select a primary care physician within the Metro Detroit HMO network. The PCP will coordinate care with local network specialists and hospitals. The PCP's medical care group can provide guidance on which specialists and hospitals should be used for Metro Detroit HMO members.
- If the PCP refers a member for services within the Metro Detroit HMO local network or within the larger BCN network, standard **Blue Care Network referral and clinical review requirements** will apply.
- If the PCP refers a member for services outside of the BCN network, out-of-network rules apply. (An clinical review request must be submitted to BCN, and BCN and Care Management will conduct a clinical review prior to issuing a determination based on the clinical information we receive.)
- BCN's Woman's Choice program allows members to seek care with a BCN network obstetrician-gynecologist without a referral. Members are instructed to remain within the Metro Detroit HMO network. More information about the Woman's Choice program is available at ereferrals.bcbsm.com on the *Clinical Review & Criteria Charts* page and within the Care Management chapter of the *BCN Provider Manual*.

How to identify providers in the Metro Detroit HMO network

When selecting a servicing provider during the submission of a request in the e-referral system, the system will indicate "In" or "Out" in the Network column. In this case, "In" means the provider is in the large BCN network. The e-referral system does not yet identify providers by the local Metro Detroit HMO network.

The best way to identify providers in the Metro Detroit HMO network is to use the online provider search tool at bcbsm.com/find-a-doctor.

- Click on *Get Started*.
- Click on *Advanced Search*.
- Select *ZIP Code, Street Address or City, State or County*, type information.
- In the *Choose a plan* dropdown, click on *Individual and Family Plans (under 65)*.
- In the *Choose a sub plan* dropdown, click on *Blue Cross Metro Detroit HMO*.
- Choose the provider type.
- Add additional search criteria (optional) or click *Go*.

Download a Metro Detroit HMO informational flier from web-DENIS for more information.



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BCN updates transplant policy for Blue Distinction Centers

Beginning May 1, 2015, all transplants for Blue Care Network commercial members must be performed at a Blue Distinction® Center+. If no facility is designated as a Blue Distinction Center+ for the type of transplant needed, the members will be required to use a Blue Distinction Center facility.

Members will continue to use the current BCN process for transplants. In Michigan, the only facility currently with Blue Distinction Center+ designation for most, but not all, transplants is the University of Michigan Hospital System.

In 2013, 29 BCN commercial members had transplants. About half of those were done at the University of Michigan Hospital System. The other half were done at Henry Ford Hospital and Karmanos Cancer Center. Under the updated policy, all transplants must be done at the University of Michigan Hospital System.

Blue Distinction Centers are part of a Blue Cross and Blue Shield Association national designation program that recognizes hospitals that demonstrate expertise in delivering quality specialty care safely and effectively.

In 2013, the Blue Cross and Blue Shield Association began expanding the existing program of recognizing quality specialty care by adding another level of designation: Blue Distinction Centers+. To earn this designation, hospitals must meet the same quality criteria as Blue Distinction Centers and go an extra step to demonstrate that they do so cost efficiently.

BCN offices closed for holiday



Blue Care Network offices will be closed on April 3 for Good Friday.

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 AdvantageSM 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.

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BCN to eliminate regional toll-free phone numbers for Provider Outreach

We are eliminating toll-free regional phone numbers for Provider Outreach and the fax numbers associated with those offices, effective March 1.

Each provider consultant has a personal phone and fax number so you can contact them directly.

As of March 1, these numbers will no longer be in use.

Region	Phone number being discontinued
East Michigan (Flint)	1-800-527-1906
Mid Michigan (Lansing)	1-877-258-0168
Southeast Michigan (Southfield, Ann Arbor)	1-866-299-4667
West Michigan (Grand Rapids, Traverse City)	1-800-968-2583

Here's where you can call for assistance.

Where to call for BCN assistance	
For ...	Call ...
<p>General inquiries, like:</p> <ul style="list-style-type: none"> • Claim inquiries • Member benefits • Primary care physician assignment 	<p>BCN Provider Inquiry:</p> <ul style="list-style-type: none"> • Commercial and BCN Advantage: 1-800-255-1690 • Behavioral Health: 1-800-482-5982
<p>Enrollment inquiries, like:</p> <ul style="list-style-type: none"> • Enrollment or credentialing • Demographic updates • Issues with information displayed in our online provider search 	<p>Provider Enrollment and Data Management:</p> <ul style="list-style-type: none"> • 1-800-822-2761
<p>Contractual or education inquiries, like:</p> <ul style="list-style-type: none"> • Contractual issues • Recurring problems or unresolved issues • Training on BCN policies, procedures and programs • Discussion of primary group administration • Changes in primary care physician acceptance codes • Requests for coverage/on-call providers 	<p>Your provider consultant</p> <ul style="list-style-type: none"> • If you don't know your provider consultant, see Contact Us at bcbsm.com/providers.

For further contact information, go to our **Quick Guides** at ereferrals.bcbsm.com.

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Chronic Care Improvement Program 2014 medical record audit results

Our Chronic Care Improvement program, designed to prevent cardiovascular disease in BCN AdvantageSM members is in its fourth year. If we achieve that goal, we'll also meet our other important goals: to decrease heart attacks, strokes and related deaths in these members.

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

Where are we now?

In 2014, we conducted our second medical record audit to measure how our doctors and members were doing with clinical interventions. As in 2013, we compiled a list of all BCN Advantage members who were 40 years of age or older with a diagnosis of cardiovascular disease or with diabetes type 1 or 2 during 2013. From this list, we selected a random sample of 446 members. Our registered nurse, quality improvement coordinators either visited your offices or requested medical records to review patient charts. Here's what we found:

Measure	Number of positive results/Number of charts reviewed	Percentage positive results	Goal
Number of diabetic members	278/446	62%	N/A
Tobacco cessation			
Was there documentation of tobacco screening in the record?	353/446	79%	N/A
Number of tobacco users	125/446	28%	N/A
Was there documentation of smoking cessation counseling for smokers in the record?	33/125	26%	44%
Diabetic measures			
Did the diabetic patient have HgA1c testing?	254/278	91%	97%
Was the diabetic patient's HgA1c level below nine percent?	227/254	89%	95%
Did the patient have an LDL-C drawn	362/446	81%	88%
Aspirin use			
Documentation in record that aspirin not appropriate	12/446	3%	N/A
Number of patients who had aspirin ordered	182/446	41%	56%
Number of patients who were provided aspirin counseling	54/434	12%	31%
Blood pressure control			
Less than 59 years, blood pressure less than 140/90	5/9	56%	N/A
Greater than 60 years, blood pressure less than 150/90	343/437	79%	N/A

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Chronic Care Improvement Program,

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Opportunities for improvement:

Tobacco cessation: We fell short of our goal for tobacco cessation counseling. While 79 percent of the records audited had evidence of tobacco screening, only 26 percent contained documentation that the patient was counseled on the importance of quitting smoking.

We know that quitting smoking is hard, especially if the patient has a lifelong tobacco habit. We also know that tobacco and nicotine dependence is a condition that often requires repeated treatments¹. Don't stop counseling your patients of all ages about the health benefits they can reap if they quit smoking.

BCN Advantage members have valuable smoking cessation benefits that you can offer them. Members can receive reimbursement for over-the-counter nicotine replacement products. They can also join our free tobacco cessation program, Quit the Nic, which provides telephone counseling with a registered nurse. To enroll in Quit the Nic, members can call 1-800-811-1724 seven days a week, 24 hours a day.

Physicians can take advantage of our BCN Advantage CMS Million Hearts incentive program when they document that they have counseled their patients about the importance of quitting smoking. Physicians should report CPT II code 4000F or 4004F for each patient identified as a tobacco user who received tobacco cessation counseling.

Aspirin use: Documentation of orders for aspirin or anti-platelet therapy was evident in 41 percent of the medical records audited, short of our goal of 56 percent.

Physicians can take advantage of BCN Advantage's CMS Million Hearts incentive and receive reimbursement for patients who are prescribed, or are currently taking aspirin or anti-platelet therapy. To do so, report CPT II code 4086F for all patients meeting the criteria.

In the coming year, we'll continue to work on this important initiative. Here are some simple things that you can do for your patients that will help us reach our goals and help save lives by preventing heart attacks, strokes and related deaths in BCN Advantage members.

- Talk to your BCN Advantage patients about the CMS Million Hearts initiative and how following the ABCs will help them reduce their risk of heart attack and stroke.
- Prescribe aspirin or anti-platelet therapy for those who would benefit from it and document it in the patient's chart.
- Ask your patients about their smoking habits and provide smoking cessation counseling and tools to help smokers quit. Document your interaction with the patient in the medical record.
- Recommend our free tobacco cessation program to help BCN Advantage members quit smoking.
- Emphasize the importance of getting prescribed lab work drawn and follow up with those members who don't get their lab work drawn as ordered.

We all still have a lot of work to do and we know we can't achieve our goals without your help. As health care professionals, you play a key role in helping patients reduce their risk for heart disease and stroke and lead longer healthier lives. In 2015, we'll conduct another medical record audit to check on our progress. In the meantime, watch for updates on our Chronic Care Improvement Program in future issues of the *BCN Provider News*.

- Find information about BCN Advantage's 2015 *CMS Million Hearts Incentive Program* and the *BCN's Performance Recognition Program* on BCN Health e-BlueSM in the *Resources* section under *Incentive Documents*.
- Learn more about the **Million Hearts** initiative.

1. CDC Fact Sheet – Quitting Smoking – Smoking and Tobacco Use, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, page last reviewed June 13, 2014

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BCN Advantage and Blue Cross Blue Shield of Michigan award providers with distinction

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BCN AdvantageSM and Blue Cross Medicare Plus BlueSM PPO have recognized providers who have made outstanding contributions to the plans' star ratings with Provider Distinction Awards. This is the second year we have recognized Medicare Advantage providers for their contributions to our star quality measures. Our partnership with providers is critical to the continued success of our star ratings.

The Centers for Medicare & Medicaid Services uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system. This rating system applies to all Medicare Advantage lines of business.

The award criteria included the following:

- Achieve a Quality Score (Star Measure Screenings: diabetes care, colorectal cancer screening, and other measures) of 80 percent or above on these measures either with their patients that have Blue Cross Blue Shield of Michigan only, BCN Advantage only, or jointly with patients from both plans. If providers achieve greater than 80 percent in any of those categories, then they pass the first eligibility test for the award.
- Providers must have a minimum of five services that count toward the star rating (for example, a diabetes test, colorectal screening.) [The number of services completed divided by the number of eligible services equals the quality score.]
- Providers must be currently credentialed and contracted with Blue Cross and Blue Shield of Michigan and BCN Advantage, and in good standing.
- Providers may not be in the low quality score rating quality score rating program. (Those providers with low quality scores will be eligible for future awards once they have completed the QSR program.)

Plaques were awarded in the following categories:

- BCN Advantage only award
- Medicare Plus BlueSM only award
- Joint award

The providers who received plaques also receive gifts for office staff that help do the administrative work. Office staff gifts included coffee travel mugs, sandwich lunch bags, sandwich and salad lunch holder, and a stylus/pen/flashlight.



[Providers Distinction Awards](#)





Medicare Advantage Diagnosis Closure Incentive program continues in 2015

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Blue Care Network and Blue Cross Blue Shield of Michigan will continue the Medicare Advantage Diagnosis Closure Incentive program in 2015.

The incentive program applies to Blues Medicare Advantage patients, including those with BCN Advantage HMO-POSSM, BCN Advantage HMOSM, Blue Cross Medicare Plus Blue PPOSM, and Medicare Plus Blue GroupSM PPO coverage.

Diagnosis Closure Incentive program

The incentive program rewards participating primary care doctors for having annual, face-to-face visits with Blues Medicare Advantage patients to evaluate, document and code diagnoses according to standards set by the Centers for Medicare & Medicaid Services. Doctors will receive a financial incentive for closing diagnosis gaps identified by the Blues.

A “gap” is a suspected or past condition that hasn’t been documented and coded in the current year.

The *Diagnosis Evaluation Panel* on Health e-BlueSM lists patients who are suspected of having a condition based on:

- Pharmacy claims
- Medical claims
- Other supplemental data sources
- Prior-year diagnoses

The diagnoses for patients listed in the report haven’t been submitted to the Blues in the current year. The report will be refreshed monthly so doctors can track their progress in closing these identified diagnosis gaps.

The Blues will pay doctors \$100 for each Medicare Advantage member with one or more gaps identified between Jan. 1, 2015, and Sept. 30, 2015, and for whom all gaps are closed during a face-to-face visit by Dec. 31, 2015.

During this visit, the doctor should manage, evaluate, assess or treat the condition, and the diagnosis should be documented in the patient’s medical record following CMS guidelines. The gap can then be closed through one of the following methods:

- Confirm the diagnosis code:
 - By submitting a claim with the diagnosis code
 - Through Health e-Blue
 - By submitting a paper *Member Diagnosis Evaluation* and *Treatment Opportunities Report* (for those without access to Health e-Blue)
 - By submitting a patient medical record
- Notify the Blues that the patient does not have the suspected condition:
 - Through Health e-Blue
 - By submitting a paper *Member Diagnosis Evaluation* and *Treatment Opportunities Report* (for those without access to Health e-Blue)

Note that a gap should not be closed solely because you are not actively treating the condition. A diagnosis gap should only be closed if you have conducted an office visit, addressed the condition and determined that the patient no longer has the condition or the suspected condition does not exist.

More information about this incentive program will be posted on Health e-Blue for Medicare Advantage primary care doctors in the first quarter 2015. If you don’t have access to Health e-Blue, **sign up today**. Contact your provider consultant if you need assistance.

2014 incentive payment

If you participated in the 2014 Diagnosis Closure Incentive program, your incentive payment will be mailed to you by the end of the third quarter.

Please see [Medicare Advantage Diagnosis Closure Incentive program](#) , continued on Page 16

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Medicare Advantage Diagnosis Closure Incentive program, continued from Page 15

Web-DENIS member care alerts

When checking patient eligibility and benefits on web-DENIS, be sure to check your member care alerts, which have been updated to include 2015 patient gaps in care.

These alerts are color-coded to help you identify patient needs quickly, and they display a printable list of diagnosis gaps and treatment opportunities for patients.

Training available

The Blues can provide training to doctors and their office staff on proper documentation and coding guidelines and the importance of closing gaps for Medicare Advantage patients. Contact your provider consultant for more information.

Ask your provider consultant for a set of tip cards for your office called *Documentation and Coding Tips for Professional Offices*. The tip cards are also available electronically on web-DENIS. From the web-DENIS home page:

- Click on *BCBSM Provider Publications and Resources*.
- Click on *Newsletters and Resources*.
- Click on *Patient Care Reporting*.

See also [Health e-Blue can generate treatment opportunity letters](#), Page 17.

Address chronic conditions, past diagnoses

As you conduct face-to-face, annual wellness visits with Blues Medicare Advantage patients, make sure you address every chronic condition or past diagnosis that still applies to the patient. Then document this information in the patient's medical record following coding guidelines. Include all of the diagnoses in your claim submission.

The Diagnosis Closure Incentive program is in effect this year for dates of service on or after Jan. 1, 2015.



Medicare Part D prescribers must be enrolled in Medicare in an approved status

Effective June 1, 2015, the Centers for Medicare and Medicaid Services will require physicians and other eligible professionals who write prescriptions for Part D drugs to be enrolled in Medicare in an approved status or to have a valid opt-out affidavit on file in order for their prescriptions to be covered under Part D.

See full article, [Page 35](#)

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Health e-Blue can generate treatment opportunity letters

Blue Care Network wants to help our physicians offer their patients the best care possible. As you are aware, you can use Health e-BlueSM to track gaps in care, or treatment opportunities, for your commercial HMO or BCN AdvantageSM patients.

To make sure your patients are visiting your office to manage chronic conditions and for preventive tests, our Health e-Blue system makes it easy for you to send customized letters reminding your patients to make an appointment with you.

To generate a pre-populated letter to your patient, follow these directions:

- Sign on to Health e-Blue.
- Click on the *Generate Member Letters* tab.
- Select the Provider or practice group in the dropdown menu.
- Select the letter type (Treatment opportunity or Emergency Room).
- For Treatment opportunity, select the condition (for example, diabetes, asthma).
- Alternatively, you can select *View all members* instead of selecting the letter type. This will let you see treatment opportunities for all your members.

The system will generate a personalized letter to your patients notifying them of the recommended tests they need and asking them to call your office to make an appointment. Providers cannot edit the letters; therefore, we recommend that you print letters on your office letterhead that includes your phone number.

How to refer members in the BCN Advantage HMO ConnectedCare network

Blue Care Network has created an information sheet and FAQ document that helps explain how referrals work in the new BCN AdvantageSM HMO ConnectedCare Network.

BCN Advantage ConnectedCare is an individual Medicare Advantage local HMO offered in seven counties in southeast Michigan and Kalamazoo.

Refer to the PDFs below to view the FAQ document and information sheet.

You can learn more about ConnectedCare in an **online presentation**. Audio is required.

For more details about BCN Advantage HMO ConnectedCare, see the article in the **Nov.-Dec. 2014 issue**.



[Information sheet PDF](#)



[FAQ document PDF](#)

Integrating fall prevention into practice

Among older adults, falls are the leading cause of both fatal and nonfatal injuries. According to the Centers for Disease Control and Prevention, one in three adults age 65 and older fall each year, but less than half talk to their health care provider about it. It's an important conversation to have. Since fall risk prevention is a Healthcare Effectiveness Data Information Set® measure, please be sure to document your discussions and interventions related to fall risk and prevention in the patient's medical record.

Falls aren't only associated with morbidity and mortality in the older population, but are also linked to poorer overall functioning and early admission to long-term care facilities. For the older population, effective fall prevention initiatives have the potential to reduce serious fall-related injuries, emergency department visits, hospitalizations, nursing home placements and functional decline.

Healthcare providers can lower a person's risk for falling by reducing or minimizing an individual's modifiable risk factors in the following ways:

- Be proactive: Ask all patients 65 and older if they have fallen in the past year.
- Identify and address fall risk factors, such as:
 - Lower body weakness
 - Gait and balance problems
 - Chronic medical conditions such as diabetes, stroke, urinary incontinence and dementia
 - Psychotropic medication use and polypharmacy
 - Postural dizziness
 - Poor vision
 - Problems with feet or shoes
 - Home safety
- Refer, as needed, to specialist or community programs.
- Follow up with the patient within 30 days.

References:

American Academy of Orthopedic Surgeons; American Geriatric Society; Centers for Disease Control and Prevention

1. Johnell O, Kanis JA. An estimate of the worldwide prevalence and disability associated with osteoporotic fractures. *Osteoporosis Int* 2006; 17:1726.

Key fall prevention interventions may include one or more of the following:

- Providing patient education and information on fall prevention
- Enhancing strength and balance through a customized exercise program
- Minimizing medications, if appropriate, to include reduction or discontinuation of any psychotropic medications
- Managing postural hypotension
- Supplementing vitamin D and calcium, as needed
- Managing foot and footwear problems
- Treating visual impairment
- Optimizing home safety by discussing with the patient safety measures, including
 - Reducing clutter in the home
 - Installing handrails on stairways and grab bars in bathrooms
 - Improving lighting in the bedroom and hallways

Screen for osteoporosis

While you may not be able to prevent all falls, you can reduce the risk of fracture in some patients by screening for and managing osteoporosis effectively. Osteoporosis increases the risk for fractures from falls that wouldn't hurt a person with healthy bones. Osteoporotic fractures (fragility fractures) occur as a result of a fall from a standing height or less without major trauma.¹

Blue Care Network endorses Michigan Quality Improvement Consortium's evidence-based clinical practice guidelines for the **Management and Prevention of Osteoporosis**.

For more information on fall risk prevention and additional tools you can use to assess your patient's risk for falls, please refer to the **Stopping Elderly Accidents, Deaths and Injury (STEADI)** toolkit, designed specifically for health care providers.

REMINDER

2015 Blue Advantage Rewards program expands reward opportunities

The Blue Advantage Rewards program is underway. BCN AdvantageSM members who get any of the five preventive services in the 2015 program, appropriate for them, will get a custom Entertainment[®] coupon booklet or set of coupons.

Five different rewards are available.

In 2015, members are encouraged to get the following services:

- Member health evaluation
- Retinal eye exam
- Mammogram
- Flu vaccine
- Diabetes testing

Rewards will go to members who complete and return the form provided for each procedure. Members must get evaluations or screenings between Jan. 1 and Dec. 31, 2015 to qualify for rewards.

The member health evaluation, introduced to the program a couple of years ago, encourages members to visit their primary care physician at least annually for the following wellness services:

- Creation of a personal prevention or treatment plan, including any needed tests, vaccines or screenings
- Blood pressure check
- Body mass index assessment
- Review of medications, including over-the-counter medicines, vitamins and supplements
- Discussion of safety concerns, such as preventing falls

Remember, only services that take place between Jan. 1 and Dec. 31, 2015 will qualify for a reward. The attestation for the member health evaluation and the other test and exam reward forms must be postmarked or faxed to BCN by Jan. 12, 2016.





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Completing the new CMS-1500 claim form correctly

To accommodate the reporting needs for the ICD-10 and align with the requirements of the HIPAA X2 5010 format, Blue Cross Complete of Michigan started to accept the revised CMS-1500 Health Insurance Claim Form (version 02/12) in April 2014. That time marked the beginning of a testing period to allow providers to become familiar with the new CMS-1500 format. Effective April 1, 2015, claims received that have been completed improperly will be rejected.

To assist providers with accurate claim submission, Blue Cross Complete has identified the most common errors received on both the revised CMS-1500 claim form and existing UB-04 claim form. Look for the billing reference document available at mibluccrosscomplete.com/providers.



Blue Cross Complete offers language assistance

Blue Cross Complete serves a diverse population and providers may see patients who do not speak English, or who have limited English proficiency.

Blue Cross Complete has members whose primary languages are Arabic, Spanish, Chinese and French, in addition to other languages that are less common. While these members represent less than 1 percent of our population, it is important to communicate with members in the language they are most comfortable with. Providers practicing in Wayne County, for example, may see more members who speak Arabic or Spanish.

Blue Cross Complete offers language assistance to members who may not speak English, or have limited English proficiency, when communicating with providers. Blue Cross Complete contracts with a certified translation service and encourages our providers to use this service to ensure all information is accurately communicated. Members who access care in any setting (ambulatory, outpatient or inpatient) can call Blue Cross Complete Customer Service at 1-800-228-3354 for assistance with any or all of the following:

- Interpreting conversations with providers or health care staff
- Translating health plan documents
- Obtaining health plan documents in alternative formats

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Healthy Michigan Plan reminders

Here are some important things to remember about the Healthy Michigan Plan.

Copayments

The Michigan Department of Community Health requires that Healthy Michigan Plan beneficiaries must receive information on potential copayments at the point of service. As long as the service is covered by the health plan, beneficiaries are not responsible for copays at the point of service. Copays for covered services are collected through the MI Health Account. It is important that Healthy Michigan Plan members understand how cost-sharing works. A standard notice is available for providers to present to Healthy Michigan Plan members at their appointments. For this notice and full details, please see the **notice** on the MDCH website.

Health risk assessments

Primary care physicians must complete a health risk assessment form for members at the time of the appointment. Blue Cross Complete members receive a copy of the HRA form in their welcome packets and should bring it to their appointments. If your patients forget to bring the form to the office visit, it is also available on **mbluecrosscomplete.com/providers** and on **NaviNet**.

Please follow these guidelines for the health risk assessment:

- Complete the HRA form legibly and in its entirety.
- When completing Section 4 Member Results, be sure to include all required information if a diagnosis is checked “yes.” Incomplete assessments will not be eligible for the incentive payment.
- A member of the clinical team can complete the health risk assessment, but the PCP will need to sign it.
- Fax the entire form to 1-855-287-7886 within five business days of the appointment.
- Submit a claim with CPT code *99420 with modifier 25 to indicate that an assessment was completed.
- Direct any questions about the status of the health risk assessment to 1-888-312-5713.

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

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

Use Emdeon enrollment for EFT

Blue Cross Complete uses Emdeon® for electronic payments. If you are already enrolled with Emdeon through another health plan, you can access Emdeon and select Blue Cross Complete using BCC Payer ID 32002. For providers not already enrolled with Emdeon, visit **emdeon.com/epayment**.



Blue Cross Complete providers can help reduce Medicaid fraud, waste and abuse

Blue Cross Complete and federal agencies are working together to help prevent fraud and abuse. Health care fraud takes money from health care programs, which leaves less money for true medical care.

What can providers do to assist with compliance efforts?

- Exhibit ethical and professional behavior when providing services to Blue Cross Complete members.
- Ensure billing practices are truthful. Only bill for services that were provided and medically necessary.
- Notify Blue Cross Complete immediately of any concerns about member or provider fraud and abuse.

Providers who suspect that another Blue Cross Complete provider, employer group, employee or member is committing fraud should report it immediately. Call 1-855-232-7640 (TTY users should call the National Relay Service at 711.)

You can also report fraud and abuse by mail:

Blue Cross Complete Anti-fraud Unit
Mail Code 1825
600 E. Lafayette Blvd.
Detroit, MI 48226

All information referred to the Blue Cross Complete Anti-fraud Unit will be handled in cooperation with the Michigan Department of Community Health and the Michigan Office of the Attorney General. The Blue Cross Complete Anti-fraud Unit supports the efforts of local and state authorities in the prosecution of reported cases of fraud.

Reports of suspected fraud regarding Blue Cross Complete may also be made directly to MDCH by calling toll free to 1-855-MI-FRAUD (1-855-643-7283) or by writing:

Office of Health Services Inspector General
P.O. Box 30479
Lansing, MI 48909

Information may be left anonymously. In an effort to help reduce unnecessary costs to the Medicaid program, Blue Cross Complete conducts internal audits, produces data reports and provides open channels to report suspected violations.

Member rights and responsibilities outlined in 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**.

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We need to step up efforts to help members quit smoking

By Duane DiFranco, M.D.



The statistics remain grave, but we are so well acquainted with them, and we hear them repeated so often that, after a while, they can fail to deliver their deservedly shocking effects.

Tobacco use is responsible for one out of every five deaths in the United States — more deaths than from illicit drug use, alcohol use, motor vehicle accidents, murder, suicide and HIV

combined. It causes 85 percent of lung cancer deaths and 90 percent of deaths related to chronic obstructive pulmonary disease. Tobacco users are at increased risk of heart disease and stroke. They face a 2,800 percent increase risk of developing cancer, and of more than just lung cancer. Smokers are more likely to develop leukemia as well as cancer of the cervix, oral cavity, larynx, esophagus, stomach, pancreas, kidney and bladder. And, I have not yet mentioned tobacco's positive correlation with infertility, preterm labor, stillbirth, low birth weight, Sudden Infant Death Syndrome, osteoporosis and hip fracture.

Experts have argued that quitting tobacco may be the single healthiest thing a user can do and that, for a population, reducing the smoking rate may be the single healthiest goal to pursue.

But what can we do to help? Nicotine is a powerfully addictive substance and quitting is very difficult, even with the entire arsenal of available interventions aimed at the problem. It seems a very daunting task indeed. It must seem so for busy primary care physicians.

Recent data from the Million Hearts Initiative (See [Chronic Care Improvement Program 2014 medical record audit results](#), Page 12) reveal that only 26 percent of smokers who are members of BCN AdvantageSM — those with diabetes and heart disease — had evidence of cessation counseling in their medical records. Our member data from the Consumer Assessment of Healthcare Providers and Systems survey indicate that less than 60 percent of smokers were given any information at all in the last 12 months about strategies that they can use to help them quit. The number that report having received information about medication they can use is only slightly higher than that.

Recognizing both the importance of the issue of tobacco use and the challenging nature of the problem physicians and smokers face in trying to tackle the problem, BCN has done a number of things to try to help.

- We have published a *Quit Guide* that contains advice and information on both pharmacological and nonpharmacological aids available to smokers as well as regional and national resource lists. Our *Quit Guide* was distributed to primary care offices in September 2014.
- We have put a number of member incentives in place. These are described at our member landing page for smoking cessation, bcbsm.com/bcnquit. Look for new member incentives in 2015, such as financial rewards for six-month and 12-month cotinine-free tests.

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

Please see [Medical director](#), continued on Page 24

Medical Director, continued from Page 23

- In order to increase circulation of our *Quit Guide* among members, we have also created a way for front office staff to earn incentive rewards for distributing the *Quit Guide*. This program was rolled out in October 2014. If you have not heard about it, please let your provider consultant know and we will get you the necessary materials.
- We have put into place an incentive for physicians to bill smoking-related CPT codes. Physicians who bill these codes on five or more BCN members per quarter are eligible for a quarterly drawing for \$3,000; the more codes billed, the greater a physician's odds of winning. Details can be found on **Page 8** of this issue.

We are also working with our employer groups to craft employer-facing wellness programs.

Our collective efforts may seem inadequate when contrasted with the magnitude of the problem, but your efforts can and do matter. Remember, research shows that even a very brief word of encouragement and advice from you can increase a smoker's chance of quitting. Tell your patients about our incentives. Distribute our *Quit Guides* and, if it suits your office, engage your front office staff in our reward contest. Your provider consultant can get you supplies and answer questions.

It may be true that most quit attempts fail, but that should not discourage you. Good research shows that simple advice and information, counseling, nicotine replacement and other pharmacotherapy all can have a positive impact. Together, we believe we can increase the quit rate among the people we serve.

Physicians are critical to improving member compliance in cardiac disease treatment

Heart disease is the leading cause of death in the United States, according to the Centers for Disease Control and Prevention. Patient compliance in managing cardiac disease is an important factor in reducing hospitalization.

Blue Care Network offers the following tips for providers to help patients manage their care.

- Reinforce to members who have had an acute myocardial infarction that beta blocker medication therapy is for life unless contraindicated.
- Instruct members not to discontinue any medication without discussing it with you first.
- Keep the member on the prescribed therapy, try lowering dosage or using a different beta blocker if the member isn't tolerating his or her current medication.
- Order cardiac rehabilitation and encourage the member to attend. This increases the likelihood that the patient will follow the prescribed medication regimen.
- Discuss adherence to cardiac medications and smoking cessation as an essential part of every outpatient visit. Our smoking cessation program, *Quit the Nic*, is available at no cost to members. Call 1-800-811-1764 for information.
- Use of a highly effective statin can help reduce member's risk of a subsequent myocardial infarction.
- Use our Health e-BlueSM website reports to help you identify the screenings your patients need. Ask your provider consultant for details. (*To obtain access to the website, you must be registered for Provider Secured Services at bcbsm.com.*)
- BCN case managers continue to work with you, your office staff and our members to help ensure that members comply with treatment plans. To reach a BCN case manager, call 1-800-392-2512



Blue Care Network offers preventive care brochure

Blue Care Network has a member brochure that includes all the preventive care guidelines from the Michigan Quality Improvement Consortium. The brochure lets members know about important screenings.

Preventive care is available with little or no cost sharing to the member when members get services in the network

The brochure is available at **bcbasm.com** under *Healthy Living Tools*.

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Clinical review decisions are based solely on appropriateness of care

Blue Care Network makes utilization decisions regarding care and service solely on the appropriateness of care prescribed in relation to each member’s medical or behavioral health condition. BCN’s clinical review staff doesn’t have financial arrangements that encourage denial of coverage or service. BCN-employed clinical staff and physicians don’t receive bonuses or incentives based on their review decisions. Review decisions are based strictly on medical necessity within the limits of a member’s plan coverage.

Providers may discuss decisions with BCN physician reviewers

Blue Care Network demonstrates its commitment to a fair and thorough review process by working collaboratively with its participating physicians.

BCN’s Care Management plan medical directors may attempt to contact the treating health care practitioner for additional information in regard to any review as deemed necessary. When BCN doesn’t approve a request, we send written notification to the appropriate practitioners and providers, and the member. The notification includes the reason the service wasn’t approved as well as the phone number to contact BCN’s plan medical directors to discuss the decision. Practitioners may discuss any decision with a plan medical director.

If you’re a practitioner and would like to discuss your patient’s condition or treatment with one of our plan medical directors, call Care Management at 248-799-6312, Monday through Friday, between 8 a.m. and 4:30 p.m. To discuss an urgent case with one of our plan medical directors after normal business hours, please call 1-800-851-3904.

How to obtain a copy of Care Management criteria

Upon practitioner request, Blue Care Network provides the criteria used in the decision making process. Call Care Management at 248-799-6312, weekdays from 8 a.m. to 4:30 p.m. for further information. Due to licensing restrictions, BCN is unable to distribute complete copies of the InterQual® criteria. (All contracted hospitals have copies of the criteria as part of BCN’s licensing agreement.)

If you wish to obtain further information about purchasing copies of InterQual criteria, call McKesson Health Solutions, InterQual Support, at 1-800-274-8374.

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Medical policy updates

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

Noncovered services

- Genetic testing — Molecular panel testing of cancers to identify targeted therapies
- Genetic testing — Whole exome and whole genome sequencing for the diagnosis of genetic disorders
- Quantitative pupillometry/pupillography

Covered services

- Isolated limb perfusion/infusion chemotherapy, with or without hyperthermia
- Subcutaneous implantable cardiac defibrillator
- Genetic testing for Bloom syndrome
- Genetic testing for the diagnosis of inherited peripheral neuropathies



[Medical Policy Updates PDF](#)

March is National Kidney Month

The National Kidney Foundation has designated March as National Kidney Month to raise awareness and promote kidney health.

Blue Care Network wants to share some reminders to help you manage your patients' kidney health.

People with diabetes, high blood pressure and family history of kidney disease are at risk of developing chronic kidney disease. African Americans, Hispanics and senior citizens have a much higher risk of developing chronic kidney disease.

As a BCN physician you can do your part by monitoring the blood pressure of diabetic and hypertensive members and evaluating their kidney function annually by performing tests such as urine albumin and glomerular filtration rate. Additionally, you can encourage healthy lifestyle changes that include diet, exercise and symptom management, such as a stable hemoglobin A1C and cholesterol level.

BCN has registered nurses available to support your treatment plan for members with chronic kidney disease and answer member questions. You and your patients may contact a chronic condition management specialist by calling 1-800-392-4247. For more information regarding kidney disease you may also want to check out the **National Kidney Foundation** website.

We want to stress the importance of educating your at-risk patients about CKD. Early detection of chronic kidney disease and member education can often keep the disease from getting worse in addition to minimizing other medical conditions associated with chronic kidney disease, such as heart disease and stroke. For additional information, refer to the **Michigan Quality Improvement Consortium Guidelines**.

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BCN's Adult Kidney Health Management Program helps manage members' care

Blue Care Network's Adult Kidney Health Management Program offers support to members diagnosed with chronic kidney disease. The program emphasizes screening members at risk for developing chronic kidney disease (including those with hypertension or diabetes), monitoring and treatment to prevent or delay disease progression, and to facilitate referral of patients to nephrologists when indicated for treatment of progressive or advanced disease.

The program is based on the Michigan Quality Improvement Consortium's *Guideline for the Diagnosis and Treatment of Adults with Chronic Kidney Disease*, posted on the MQIC website at mqic.org.

Program goals include:

- Increase annual assessments of glomerular filtration rate in members at risk for kidney disease or with kidney disease (identified as having hypertension or diabetes or GFR < 45 ml/min/1.73²)
- Annual assessment of urine albumin or protein in members with diabetes not filling prescriptions for ACE-1 or ARB medications
- Increase use of ACE inhibitors or angiotensin receptor blockers to slow progression of chronic kidney disease in members with GFR between 44-15 ml/min/1.73m²
- Increase referrals to nephrologists for members with advanced disease GFR <30 ml/min/1.73m² who aren't receiving renal replacement

BCN identifies members for the program through medical and pharmacy claims related to hypertension, diabetes, chronic kidney disease; by laboratory results for serum creatinine tests; and from claims for urine albumin/protein tests. We also accept referrals to the program from physicians, other BCN departments, member health assessments and member self-referral. Identified members are automatically enrolled in the program. They may opt out of the program by notifying BCN's Chronic Condition Management department.

BCN implements interventions based on MQIC's criteria:

- **Members with diabetes and hypertension at risk for developing stage 1 and 2 CKD with a GFR >60ml/min/1.73m²** – Primary care physicians should encourage these members to have an annual GFR and work with their physician to keep their blood pressure under control. You should also encourage your patients to avoid nonsteroidal anti-inflammatory drugs.
- **Members with stage 3A CKD and a GFR 45-59ml/min/1.73m²** – BCN sends these members self care educational booklet about kidney health management, a personal health card and a chronic kidney disease management plan. We also send them reminders about needed services, such as annual assessment of GFR, urinary and albumin excretion (if not on ACE-I or ARB) as well as program newsletters.

Please see [Adult Kidney Health Management Program](#), continued on Page 28



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Adult Kidney Health Management Program, continued from Page 27

- **Members with stage 3B CKD and GFR between 30-44ml/min/1.73m² and members with stage 4 CKD with GFR between 15-29ml/min/1.73m²** – We send these members a program introductory letter and packet, reminders for needed services including ACE-I or ARB treatment, blood pressure control, lipid management, smoking cessation and glycemic control (if diabetic). We also send them information about avoiding nephrotoxic drugs, including nonsteroidal anti-inflammatory drugs and iodine contrast.

BCN's Kidney Health Management program, in concordance with MQIC guidelines, recommends that members with stage 4 or unstable stage 3B chronic kidney disease be referred to a nephrologist for counseling and management including assessment of calcium and phosphate balance, bone health, anemia, vaccinations, end stage renal disease planning and advance directives. We send reminder letters to the primary care physician about referring the member to a nephrologist. We may also enroll these members in BCN's case management program.

- **Members identified with stage 5 CKD (GFR <15 ml/min/1.73m²) on dialysis** – We refer these members to a BCN specialty case management program for dialysis management.

When your member is enrolled in the adult Kidney Health Management program, BCN provides the following support:

- Health e-BlueSM reports letting you know which patients meet the above criteria
- Health e-Blue reports displaying members overdue for testing and medication refill
- Program assistance from a registered nurse chronic condition management specialist at 1-800-392-4247, Monday through Friday, 8:30 a.m. to 5 p.m. (holidays excluded).
- Case management nurse assistance at 1-800-392-2512, Monday through Friday, 8 a.m. to 5 p.m. (holidays excluded)
- Customer service assistance at 1-800-662-6667, Monday through Friday, 8:30 a.m. to 5 p.m. (holidays excluded)
- Chronic condition management website
- BCN's pharmacy benefit manager performs concurrent evaluation to identify potential drug related interactions

To learn more about BCN's Kidney Health Management program or to refer a member, call the Chronic Condition Management department at 1-800-392-4247 Monday through Friday, 8:30 a.m. to 5 p.m. (holidays excluded).





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BCN programs help members with chronic conditions

Blue Care Network identifies members with select chronic illnesses and automatically enrolls them in one or more of the following BCN Chronic Condition Management programs:

- Asthma (adult and child)
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Ischemic heart disease
- Heart failure
- Kidney health management

The goals of chronic condition management are to help members understand and manage their condition and identify gaps in care. We mail educational materials to members to educate them about self-management, preventive health issues, relevant medical tests, lifestyle issues and medication compliance. The program offers registered nurse chronic condition managers who make outreach calls to identified members.

We welcome referrals to our programs from providers and can help improve your members' health by working as part of your team. Membership is voluntary and members can opt out of the program at any time. Call 1-800-392-4247 for more information.

BCN commercial and BCN AdvantageSM members can also get help to quit tobacco use by calling our Quit the Nic smoking cessation program at 1-800-811-1764.

Stay up-to-date with new vaccination waiver rules, immunization schedules

The State of Michigan's Joint Commission on Administrative Rules approved new waiver rules for parents who want an exception from vaccinations for their children. The new rule, effective Jan. 1, 2015, requires parents who want a nonmedical waiver to receive education regarding the benefits of vaccination from a county health department before obtaining the waiver.

To learn more about the new requirements visit **the Michigan Department of Community Health** website.

The Advisory Committee on Immunization Practices approved changes in October 2014 for the 2015 immunization year. There were schedule changes, age group changes and language clarifications. Catch up with all the changes at **mcir.org**.

The Centers for Disease Control and Prevention provides information to help providers increase immunization levels through AFIX – Assessment, Feedback, Incentives and eXchange. Information is available at the CDC's **AFIX Web page**.

Immunizations and well child care are Healthcare Effectiveness and Data Information Set[®] measures. For questions about HEDIS, visit the **National Committee for Quality Assurance Web page**.

Remind patients about immunizations

Don't forget to remind your patients about the importance of immunizations for both children and adolescents. Getting youngsters into the doctor's office can be a challenge especially when they are not sick. Preventive care and educational guidance are a large part of compliance. Blue Care Network endorses Michigan Quality Improvement Consortium's age specific **guidelines**, available at **mqi.org**.

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Feedback

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:

Pediatric Nursery subset, Episode Day 1, p 434: clarification of the Special Care Level II finding/ intervention “Specialist Evaluation ≤24h”

Is it appropriate to use this finding when the admitting physician is also a specialist and sees the baby in the first 24 hours?

Answer:

The criteria point, “Specialist evaluation ≤24h,” cannot be applied for an evaluation by the attending physician, even when the attending is a specialist. This criteria point is applied when a specialist other than the attending, is called in to provide an evaluation. It isn’t applied for an evaluation by the specialist who is the infant’s admitting physician. The intent of this criteria point is that it be applied for an evaluation or consult from another service, such as cardiology or nephrology.

The criteria point endpoint, “≤24h”, doesn’t refer to the specialist evaluation being done within 24 hours of admission. It refers to the amount of time that can be approved with this criteria point, which is one Episode Day, since one Episode Day encompasses a 24- hour period.

Question:

On the guidelines for surgery and procedures in the inpatient setting Page 9: Can a parathyroidectomy be included under Parathyroid Exploration/Excision?

Answer:

Yes, the listing on our Inpatient list Page 9: Parathyroid Exploration/Excision, refers to parathyroidectomy.

March is colorectal cancer month

Every year Blue Care Network participates in the Healthcare Effectiveness Data and Information Set® which measures the performance of managed care organizations. HEDIS® has a performance measure for colorectal cancer screening. The 2014 results showed BCN had significant improvement in the BCN AdvantageSM colorectal cancer screening rates. However, we would like to see improvement in the commercial HMO population.

The description of the measure is the percentage of members age 50 to 75 that had appropriate screening for colorectal cancer. Appropriate screenings are defined by any one of the three criteria below:

- Fecal occult blood test during the measurement year
 - Guaiac (g FOBT) or immunochemical (i FOBT)
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

Digital rectal exam doesn’t count as evidence of a colorectal screening because it isn’t comprehensive enough to screen for colorectal cancer.

The Michigan Quality Improvement Consortium has clinical practice **guidelines for colorectal screening** under the Adult Preventive Services guidelines. MQIC health guidelines are a tool to support practitioners and aren’t intended to be a substitute for medical judgment. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Primary care practitioners are valued partners central to the mission of providing quality, cost effective care. Thank you to all of our affiliated practitioners for their commitment to positively impact the health and well being of members.

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Blue Care Network's 2015 Behavioral Health Incentive Program documents are on web-DENIS

Blue Care Network's 2015 Behavioral Health Incentive Program is specifically designed for psychiatrists, fully licensed psychologists and clinically licensed certified social workers.

If you are not familiar with the program, we strongly encourage you to access it on web-DENIS.

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

Please note we have made a few changes to the 2015 program. The changes are indicated with an asterisk below: Follow-up After Hospitalization measure incentive payment has increased to \$125; Appropriate Glucose Monitoring is a new measure for 2015; Therapeutic Alliance measure incentive payment has increased to \$15; PCP Contact measure incentive payment has increased to \$30.

The following is a summary of the measures and payment information.

Measure	Provider type	Intake period	Payment	Projected payout	Provider action
Follow-up after hospitalization	All qualified mental health practitioners	1/1/15-10/31/15	Flat fee - \$125.00*	Second quarter of 2016	None – claims data
Anti-depressant medication management – Acute	Prescribing Providers	1/1/15-4/30/15	Flat fee - \$40.00	Second quarter of 2016	None – claims data
Anti-depressant medication management – Continuation	Prescribing Providers	1/1/15-4/30/15	Flat fee - \$60.00	Second quarter of 2016	None – claims data
Pharmacotherapy adherence for bipolar disorder	Prescribing Providers	1/1/15-12/31/15	Flat fee - \$80.00	Second quarter of 2016	None – claims data
Appropriate Glucose Monitoring*	Prescribing Providers	1/1/15-12/31/15	Flat fee - \$80.00	Second quarter of 2016	None – claims data
Therapeutic alliance	Non-prescribing Providers	1/1/15-12/31/15	Flat fee - \$15.00*	Third quarter of 2015; second quarter of 2016	Submit forms
Primary Care Physician Contact	Prescribing and Non-prescribing Providers	1/1/15-12/31/15	Flat fee - \$30.00*	Third quarter of 2015; second quarter of 2016	Submit forms

Note: BCN retains the right to modify Behavioral Health Incentive Program at any time. Modifications may include, but are not limited to, changes to the program's scoring and calculation methodologies.

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Two new autism evaluation centers added

The Blues have added two new approved autism evaluation centers.

- Central Autism Assessment & Treatment Center at CMU (CAAT)
- UP Health System Marquette – Specialty Clinic

The updated list is posted on web-DENIS.

The list can also be found on bcbsm.com. Go to *Find A Doctor*. Then click on *Dental, Vision and Other Directories* under More Information. Then click on *Approved Autism Evaluation Centers*.

Behavioral health webinar coming in April

Watch for an invitation to our Behavioral Health webinar planned for April. We'll provide an overview of behavioral health tools and resources to help you better understand both Blue Cross Blue Shield of Michigan and Blue Care Network products.

Behavioral health providers may discuss decisions with BCN physician reviewers

Blue Care Network is committed to a fair and thorough process of determining utilization by working collaboratively with its participating behavioral health practitioners. BCN's behavioral health physician reviewers may contact practitioners for additional information about their patients during their review of all levels of care, patient admissions, additional hospital days and requests for services that require medical policy and benefit interpretations.

When BCN doesn't approve a service request, we send written notification to the requesting practitioner. The notification includes the reason the service wasn't approved as well as the phone number to call BCN's behavioral health physician reviewers to discuss the decision.

Practitioners may discuss any decision with a BCN behavioral health physician reviewer. If you are a practitioner and would like to discuss your patient's condition or treatment with one of our physician reviewers, call Behavioral Health at 734-332-2567 Monday through Friday, between 8 a.m. and 5 p.m. To discuss an urgent case after normal business hours with one of our behavioral health physician reviewers, please call 1-800-482-5982.

How to obtain a copy of behavioral health criteria

Upon practitioner request, Blue Care Network provides the behavioral health criteria used in the decision-making process. Call Behavioral Health at 734-332-2567, weekdays between 8 a.m. and 5 p.m. to request a copy of the criteria.

Clinical review decisions are based solely on appropriateness of care

We base utilization decisions regarding care and service solely on the appropriateness of care prescribed in relation to each member's medical or behavioral health condition. BCN's clinical review staff members don't have financial arrangements that encourage denial of coverage or service. BCN-employed clinical staff and physicians don't receive bonuses or incentives based on their review decisions. Review decisions are based strictly on medical necessity within the limits of a member's plan coverage.



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Blue Care Network recommends URI guidelines, HEDIS measures addressing antibiotics

Blue Care Network is committed to quality care and continued support of primary care practitioners. BCN has two clinical guidelines to assist in ensuring healthy outcomes for upper respiratory infections:

- **Acute Pharyngitis in Children 2-18 Years Old**
- **Management of Uncomplicated Acute Bronchitis in Adults**

These guidelines are available at the Michigan Quality Improvement Consortium website, at mqic.org. They include levels of evidence for the most significant recommendations. These guidelines are a tool to support practitioners and aren't intended to be a substitute for medical judgment. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

BCN participates in the Healthcare Effectiveness Data and Information Set®. HEDIS® is a part of an integrated system that measures the performance and establishes accountability in the managed care industry. The performance results and subsequent ratings of the participating managed care organizations are used by public purchasers, regulators and consumers. Three HEDIS measures address appropriate antibiotic utilization in the treatment of upper respiratory infections:

- **Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis**
 - Percentage of adults 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.
- **Appropriate Treatment for Children With Upper Respiratory Infection**
 - Percentage of children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription.
- **Appropriate Testing for Children With Pharyngitis**
 - Percentage of children 2 to 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic *and* received a group A streptococcus (strep) test for the episode. A higher rate represents better performance since it reflects appropriate testing.

The **Centers of Disease Control and Prevention** and the **Michigan Antibiotic Resistance Reduction Coalition** have programs and materials to support practitioners working with patients who are requesting an antibiotic when it isn't appropriate.

Get Smart is a CDC program that lists strategies that can improve patient satisfaction and understanding when antibiotics aren't necessary for their condition. The CDC website also has brochures and posters for educating patients.

Thanks to all of our practitioners for their contribution toward providing quality care to our members and allowing BCN staff to conduct the medical record reviews necessary for HEDIS.



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BCN expanding specialty medical drug approval program on April 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 April 1, 2015, BCN will require prior authorization before these drugs will be covered under members' medical benefits.

J code	Brand name	Prior authorization / clinical review is required for these members...
J0180	Fabrazyme®	All members except those with BCN Advantage SM coverage
J0256	Aralast NP	
	Prolastin®	
	Zemaira®	
J0257	Glassia	
J0638	Ilaris®	
J1300	Soliris®	
J1786	Cerezyme®	
J1743	Elaprase®	
J3060	Elelyso™	
J3385	Vpriv®	
J9999	All	All members

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 April 1, 2015. Members who have a paid claim for one of these medications by the end of March 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 section**. The updated criteria charts will be posted to the website by April 1, 2015.



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Medicare Part D prescribers must be enrolled in Medicare in an approved status

Effective June 1, 2015, the Centers for Medicare and Medicaid Services will require physicians and other eligible professionals who write prescriptions for Part D drugs to be enrolled in Medicare in an approved status or to have a valid opt-out affidavit on file in order for their prescriptions to be covered under Part D.

While CMS has announced that it will delay enforcement of the requirements in 42 CFR § 423.120(c)(6) until December 1, 2015, prescribers of Part D drugs must submit their Medicare enrollment applications or opt-out affidavits to their Medicare administrative contractors by June 1, 2015, or earlier. This ensures that Medicare administrative contractors have sufficient time to process the applications or opt-out affidavits and avoid their patients' prescription drug claims from being denied by their Part D plans beginning December 1, 2015.

For the latest information about these requirements, please visit [Part D Enrollment Information](#) at CMS.

BCBSM and BCN drug lists updated, available online

The Blue Cross Blue Shield of Michigan and Blue Care Network Pharmacy and Therapeutics Committee reviewed the pharmaceutical products listed in the PDF below for inclusion in the *BCBSM/BCN Custom Drug List 2015*, *Custom Select Drug List 2015* and the *BCN AdvantageSM HMO-POS Formulary*. 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.



Additional vaccines available at participating network pharmacies

Blue Care Network is committed to helping our member stay healthy. To encourage members to keep their immunizations up-to-date, starting April 1, 2015, BCN is expanding its pharmacy vaccine program. Eligible commercial members can receive their Tdap, HPV, and quadrivalent meningitis (ACYW) vaccines at participating pharmacies. Currently, members can get influenza, pneumonia and shingles vaccines at the pharmacy.

Members can still receive immunizations at their doctor's office.

BCN reimburses participating pharmacies for vaccines covered under the medical benefit and processed through the pharmacy claims system using the current NCPDP format. Vaccines administered under this program require administration by certified, trained and qualified registered pharmacists.

This change applies to eligible commercial HMO members, including those who do not have pharmacy coverage through BCN. For members who have Medicare Part D coverage, the vaccines may be administered at pharmacies and will continue to be covered under the pharmacy benefit.

Pharmacies with questions about billing should contact the Express Scripts Technical Help Desk at 1-800-922-1557.

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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 minimum of eight and a maximum of 48 hours of observation care may be reimbursed.

If a member is admitted for inpatient care but the admission is denied, the services the member received may be billed as observation only if the member was actually in observation and observation care was the appropriate level of care for the member's condition at the time.

If the member did not spend time in observation, services rendered during the first 48 hours of patient care may be billed as ancillary services, for BCN HMOSM commercial members only. If the member is admitted and there are no emergency or observation charges associated with the admission, some services may have referral and clinical review requirements. Examples of these services include:

- Surgeries
- CT scans
- MRIs

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 as a provider to Provider Secured Services, click *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 as a provider to Provider Secured Services, click *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**.

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Reporting postpartum care

Postpartum care is an important part of maternity care. It is also a measure against which Blue Care Network and its physician network is measured in the Healthcare Effectiveness Data and Information Set.

For a postpartum visit to qualify as a reportable visit in accord with the HEDIS® measures, the visit must occur between 21 and 56 days after the delivery date. The postpartum visit must be reported with an acceptable and valid procedure code. These include: *59430, *58300, *57170, *99501, *0503F or G0101. It is important to verify the referral and clinical review requirements for the services.

The global maternity codes that include the delivery and the postpartum visit are not accepted by HEDIS®. Therefore, health care providers are now required to report procedure code *0503F when billing one of the global delivery and postpartum codes accepted by BCN (*59410, *59515, *59610, *59614, or *59622).

In addition, report a penny (\$0.01) on the 0503F line as the charge billed. You will not receive reimbursement of the penny, as the fee for postpartum care is already included in the global procedure code. The line will include an explanation that it is a reporting code only (BO3), indicating there is no member liability.

HEDIS® uses the reporting of the code to quantify the number of days between the actual delivery date and postpartum visit.

For questions regarding this process, please contact your provider consultant.

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



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Feedback

Question:

What are the guidelines for billing preventive visits to Blue Care Network?

Answer:

Codes for preventive visits should reflect the age of the patient and whether the patient is a new or established patient to the physician or group. The preventive medicine code range (*99381 to *99397) incorporate an age- and gender-appropriate preventive medical examination. Please remember to record the components of the exam in the medical record.

BCN's policy is to only reimburse for one evaluation and management service on a date of service. Therefore, you should only report the most appropriate and comprehensive code.

Question:

Does BCN Advantage follow Blue Cross billing policies for physician assistants?

Answer:

Physician assistants may bill for services they provide to BCN Advantage members based on their individual contracts.

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

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:

- New modifiers
- When to submit an appeal for a clinical edit
- Modifier 25 usage
- Reporting transvaginal and pelvic ultrasound services



[Clinical editing
billing tips PDF](#)

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. You may want to direct urgent questions to your provider consultant. Please do not include any personal health information, such as patient names or contract numbers, in your question to us.

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Coding Corner

Documentation is key when coding morbid obesity

With increasing numbers of our population suffering from obesity, it's crucial for physicians to recognize severity of weight and the degree to which obesity, and its ever-present complications, negatively impacts patient health.

"Overweight," "obesity" and "morbid obesity" are distinct diagnoses that should be properly documented.

The Centers for Medicare and Medicaid Services includes morbid obesity (ICD-9-CM code 278.01) and its associated body mass index values (40 and above, ICD-9-CM code range; V85.41-V85.45) in its 2014 Hierarchical Condition Categories Model. This inclusion substantially impacts the way providers should document the condition.

From a coding perspective, documentation indicating morbid obesity in the medical record makes it easier to assign code 278.01 with an associated V code. The problem arises when obesity is assessed in the medical record, but evidence indicates that the patient is morbidly obese. (For example, the patient has a BMI of 40 with comorbid conditions and management of those conditions.)

Can a BMI value of 40 with co-morbid conditions be used to validate the HCC for morbid obesity when there is a differential diagnosis? Yes, consider the following guidelines for a morbid obesity diagnosis:

- Patients with a BMI greater than 35 who are seen with comorbid conditions such as osteoarthritis, sleep apnea, diabetes, coronary artery disease, hypertension, hyperlipidemia and/or gastroesophageal reflux disease.
- Patients with a BMI equal to or above 40.

According to Dr. Laurie Knight, Blue Cross associate medical director, you should capture all of the medical complications that are associated with an obesity diagnosis, (for example, sleep apnea, uncontrolled diabetes, hypertension, hyperlipidemia). This will then prompt you to define and document the specific clinical condition (morbid obesity).

"The BMI value is one of the key elements to consider when assessing morbid obesity. Clinical complications should also be evaluated and treated," says Knight. "Sometimes multiple interventions are required to evaluate and identify a clinical condition like morbid obesity. Observing the impact of weight on other medical conditions is often a clear indicator."

A provider may recommend several interventions that could include a dietitian, incorporating an exercise regimen, and education about managing other comorbidities that can impact the total health of the patient. "Morbid obesity may not be documented early in the year as you may opt to evaluate the patient over time," says Knight. "However, once you've determined the patient to be morbidly obese, and you code it as such, the diagnosis must continue to be coded as morbid obesity on subsequent visits."

Documentation is the key to coding morbid obesity and a coder must review the medical record thoroughly when obesity is documented with a BMI of 40 or above with comorbid conditions affecting the patient's overall health. In this situation, a code for the BMI (same HCC as morbid obesity) should be used to support morbid obesity.

Reminder: Member compliance required before reauthorizing positive airway pressure devices

Effective with requests for authorization initiated on or after Jan. 1, 2015, BCN HMOSM and BCN AdvantageSM members who use positive airway pressure devices must show they're complying with their treatment recommendations in order to use the devices for longer than 90 days. Northwood, Inc., BCN's durable medical equipment benefit manager, will no longer authorize use of the devices for 12-month periods.

Durable medical equipment suppliers play a key role in coordinating the member's compliance data. This information will show whether the member is benefiting from the equipment and is complying with treatment recommendations. The DME suppliers will make sure the member's practitioner knows whether the member is complying.

Here's how the new arrangements work:

Responsible party	When the PAP device is prescribed	Between day 1 and day 90
Practitioner	<ul style="list-style-type: none"> Sends the initial request for authorization to a DME supplier that's part of the Northwood network Note: If you need assistance locating a network provider, contact Northwood at 1-800-393-6432. 	<ul style="list-style-type: none"> Manages the member, as appropriate Sees the member for a face-to-face evaluation Documents whether the member's symptoms have improved Determines whether the member needs to use the equipment beyond 90 days
Northwood	<ul style="list-style-type: none"> Processes the request for authorization 	—
DME supplier	<ul style="list-style-type: none"> Delivers the equipment to the member Instructs the member on how to use the equipment Reviews the Northwood PAP compliance acknowledgement letter with the member Has the member sign the letter Places the letter in the member's file 	<ul style="list-style-type: none"> Receives the member's compliance updates and place them in the member's file Contacts the practitioner for the order to extend the authorization beyond 90 days
Member	<ul style="list-style-type: none"> Signs the agreement to indicate his or her intention to comply with treatment recommendations and willingness to verify compliance 	<ul style="list-style-type: none"> Documents compliance by bringing the device's memory card to the DME supplier or uploading compliance data using online software Sees the practitioner for a face-to-face evaluation within 90 days

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Member compliance required,

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If the practitioner has determined the PAP device is needed for more than 90 days and the member's compliance has been verified during the first 90 days, the DME supplier submits the completed *Northwood PAP Therapy Reauthorization Request Form* to Northwood. No additional documentation is required. The DME supplier should keep all compliance documentation and notes in the member's medical record and make them available for audit as necessary. Benefits will be extended for the remaining rental months of the PAP device.

If the practitioner determines that the PAP device is needed for more than 90 days but the member did not verify his or her compliance during the first 90 days, the DME supplier must submit the following to Northwood:

- The acknowledgment letter the member signed at the initial visit
- The completed *Northwood PAP Therapy Reauthorization Request Form*, including the date of the member's face-to-face evaluation with the practitioner
- The practitioner's notes from the member's face-to-face evaluation
- The compliance data from the first 90 days

Members are noncompliant with treatment recommendations if their usage information shows they used their PAP device for less than four hours per night on 70 percent of nights during each consecutive 30-day period of the 90 days following receipt of equipment.

Members who do not comply with treatment recommendations, who have not had the face-to-face evaluation with their practitioner or whose symptoms have not improved may not be approved by the plan for an extension of benefits. Members not approved for an extension must return the PAP device to the supplier or be responsible for paying for the device when the authorized period ends.

For details about how referrals and authorizations work for Blue Cross® Metro Detroit HMO, see **Page 9**.

Issues resolved in e-referral

Since e-referral's re-launch in September 2014, a number of known issues have been resolved. These issues, as well as helpful tips, have been posted on the **e-referral website**.

Here are some of the issues that have been corrected:

- **The printer-friendly Referral Request Confirmation file does not include the Reference ID.** Providers can now see the Case ID on the printer-friendly version. The ID is found under the date in the confirmation PDF.
- **High-tech radiology cases require users to complete a questionnaire.** Providers submitting CPT codes for any of **these procedures** will now see a message directing them to visit the **CareCore National** website, or call 1-855-774-1317.
- **Physical therapy/occupational therapy/speech therapy cases pend.** Once Landmark makes a determination on a request, the provider will receive the message to contact **Landmark** through their website, or call 1-877-531-9139. Providers will not be able to edit the request at this point.
- **Providers are missing from the drop-down menu.** Many providers have been loaded to the e-referral system and are now listed in the Provider Set lists. BCN continues to work with provider offices and groups to ensure that their associated provider lists are accurate. Offices are encouraged to complete the appropriate forms and submit them to the when updates to their users or providers occur.



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