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The Blues to offer a variety of individual products for 2015

When the Health Insurance Marketplace opens Nov. 15, Blue Care Network and Blue Cross Blue Shield of Michigan will have many new products available for coverage beginning Jan. 1, 2015, or later.

Blue Cross and BCN are offering 41 individual products; 24 of them are BCN HMO plans and 17 are Blue Cross PPO plans. All of the products sold on the Marketplace will be sold with Blue Cross names. (Please see the article on [Page 8](#) for some tips to identify Blue Cross and BCN plans by their names.)

Blue Care of Michigan's Personal PlusSM will remain open in 2015, but it will not be open to new contracts. Some changes to Personal Plus were made to comply with certain Federal and State mandates. For example, elective abortion was added as a rider and, for the applied behavioral analysis benefit for autism, the line therapy hour limit to treat autism spectrum disorders will be removed effective January 2015.

Some plans are discontinuing.

- BCBSM's Keep FitSM will no longer be offered. Keep Fit members will need to have purchased another individual plan that becomes effective January 2015.
- Blue Cross Partnered Value and Blue Cross Preferred Value plans are discontinued effective Dec. 31, 2014.

New plans will be offered for 2015:

- Blue Cross[®] Metro Detroit HMO – a local network HMO in three counties offered by Blue Care Network. Members must reside in Wayne, Oakland or Macomb counties. (More information on [Page 3](#).)
- Blue Cross[®] Metro Detroit EPO – an exclusive provider organization in six counties offered by Blue Cross. (More information is on [Page 5](#).)
- New "Extra" plans – these plans include a basic individual product benefit design plus the following:
 - The plan pays the first four specialist office visits per member before the deductible (copayments will apply)
 - The plan pays Tier 1A and Tier 1B generic prescription drugs before the deductible (copays will apply.)



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- Blue Care Network provides office staff incentives for tobacco cessation campaign [Page 12](#)
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[BCN Provider News User Guide PDF](#)



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Blues products, continued from Page 1

Highlights of cost sharing changes for the BCN Extra plans include:

- Simplified cost sharing by removing copays for imaging services, such as CTs, PET scans or MRIs.
- Removed copays for mental health and substance abuse outpatient services.
- Inpatient copay – No \$500 copay for a stay in a hospital, mental health, substance abuse and skilled nursing facility. Also no copay for delivery and all inpatient maternity services. Coinsurance will continue to apply.
- Office visits – Primary care physician office copay reduced to \$20 for Silver and Gold Extra plans. For Bronze Extra plans the PCP office copay is \$40 and the specialist office copay is \$75. (*Applies to Blue Care Network only.*)

Blue Cross will continue to offer the Premier and Multi-State PPO. The plan gives members a broad choice of doctors and hospitals in the Blue Cross statewide PPO network, including nationwide coverage. Members may receive services from hospitals or doctors outside the network, but will pay less if they use in-network providers.

New Medicare Advantage product

BCN Advantage ConnectedCare HMO is a new individual Medicare Advantage HMO product with an exclusive provider network developed primarily around Southeast Michigan and Kalamazoo County. Open enrollment for Medicare Advantage began on Oct. 1, 2014 for a Jan. 1, 2015 effective date. (For details about BCN Advantage ConnectedCare HMO, see the article on **Page 20.**)

Check member eligibility and benefits

Providers should be sure to check eligibility and benefits before providing services. It's important to check both the plan name and the network associated with the plan. For local plans, such as the Metro Detroit HMO, providers need to refer within the local network. For information about how to find the Blues plans you are contracted to provide services for, see the PDF below.



[Finding your Blues plans PDF](#)

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

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Blue Cross Metro Detroit HMO provides new low-cost coverage to individuals in Southeast Michigan

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Blue Care Network is offering a new, affordable HMO individual coverage option for 2015, Blue Cross[®] Metro Detroit HMO. The product will be offered to individuals residing in three counties – Oakland, Macomb and Wayne – with gold, silver and bronze options. The HMO product will be offered both on and off the Health Insurance Marketplace. Individuals can purchase the product during open enrollment, Nov. 15, 2014 through Feb. 15, 2015, with coverage beginning Jan. 1, 2015, or later depending on the date of purchase.

The new Blue Cross Metro Detroit HMO product is priced to appeal to people in the three counties seeking affordable health insurance and care coordinated through local doctors and hospitals. Metro Detroit HMO has a local network that is a subset of the larger BCN provider network. The local network includes primary care physicians from the medical care groups listed below. Members must select a PCP contracted within the local network. The PCP will coordinate care with local network specialists and hospitals.

The Metro Detroit HMO local network includes PCPs from these medical care groups:

- Accountable Healthcare Advantage
- Macomb St. Clair Primary Physicians Group
- Medical Network One
- Midwest Medical Center, P.C.
- Oakland General Associates
- Oakland Southfield Physicians Group
- Oakwood Accountable Care Organization
- Providence Partners in Mission
- St. John Macomb PHO
- St. John Physician Hospital Organization
- St. John River District
- United Physicians



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Metro Detroit HMO, continued from Page 3

The Metro Detroit HMO local network includes these hospital systems and hospitals:

- St. John Providence Health/Ascension
 - St. John Hospital and Medical Center (Detroit)
 - Providence Hospital (Southfield)
 - St. John Macomb – Oakland Hospital Macomb Center
 - St. John Macomb – Oakland Hospital Oakland Center
 - St. John River District Hospital (East China)
- Oakwood Healthcare System
 - Oakwood Hospital and Medical Center
 - Oakwood Southshore Medical Center
 - Oakwood Annapolis Hospital
 - Oakwood Heritage Hospital
- Trinity Health
 - St. Joseph Mercy Hospital Ann Arbor
 - St. Joseph Livingston Hospital (Howell)
 - St. Mary Mercy Hospital Livonia
 - St. Joseph Mercy Oakland Hospital (Pontiac)
- Detroit Medical Center
 - Huron Valley – Sinai Hospital
 - Sinai-Grace Hospital
 - Harper University/Hutzel Women’s
 - Children’s Hospital of Michigan
 - Detroit Receiving Hospital
 - Rehabilitative Institute of Michigan
- Botsford Hospital

You can view network doctors and specialists in more detail by doing a search on the *Find a Doctor* feature on bcbsm.com.

When Metro Detroit HMO members are referred for services within the Metro Detroit HMO local network, standard BCN referral and clinical review requirements apply. Services performed outside the Metro Detroit HMO local network require authorization by BCN, even if the providers are in the larger BCN network. The only exception to this is for urgent and emergent services.

Women are required to use obstetrician-gynecologist providers in the network. If they wish to visit an OB-GYN outside the network, services require clinical review.

Pharmacy coverage uses the Custom Select Drug List. The ID card will feature MyBlueSM in the upper right portion of the card, signifying that this is an individual Blues product, with the full product name in the lower left. The Metro Detroit HMO product names include:

- Blue Cross[®] Metro Detroit HMO Gold Extra
- Blue Cross[®] Metro Detroit HMO Silver Extra
- Blue Cross[®] Metro Detroit HMO Silver
- Blue Cross[®] Metro Detroit HMO Bronze Extra
- Blue Cross[®] Metro Detroit HMO Bronze

See also these related articles:

- [Blue Cross introduces Metro Detroit EPO](#)
- [BCN Advantage introduces ConnectedCare HMO local network](#)
- [The Blues to offer a variety of individual products for 2015](#)

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Blue Cross introduces Metro Detroit EPO

The Blues are partnering with health care providers in Southeast Michigan to offer cost-conscious consumers affordable, coordinated care through localized networks.

The Metro Detroit exclusive provider organization, or EPO, network includes 25 hospitals and more than 6,300 doctors located in Livingston, Macomb, Oakland, St. Clair, Washtenaw and Wayne counties. It's part of our ongoing efforts to increase access to high-quality, lower cost health care for Michigan residents.

Here are three important points to keep in mind:

- Other than eligible emergency services and accidental injuries, members who have enrolled in a Metro Detroit EPO plan **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**. You can use the **Find a Doctor** search tool on **bcbsm.com** to verify that a doctor or hospital is in this network.
- Be sure your office staff knows if you are in this localized network.

Product names include:

- Blue Cross® Metro Detroit EPO Gold Extra
- Blue Cross® Metro Detroit EPO Silver Extra
- Blue Cross® Metro Detroit EPO Silver
- Blue Cross® Metro Detroit EPO Bronze Extra
- Blue Cross® Metro Detroit EPO Bronze

These products will be available to consumers beginning Nov. 15, when open enrollment begins, for coverage effective Jan. 1, 2015. They can be purchased on the **Health Insurance Marketplace** and directly through Blue Cross or independent insurance agents.

Participating hospitals include:

- Detroit Medical Center
 - DMC – Sinai Grace
 - DMC – Rehab Institute of Michigan
 - DMC – Huron Valley Sinai
 - DMC – Children's Hospital
 - DMC – Harper-Hutzel
 - DMC – Detroit Receiving
- Oakwood Healthcare
 - Oakwood Hospital Dearborn
 - Oakwood Hospital Southshore
 - Oakwood Hospital Taylor
 - Oakwood Hospital Wayne
- St. John Providence Health System
 - St. John Macomb – Oakland Hospital Macomb Center
 - St. John Macomb – Oakland Hospital Oakland Center
 - St. John River District Hospital
 - St. John Hospital and Medical Center
 - Providence Park Hospital
 - Providence Hospital
- Saint Joseph Mercy Health System/ Trinity Health
 - St. Joseph Mercy – Oakland
 - St. Joseph Mercy – Ann Arbor
 - St. Joseph Mercy – Livingston
 - St. Joseph Mercy – Port Huron
 - St. Mary Mercy Hospital – Livonia
 - St. Joseph Mercy – Chelsea
- Botsford Hospital
- Garden City Hospital
- Stonecrest Center for Behavioral Health
- Straith Hospital for Special Surgery

Blue Care Network continues to offer PCP Focus in 2015

Blue Care Network will continue to offer its local network plan, PCP Focus. It will continue to be available on the Health Insurance Marketplace to individuals and groups with 50 or fewer full-time equivalent employees, and off the Marketplace to groups with one to 99 employees with a physical location in one of the defined counties. The network product also will be offered to individuals on and off the Marketplace. When it is sold as an individual product, it is identified as Blue Cross® Select.

The network can be paired with many different BCN products and offers members a choice of more than 3,000 primary care physicians located across these 21 counties: Bay, Kalamazoo, Ottawa, Calhoun, Kent*, Saginaw, Clinton, Livingston, Shiawassee, Eaton, Macomb, St. Clair, Genesee, Monroe, Van Buren, Ingham, Muskegon*, Washtenaw, Jackson, Oakland and Wayne.

BCN first introduced the PCP Focus network in 2011 in seven Southeast counties. Members must select a primary care physician from the PCP Focus network in order for services to be covered. The primary care physician can refer the member to any BCN-affiliated hospital and specialist.

Providers can identify members who have the PCP Focus option by checking eligibility and benefits on web-DENIS. For members who have this option, "FOCUS" or FOCUS1 will be listed as one of the riders in the Certificate/Rider area of the Medical Benefits screen. The FOCUS rider applies to group and the FOCUS1 rider applies to individual coverage. ID cards for individual members identify the product as Blue Cross Select.

* In these two counties (Kent and Muskegon), the PCP Focus network is available only for groups, not individual members.

Embedded coinsurance maximum introduced for 2015

Beginning Jan. 1, 2015, groups can add a new rider to their benefits to include something new – an embedded coinsurance maximum.

What is an embedded coinsurance maximum?

Coinurance is a percentage of the cost of a service that the member is responsible for paying. A coinsurance maximum provides a maximum dollar amount that the member will pay for coinsurance. Once the coinsurance maximum is reached, the member will no longer pay coinsurance for the rest of the benefit year, with the exception of certain services that are exempt from the coinsurance maximum (see list at right). The coinsurance maximum is considered to be "embedded" because one member on a two-person or family contract cannot contribute more than the individual maximum amount.

The embedded coinsurance maximum will also count toward the out-of-pocket maximum along with the deductible and all other cost-sharing.

You will know whether a member has an embedded coinsurance maximum by looking at the medical benefits description page on web-DENIS. If the member has a coinsurance maximum, you will see "coinsurance maximum" listed along with the specific dollar amounts for that contract and the list of exclusions noted below.

Items that are exempt from the coinsurance maximum include:

- Deductible amounts
- Diabetic supplies
- Durable medical equipment
- Elective abortion (if covered)
- Infertility services
- Male mastectomy
- Male sterilization
- Services with a flat dollar copayment
- Orthognathic surgery
- Prosthetics and orthotics
- Reduction mammoplasty
- Temporomandibular joint dysfunction
- Weight reduction procedures



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Checking member eligibility and benefits is crucial

We've always stressed the importance of checking member eligibility and benefits every time you provide services. With health care reform, checking eligibility and benefits is even more crucial because more members are purchasing their health care coverage directly from the Blues or through the Health Insurance Marketplace.

These individuals will receive ID cards once they enroll, but their coverage will not be active until they pay their first month's premium and their effective date occurs.

- **Effective date** – In some cases, these members will have their ID cards a month or two before the effective date. If they try to use their cards before the effective date, they will not have coverage.
- **Premium unpaid** – If a member does not pay the first monthly premium, the coverage will not become effective. If a member pays the first payment but later becomes delinquent, coverage could cease. Note that there are special regulations regarding members with government subsidized premiums.
- **Coverage changes** – A member can sign up for coverage but later change that coverage. Individual members can change coverage for any reason during the open enrollment period. This year, the open enrollment period runs from Nov. 15, 2014 through Feb. 15, 2015. After that, members with a qualifying event may still be able to change coverage. So a member may not keep coverage but could still present an ID card for services.

Always check your patients' eligibility

The bottom line is that possession of a Blues ID card does not necessarily mean the member has coverage that is currently in effect. While this has always been the case, you may find more situations where ID cards are presented for coverage that is not in effect. Be aware that the Blues will not reimburse claims for treatment that is not in effect at the time of service.

As a reminder, there are three ways to check eligibility and benefits:

- Online using web-DENIS
- By calling our automated phone system, PARS (formerly CAREN)
- By calling Provider Inquiry

For more information, open the **BCN Provider Resource Guide** and click on *Benefits and Eligibility*.



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How to tell if you're providing services for a BCN or Blue Cross member

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You may remember that in 2014, all plans listed on the Marketplace carried the name “Blue Cross” whether they were actually a Blue Cross plan or a Blue Care Network plan. On occasion, this caused some confusion for members and providers. Here’s a chart that shows the plan names for Blue Cross and BCN for 2015. You can check which plans you accept by using the **Find a Doctor** feature on **bcbsm.com**. You should always check the name of the plan on the member’s ID card and confirm that you accept that plan before providing services.

| BCBSM Plans | BCN Plans |
|--|-------------------------------|
| Blue Cross® Premier | Blue Cross® Select |
| Blue Cross® Metro Detroit EPO | Blue Cross® Partnered |
| Blue Cross® Multi-State Plans | Blue Cross® Preferred |
| Blue Cross® Premier Value (Catastrophic) Plans | Blue Cross® Metro Detroit HMO |

- BCBSM plans have the word “Premier” or “EPO” or “Multi-State Plan” in their names.
- BCN plans have the word “Select” or “Partnered,” or “Preferred” or “HMO” in their names.



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The Blues make it easier for members to manage their own health plan at bcbsm.com

To help your Blues patients understand and better manage their health coverage, we encourage them to register at bcbsm.com, so you and your staff can spend less time handling benefit questions and more time providing quality health care. You may want to remind them too.

When members create an account at bcbsm.com and log in, they have access to:

Personal snapshot of their plan: Your patients with Blues coverage can go online and check out easy-to-understand charts that show deductible and coinsurance information, recent claims activity and other important cost information that will help them better understand what they may owe you after visiting your office. They can access their claims information on-demand and retrieve *Explanation of Benefits* statements before they arrive in the mail.

Virtual ID card: Now, when members forget to bring their Blues ID cards to their appointments, they can easily log in to their account at bcbsm.com through their mobile device and show their virtual ID card to you as proof of coverage. Access to this great feature and other plan information is available 24 hours a day, seven days week with a mobile device.

Powerful doctor and hospital search: Members can find doctors or hospitals that accept their coverage with our Find a Doctor feature at bcbsm.com. They can search by location, specialty, extended office hours, languages spoken and more, and even read reviews from other patients and leave reviews of their own. Plus, we've made it easy for them to compare quality for more than 400 health services across the country. Our Find a Doctor has the ability to bring you additional patients more suited to your specialty.

If you would like more information about the benefits of our site for your Blues patients, contact your provider consultant.





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CAREN has been replaced by improved IVR system called PARS

A new and enhanced interactive voice response system called the Provider Automated Response System, also known as PARS, has replaced CAREN.

We've transitioned to PARS in phases:

- On Sept. 15, 2014, the vision and hearing lines of business moved to PARS.
- On Sept. 23, 2014, professional, facility, BCN and Medicare Advantage moved to PARS.
- The Federal Employee Program® will move to PARS during the first quarter of 2015. We'll notify you of the date as we get closer to the transition.

All phone numbers will remain the same and the format of the calls will be similar, although you will hear a new "voice." And some categories will have different names; for example, OB/GYN will become "Women's Health."

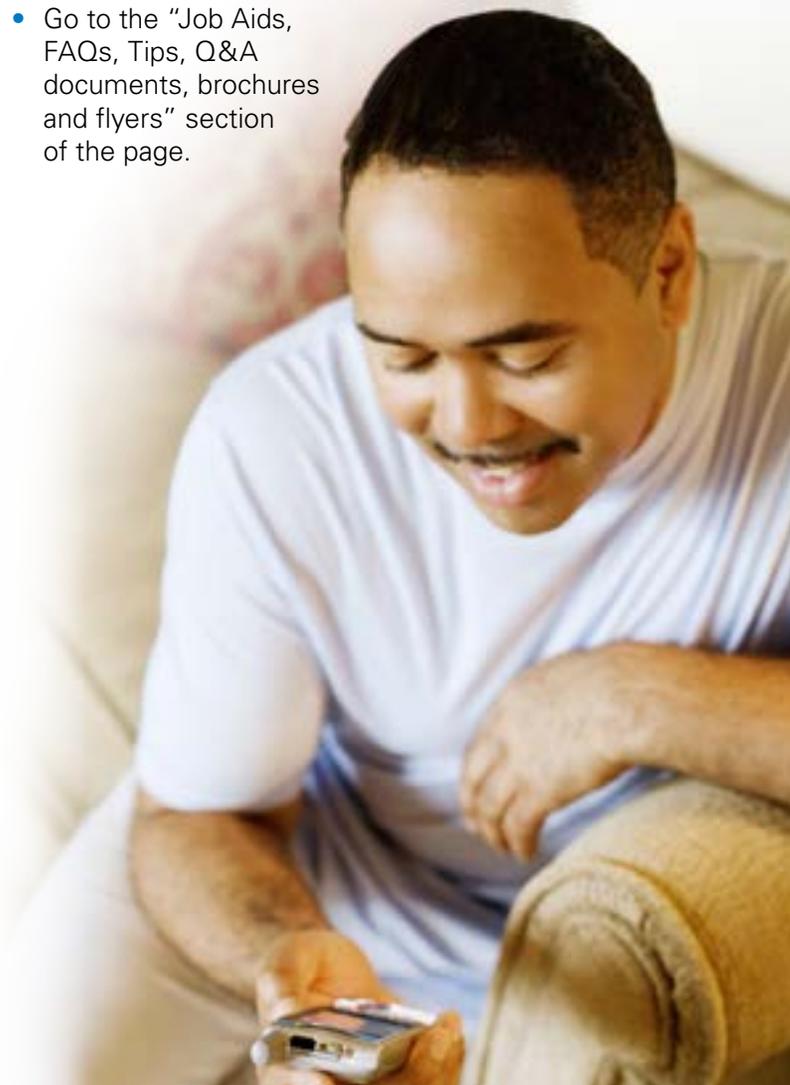
PARS features many enhancements to improve your experience, including:

- Speech recognition
- Improved process for collecting and associating email addresses with your fax number. If you already set up your email address, it will carry over to PARS.
- An improved format for fax and email documents (Please note that BCN does not have the fax and email options.)
- Multiple Inquiry Routing Selection — If you request a transfer after multiple inquiries on the IVR, you can select the specific contract you want to transfer to for accurate routing.

If you have any questions or feedback about PARS, contact us at PIBS@bcbsm.com.

Updated PARS "Navigating with Ease" brochures are available on web-DENIS. To access them:

- From the web-DENIS homepage, click on *BCBSM Provider Publications and Resources*.
- Click on *Newsletters & Resources*.
- Click on *Provider Training*.
- Go to the "Job Aids, FAQs, Tips, Q&A documents, brochures and flyers" section of the page.





Reminder: Members in Blue Elect Plus plan do not need referrals

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Providers do not need to give referrals to Blue Care Network members enrolled in the Blue Elect PlusSM product. Members covered by this product select a primary care physician and may choose to self-refer to any in-network or out-of-network Michigan provider. Members have the lowest out-of-pocket costs when their care is provided by their primary care physician or by another provider in the BCN network.

If a member self-refers to a provider outside the BCN network, but within Michigan, the member is responsible for a higher deductible and coinsurance and for any amount charged by the nonparticipating provider that exceeds the BCN-approved amount.

Members may also see any primary care physician in BCN's network, but will pay a specialist copayment when seeing a PCP who is not affiliated with the primary care physician they select.

The member's provider information card gives an overview of the billing and care management requirements for participating and nonparticipating providers. Providers should place a copy of both the member's ID card and the provider information card in the member's file. You can access the provider information card on the web-DENIS BCN Products page.

Tips:

- BCN requires benefit or clinical review in advance, regardless of network affiliation.
- Check member benefits on web-DENIS under *Subscriber Info*.
- Check clinical review requirements on web-DENIS in *BCN Provider Publications and Resources* on the *Care Management and Referrals* page or on our e-referral website at ereferrals.bcbsm.com by clicking on **Clinical Review & Criteria Charts**.

Care Management requirements

The requirements for plan notification and benefit and clinical review apply whether services are performed by in-network or out-of-network providers. Please refer to the Blue Care Network Referral and Clinical Review program for guidance.

In addition, the following requirements may apply:

- If a specific service is not available from an in-network provider and the member wishes to see an out-of-network provider, the provider must request clinical review and receive approval from BCN Care Management for the member to receive the in-network benefit.
- If a member wishes to see an out-of-network provider for a service that normally requires clinical review, the out-of-network provider must contact Care Management to obtain clinical review prior to obtaining the service.
- Clinical review is required for members to see a neurosurgeon or orthopedic surgeon as part of the Spine Care Referral Program.

Plan notification or clinical review is also required for the following services:

- Maternity: up to 48 hours following routine delivery or 96 hours following C-section
- Chiropractic services
- Spine Care Referral Program — Clinical review is required for all members for the initial visit to a spine care specialist and for office visits and procedures.

If you have questions, call BCN Provider Inquiry: 1-800-255-1690

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Reminder:

Healthy Blue Living members who complete their requirements move to the enhanced benefit level retroactively

We told you in the **Nov.-Dec. 2013** issue that Blue Care Network changed its Healthy *Blue Living*SM products as of Jan. 1, 2014, to comply with the Affordable Care Act.

As a reminder to our providers, renewing members who began the plan year at the standard level and achieve the enhanced level during the qualification period are being retroactively moved to the enhanced level effective the first day of their plan year.

Previously, these members would have moved to the enhanced benefit level effective the 91st day of the plan year.

You should be aware that BCN has continued to process claims for members who moved to an enhanced benefit level after the first 90 days in the plan. That means you may be responsible for returning money to some members because their deductibles, copayments and coinsurance have been retroactively adjusted.

Blue Care Network provides office staff incentives for tobacco cessation campaign

Blue Care Network is offering incentives for members, office staff and providers to distribute information to patients about tobacco cessation resources.

The incentives are part of our healthy lifestyle campaign aimed at decreasing the percentage of our members who smoke and use tobacco.

Provider office staffs have a chance to win \$500 in gift cards just by handing out our *Quit Guide* and Tobacco Use surveys. Every month, Blue Care Network will choose a member from the completed surveys to receive the \$250 gift card. When the member verifies the PCP office they visited through the survey, the staff members at that office automatically win \$500 in gift cards. See the FAQs PDF below for details about the contest.

Information about the smoking cessation program can be found in the **Sept.-Oct. issue**, Page 1.



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BCN offices closed for holiday

Blue Care Network offices will be closed on Nov. 27 and 28 for the Thanksgiving holiday and on Dec. 24 – 26 for the Christmas holidays.



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 releases videos to improve member experience

Blue Care Network has developed our last educational video for the year to help improve members' experiences. Earlier in the year, we produced *Getting Started* and *About Your Primary Care Physician* which we highlighted in the May-June issue. Two additional videos were featured in our September-October issue: Healthy *Blue Living*TM and Provider Networks.

The newest video, *Pharmacy*, stars BCN employees and gives members important information about how our pharmacy programs work and how to get the most from their pharmacy benefit.

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

Getting Started With Your HMO - YouTube



www.youtube.com/watch?v=qYfx6YCvKc

Jan 31, 2014 - Uploaded by Blue Cross Blue Shield of Michigan

If you're new to **Blue Care Network**, watch this video to learn about primary care physicians, referrals and ...



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Making changes or updates to facilities

If you are making changes to your primary or additional locations or you need to add an additional location, the following credentialing elements and documentation must be submitted along with your change request:

- Completed and signed Facility or Allied Change Form
- Medical director (M.D., D.O. or physical therapist for occupational physical therapy) with a valid state license and in good standing
- Valid facility state license
- Valid pharmacy license (for ambulatory infusion centers)
- Both general and professional liability malpractice insurance
- Accreditation or a current Centers for Medicare & Medicaid Services certification
- CLIA Certificate, if applicable

Changes can be made at bcbsm.com.

Reminder: Upon recredentialing, completion of the application is a BCBSM/BCN program requirement. All requested documents along with the recredentialing application must be received within 30 days of receipt of the request.

For questions about recredentialing only, please email profcredentialing@bcbsm.com.

Don't forget to reattest with CAQH every 120 days

Did you know that if you don't reattest with CAQH® every 120 days, you won't be included in our provider directories, including our "Find a Doctor" search tool?

That's one of the main reasons it's so important to take the time to perform this task.

Here are some other reasons to reattest with CAQH, a nonprofit alliance of health plans and trade associations focused on simplifying health care administration:

- To ensure that your affiliation with the Blues isn't interrupted
- To update your CAQH information if you change your practice location
- To ensure that claims payment isn't interrupted

Blue Cross Blue Shield of Michigan uses CAQH to gather and coordinate our practitioner credentialing information.

All health care practitioners, including hospital-based health care providers and nurse practitioners, need to be registered with CAQH.

If you have any questions about CAQH, call the CAQH help desk at 1-888-599-1771 or go to CAQH.org. For information about the credentialing process, contact your provider consultant.

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New physical therapy laws won't change Blues' policy

Michigan legislation related to direct access to physical therapy was signed into law in July 2014. Public Act 260 allows physical therapists to treat patients without a prescription from a licensed health care professional. But Public Acts 261-264 permit insurers to cover only prescribed physical therapy services.

As a result, the Blues will continue to adhere to our current medical policy and existing processes by requiring a prescription for physical therapy services.

Here's additional background about the laws:

- PA 260 will take effect on Jan. 1, 2015. Treatment allowed under this act is covered for 21 days or up to 10 treatments, whichever occurs first. Treatment is also covered when the patient seeks therapy to prevent injury or promote fitness.
- PA 261-264, which took effect on July 1, 2014, overrides PA 260 by allowing an insurer to require a prescription for physical therapy services to be covered.

Private duty nursing is a covered benefit for State of Michigan employees

Private duty nursing is a covered benefit for State of Michigan employees. To be eligible for private duty nursing, the member's care must be individualized, required on a 24-hour basis and be more intense than services typically provided under the home health care benefit.

The goal of private duty nursing is to facilitate the transition of care, helping the family and caregivers to be as competent and independent as possible in the care of the patient. It is expected the family and caregivers will provide a minimum of eight hours of care each day.

Private duty nursing requires clinical review and services must be ordered by a licensed physician. Beginning Oct. 1, 2014, private duty nursing care must also be preauthorized by BCN.

Blue Care Network pays the lesser of our rate or your submitted charges for PT, OT, ST therapy

Blue Care Network is changing the way we pay for physical, occupational and speech therapy. Starting Oct. 1, 2014 for BCN commercial and Jan. 1, 2015 for BCN AdvantageSM members, we will pay the lesser of our rate or your submitted charges. While this "lesser of" payment policy is already specified in provider contracts, BCN had previously paid our rate even when the provider had billed at a lower rate for these services.

The change applies to all providers who are reimbursed following the BCN professional fee schedule and the BCN Advantage physician fee schedule.

This change does not apply to PT, OT or ST for autism spectrum diagnoses.

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Enrollment for BCBSM and BCN's new freestanding radiology center networks began Oct. 1

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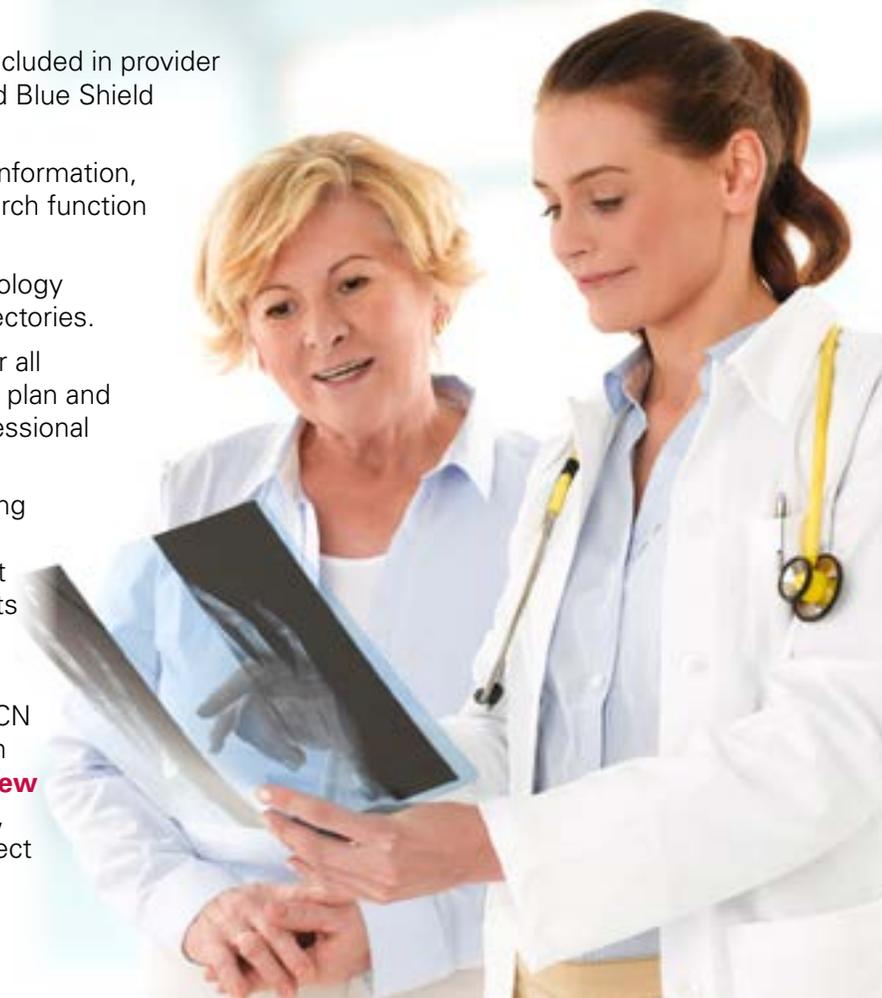
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Blue Care Network and Blue Cross Blue Shield of Michigan are establishing freestanding radiology center networks that will create the capability to uniquely recognize and reimburse freestanding diagnostic imaging services providers. BCN and BCBSM members will have access to the new networks, beginning Jan. 1, 2015.

Eligible freestanding radiology centers, including those owned by hospitals, are encouraged to begin applying for enrollment in the BCN Freestanding Radiology Centers and BCBSM Traditional networks on Oct. 1, 2014. All freestanding radiology centers participating in the BCBSM Traditional network will be considered in-network for PPO members, and out-of-network sanctions will be waived.

- Participating freestanding radiology centers will be included in provider directories at **bcbsm.com** and on the Blue Cross and Blue Shield Association® website.
- Provider-specific freestanding radiology center cost information, by procedure, will be available using the provider search function on **bcbsm.com**.
- Members will be able to search for freestanding radiology centers and their cost information in the provider directories.
- Freestanding radiology centers will be reimbursed for all diagnostic imaging services that are approved by the plan and are covered benefits using the applicable plan's professional fee schedule.
- Diagnostic imaging services performed in freestanding radiology centers in the BCBSM Traditional network will be subject to the current Radiology Management Program preauthorization and privileging requirements for members whose groups have the Radiology Management Program.
- Freestanding radiology centers participating in the BCN network will need to follow requirements specified in the **Blue Care Network Referral and Clinical Review Program** for standard radiology services. In addition, BCN freestanding radiology centers also will be subject to **high-tech radiology services preauthorization requirements** administered by CareCore National.

As part of the enrollment process, Blue Cross providers will be required to enroll in the AIM Specialty Health **OptiNet** assessment tool. **OptiNet** collects information on the provider's imaging equipment, staffing credentials, and safety and quality assurance programs. For information, see the October issue of **The Record**.





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BCN Advantage open enrollment period has begun

The Centers for Medicare & Medicaid Services annual enrollment period for Medicare Advantage began on Oct. 15 and runs through Dec. 7, 2014 for Jan. 1, 2015 coverage.

Please be aware that members may be calling your office to see if you participate in BCN AdvantageSM.

We have made changes to some of our plans for 2015. We have also introduced a new plan, BCN Advantage ConnectedCare HMO, and have discontinued BCN Advantage Local. Members who were in BCN Advantage Local will be transitioned to ConnectedCare. (See articles on [Page 20](#) for details.)



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BCN Advantage benefit changes for 2015

BCN AdvantageSM is offering six plans for 2015, including ConnectedCare, a new plan that replaces BCN Advantage local. In addition, we are making some changes to deductibles, copayments and supplemental benefits that providers should be aware of.

The plans for 2015 are:

- Elements
- Basic
- Classic
- Prestige
- My Choice Wellness HMO
- BCN Advantage ConnectedCare HMO – BCN Local members will be transitioned to the new ConnectedCare plan unless they choose another plan. See **Page 20** for details about ConnectedCare.

Most of the plans have certain benefits in common:

- Members in any BCN Advantage plan can purchase optional supplemental dental/vision/hearing benefits. The hearing benefit was removed from base coverage but added for 2015 to the optional supplemental buy-up. It includes non-Medicare covered hearing benefits.
- All plans include MTM Transportation benefit. The benefit was added to the Basic plan for 2015.
- All plans include bathroom safety items through Northwood (see sidebar).
- The SilverSneakers fitness benefit is included in all plans, except for Elements.

Here are some of the medical benefit changes to the plans:

- Although the copay amount for inpatient care is not changing, in 2015 members will be assessed the copay for days 1-6 instead of 1-5. Cardio and pulmonary rehabilitation has moved from specialist to therapy copayments, which results in a lower copayment for these services
- Copayments are increasing for skilled nursing benefits. For days 21 to 100, copayments have increased from \$130 to \$150
- The copayment for ambulance services are increasing to \$100 for Classic and Prestige

Please see [BCNA benefit changes](#), continued on Page 19

My Choice Wellness HMO

This HMO will continue to be offered in Kent, Muskegon and Oceana counties. The network includes Mercy-affiliated providers and network hospitals. There is no copayment for office visits and no deductible.

MyChoice is a provider-specific network. The following Mercy Health-affiliated provider network hospitals are included:

- Mercy Health — Mercy Campus, Muskegon
- Mercy Health — Hackley Campus, Muskegon
- Mercy Health — Lakeshore Campus, Shelby/Hart
- Mercy Health — Saint Mary's Campus, Grand Rapids

It includes the following benefits:

- MTM Transportation — 36 round trip non-emergency transportation
- SilverSneakers fitness benefits
- Worldwide urgent care and emergency benefits
- Preventive dental
- Routine eye exams

For plan details, benefit specifics, premiums and payment tables, please refer to the **BCN Advantage Web** pages.

Bathroom safety items

All BCN Advantage plans include non-Medicare covered bathroom safety items. The in-network benefit for bathroom safety items is 50 percent coinsurance for up to \$100 combined annual maximum.

Members can obtain one or a combination of five safety items. The items include

- Shower grab bar
- Bath tub grab bar
- Bench
- Commode rails
- Elevated toilet seat

A physician's order is required for the benefit. Safety bars can only be purchased through our durable medical equipment supplier, Northwood. The benefit does not include installation.

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BCNA benefit changes, continued from Page 18

Elements and Basic plans

- We removed \$25 copayment for days 1 to 20 for skilled nursing benefits for both plans.
- We added a transportation benefit through MTM for Basic Plan (36 round trips).
- Members who enroll in Basic will receive a Part B premium credit of \$3.50, which will be reflected in their Social Security checks.

Classic and Prestige

- The embedded vision benefit no longer has a \$10 copayment for eyeglasses (lenses and frames) and contact lenses.

Part D accumulators and coverage gap changing

- The initial coverage limit or threshold before members enter into the Part D gap, otherwise known as the donut hole, is changing from \$2,850 to \$2,960. The True-Out Of-Pocket threshold to be reached before members exit the Part D gap and enter the Catastrophic phase of the Part D benefit, is changing from \$4,550 to \$4,700

Prescription drug benefits

There are several changes in prescription drugs benefits that will affect individual BCN AdvantageSM members.

We encourage providers to check members' drug lists before prescribing. Some drugs were removed from our drug lists. Others may require step therapy or prior authorization for new prescriptions.

Transition period for members

Physicians can use the 90-day transition period for patients whose formularies are changing. BCN allows members to obtain one 34-day fill for prescriptions that now require prior authorization, step therapy or quantity limits or that are non-formulary. Members or physicians can request formulary exceptions during this 90-day period or switch to another formulary medication so the patient's drug therapy is not interrupted.

BCN Advantage has expanded its service area for Individual and Group plans

We are expanding the service area for BCN Advantage Individual plans for 2015. Effective Jan. 1, 2015, BCN Advantage plans will be offered in six additional counties and one partial county (St. Joseph.) The six counties are Alpena, Benzie, Charlevoix, Emmett, Leelanau and Lenawee.

St. Joseph County includes only the following Zip codes: 49011, 49030, 49052, 49072, 49093 and 49097.

In addition, the Centers for Medicare & Medicaid Services has approved an expansion of our group service area to the entire Upper Peninsula.

BCN Advantage currently has almost 62,000 members enrolled in 59 counties throughout Michigan. As of 2015, BCN Advantage will service members in 66 counties, including one partial county (St. Joseph).



[BCN Advantage Service Area Map PDF](#)



[BCN Advantage ConnectedCare Service Area Map PDF](#)



[BCN Advantage MyChoice Service Area Map PDF](#)



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BCN Advantage introduces ConnectedCare HMO local network

BCN AdvantageSM is introducing a new plan for 2015 enrollment, called BCN Advantage ConnectedCare HMO. ConnectedCare is an individual Medicare Advantage local HMO offered in seven counties in southeast Michigan and Kalamazoo. The counties include Genesee, Kalamazoo, Livingston, Macomb, Oakland, St. Clair, Washtenaw and Wayne. Members must reside in these counties for at least six months of the year. Open enrollment began in October for a January 2015 effective date.

BCN Advantage is closing BCN Local, a local network HMO for Wayne County members. Current BCN Local members will be automatically enrolled in ConnectedCare unless they choose another plan.

ConnectedCare is a partnership backed by local doctors and hospitals affiliated with Oakwood ACO — a partnership between Oakwood Healthcare and affiliated, private and employed physicians — and Together Health Network, an integrated group of physicians in partnership with Ascension Health Michigan and CHE Trinity Health, two of the largest health systems in Michigan. The product includes more than 5,000 providers and 20 hospitals across the state.

Members must select a ConnectedCare primary care physician. Any referrals for services should remain within the local ConnectedCare network whenever possible. Standard BCN Advantage referral and clinical review program requirements apply as long as the provider is in the ConnectedCare network. Clinical review is required for any service provided outside of the ConnectedCare network, even if the provider is part of the larger BCN Advantage network. Exceptions to this requirement include urgent and emergent care, ambulance services, out-of-area dialysis and Part B vaccine services; normal copayments apply.

Providers can check their network status at **bcbsm.com/find-a-doctor**. The provider page lists the plans accepted by the provider. Contact your provider consultant if you need assistance.

Members can find providers on **bcbsm.com**.

- Go to Provider Search
- Click on *BCN Advantage*
- Click on *ConnectedCare HMO*

Remember to always check member eligibility and benefits before providing services. Local networks do not permit referrals outside of the specific network.



Blue Care Network of Michigan **BCN AdvantageSM HMO ConnectedCare**

| | |
|---|-------------------------------|
| Enrollee Name FIRST M LASTNAME JR | RxBIN: 610014 |
| Enrollee ID XYK888888888 | RxPCN: MEDDPRIME |
| Issuer (80840) 9101000021 | RxGrp: BCNRXPD |
| Group Number 00277566 | Rx ID: XXXXXXXXXXXX |
| | CMS Plan H5883 007 |

MEDICARE ADVANTAGE | **HMO**

Medicare^{Rx}
Prescription Drug Coverage

www.bcbsm.com/bcna

| | | |
|--|--|--|
| Blue Care Network of MI Anonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association | Customer Service: 800-450-3680 TTY/TDD: 711 | |
| Providers in Michigan, file hospital and medical claims with: BCN Advantage P.O. Box 68753 Grand Rapids, MI 49516-8753 | If you suspect fraud: Mental health/substance abuse treatment: 800-431-1059 | |
| Pharmacy claims, file with PBM: ATTN: Medicare Part D P.O. Box 2858 Clinton, IA 52733-2858 | Providers Only: Provider Services: 800-255-1690 Medical Authorizations: 800-392-2512 Rx Authorizations: 800-437-3803 Pharmacy Services: 800-922-1557 | |

Medicare limiting charges apply. Use of this card is subject to terms of applicable contracts, conditions and user agreements. Misuse may result in prosecution.

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ConnectedCare HMO, continued from Page 20

ConnectedCare does not have the BlueCard travel benefit. However, emergency, urgent care, ambulance and dialysis services are covered worldwide. There are no other services provided outside of Michigan as a benefit for ConnectedCare.

ConnectedCare has no medical or pharmacy deductibles, \$0 copay for primary care visits, and includes Part D coverage. Benefits also include extras such as routine vision exams, preventive dental, non-emergency transportation, SilverSneakers® fitness benefit and coverage for bathroom safety bars.

Some of the plan's features include the following:

- No charge for primary care office visits
- No deductibles
- Low out-of-pocket costs
- Prescription drug coverage with no deductible
- Eye exams
- Preventive dental
- Transportation to medical appointments (36 round trips)
- SilverSneakers fitness membership
- Ascension, Trinity and Oakwood provider network
- More than 20 hospitals and 5,000 physicians (see sidebar)

ConnectedCare features prescription drug coverage with no deductible through network pharmacies and a 90-day supply of most prescription drugs through retail network pharmacies or mail order from Walgreens or Express Scripts.

ConnectedCare Participating Ascension, Trinity and Oakwood Hospitals

Together Health Hospitals

• Saint Joseph Mercy Health System

- St. Joseph Mercy – Ann Arbor
- St. Joseph Mercy Chelsea
- St. Joseph Mercy – Livingston (Howell)
- St. Joseph Mercy – Oakland (Pontiac)
- St. Joseph Mercy – Port Huron
- St. Mary Mercy Hospital – Livonia

• Borgess Health

- Borgess Medical Center (Kalamazoo)
- Borgess Pipp Hospital (Plainwell)
- Borgess Lee Memorial Hospital (Dowagiac)

• Genesys Regional Medical Center (Grand Blanc)

• St. John Providence Health System

- Providence Hospital (Southfield)
- Providence Park Hospital (Novi)
- St. John Hospital and Medical Center (Detroit)
- St. John Macomb – Oakland Hospital Macomb Center (Warren)
- St. John Macomb – Oakland Hospital Oakland Center (Madison Heights)
- St. John River District Hospital (East China)

Oakwood Health System

- Oakwood Annapolis Hospital
- Oakwood Heritage Hospital
- Oakwood Hospital and Medical Center
- Oakwood Southshore Medical Center

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Reminder: Conduct patient visits by year-end to close diagnosis gaps for 2014 incentive program

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Blue Cross Blue Shield of Michigan and Blue Care Network are nearing the conclusion of this year’s Diagnosis Closure Incentive Program for primary care physicians who close diagnosis and treatment opportunity gaps for their Blues Medicare Advantage patients. Here are the details you need to know.

Be sure to see your Blues Medicare Advantage patients before the end of the year to document and close diagnosis and treatment opportunity gaps. It’s important that all member conditions are addressed each year during an office visit and that diagnosis code data is accurately documented and reported, following MEAT (manage, evaluate, assess and treat) guidelines to support medical necessity.

Information about gap closures should be submitted via Health e-BlueSM under *Panel – Diagnosis Closure and Treatment Opportunities by Condition/Measure Panel* by Jan. 22, 2015. You may also submit a claim as part of your documentation. In addition, if you received a paper *Member Diagnosis Closure and Treatment Opportunities* report in the mail, you should fax it to 1-866-707-4723.

Be sure that you are closing a diagnosis gap **only** if you have conducted an office visit and the patient no longer has the suspected (or historic) condition. A gap cannot be closed because you are not actively treating the condition.

Diagnosis and treatment opportunity closures must be submitted to the Blues by the following dates:

| Method | Deadline |
|---|--------------------------------------|
| Claim submission | Received by Feb. 27, 2015 |
| Health e-Blue | Entered by Jan. 22, 2015 |
| Paper <i>Member Diagnosis Evaluation and Treatment Opportunities</i> report (for BCBSM out-of-state physicians and in-state physicians without access to Health e-Blue) | Faxed or postmarked by Jan. 30, 2015 |
| Paper medical record (for BCBSM physicians) | |
| - Diagnosis closure submission | Faxed or postmarked by Jan. 30, 2015 |
| - Treatment opportunities submission | Faxed or postmarked by Jan. 15, 2015 |

The suspected or historic condition must be addressed during a patient visit and you must confirm that the patient no longer has the condition or that the suspected condition does not exist.

All the diagnosis gaps included in the 2014 Diagnosis Closure Incentive for Jan. 1 through Sept. 30, 2014, are listed on Health e-BlueSM under *Panel – Diagnosis Evaluation*. To earn incentives, physicians must close **all** the diagnosis gaps (identified through Sept. 30, 2014) that exist for a patient through a face-to-face visit before the end of 2014. Following a face-to-face visit, you can also confirm that the patient does not have the condition, if applicable.

Diagnosis gaps will continue to appear on Health e-Blue from Oct. 1 through Dec. 31, 2014. While we’ll continue to display new gaps, physicians are responsible for closing diagnosis gaps identified prior to Oct. 1 for purposes of earning an incentive.

More information is available in the *Resources* section of Health e-Blue; select *2014 Diagnosis Closure Incentive Program*. An FAQ and fact sheet can also be found on web-DENIS in the *Newsletters and Resources* section by clicking on *Medicare Advantage resources*.

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Diagnosis gaps, continued from Page 22

If you don't have access to Health e-Blue, go to **bcbsm.com**, click on *Providers*; then click on *Provider Secured services* and then click on **Health-e-Blue** to sign up. If you have questions, contact your provider consultant.

Physicians who close 100 percent of all identified gaps for each attributed patient will receive \$100 per patient. Your incentive payment will be mailed to you by the end of third quarter 2015.

New information about the Diagnosis Closure Incentive program will be announced next year. In the meantime, physicians are encouraged to continue to check Health e-Blue for patient conditions, schedule face-to-face office visits and close historical or suspected patient diagnosis and treatment opportunity gaps in the coming year.

BCN and BCBSM offer \$200 incentive for each Medicare Advantage member with diabetes and hypertension started on an ACEI or ARB

The Blues are offering a \$200 incentive to BCN AdvantageSM primary care physicians and BCBSM Medicare Plus Blue PPOSM prescribing physicians for each member with diabetes and hypertension who starts on treatment with an ACEI or ARB between Sept. 24, 2014, and Dec. 31, 2014. The member must have one new pharmacy claim for an ACEI or ARB within the designated time frame to qualify for the incentive. Payments will be made in the first quarter of 2015.

Blue Care Network of Michigan, Blue Cross Blue Shield of Michigan and the Centers for Medicare & Medicaid Services endorse angiotensin converting enzyme inhibitor and angiotensin receptor blocker therapy as a best practice in treating patients with diabetes and hypertension. CMS considers this therapy so important that it monitors adherence among Medicare Advantage patients.

Important note about closing diagnosis gaps

When using Health e-Blue's *Diagnosis Evaluation* panel or other methods to indicate that a diagnosis gap is closed because the condition does not exist, be sure that you are closing a diagnosis gap **only** if you have conducted an office visit and the patient no longer has the suspected (or historic) condition. A gap cannot be closed solely for the reason that you are not actively treating the condition. The suspected or historic condition must be addressed during a patient visit and you must confirm that the patient no longer has the condition or that the suspected condition does not exist.

The benefits of ACEI/ARB therapy in diabetics include:

- Inhibited renal function decline
- Decreased cardiovascular risk
- Decreased mortality
- Decreased microvascular diabetic complications

While ACEI/ARBs may not be appropriate for some patients due to adverse effects, most side effects can be managed using an alternative medication within one of the drug classes, dose reduction, or close monitoring during the initiation of therapy. Talk to your patients about the risks versus benefits for each individual to determine if an ACEI or ARB is best for them.

Blue Care Network supports physicians with cholesterol management efforts

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We're well into the third year of our Chronic Care Improvement program. The program helps to prevent cardiovascular disease in BCN AdvantageSM members, emphasizes member self-management strategies and partnership with physicians. Our program focuses on the ABCS, the clinical interventions championed by the CMS Million HeartsTM Initiative.

The Million Hearts ABCS are:

- **A**spirin use
- **B**lood pressure control
- **C**holesterol management
- **S**moking cessation



In this article, we'll address cholesterol management. It's an important topic because high cholesterol affects many Americans and is a risk factor for heart disease, the leading cause of death in the United States.

Here are a few facts about the prevalence of high cholesterol:

- **Seventy-one million American adults (33.5 percent)** have high low-density lipoprotein, or "bad," cholesterol.¹
- Only **one out of every three** adults with high LDL cholesterol has the condition under control.¹
- **Less than half** of adults with high LDL cholesterol get treatment.¹
- People with high total cholesterol have approximately **twice the risk** of heart disease as people with optimal levels.
- The average total cholesterol level for adult Americans is about **200 mg/dL**, which is borderline high risk.²

We recognize that our physicians and their staffs are the first line of defense in the battle against high cholesterol in our members. We're committed to supporting you in your efforts to manage high cholesterol levels and prevent cardiovascular disease in our members. Here are a few tools from the American Heart Association website that you can download and share with your patients who are working on cholesterol management:

- **Heart360[®]** is an online tool which helps patients track and manage heart health and provides helpful advice and information.
- **Medicine Chart** is a one-page tool that that patients can use to record their medications.
- *How can I monitor my cholesterol, blood pressure and weight?* A patient friendly **fact sheet** from the American Heart Association has information about cholesterol management, controlling blood pressure and the importance of healthy eating and weight control.

Additional resources

Michigan Quality Improvement Consortium **guidelines** provide up to date evidence-based recommendations for cholesterol management.

Performance recognition

BCN's 2014 Performance Recognition Program for BCN Advantage rewards physicians who encourage their patients to get preventive screenings and physicians who help patients control their cholesterol. More information about this program is available in BCN Health e-BlueSM. The document is located in the *Resources* section under *Incentive Documents*. If you have any questions, please contact your medical care group leadership or your BCBSM/BCN provider consultant. We appreciate your continued support of our physician incentive programs.

¹ – CDC. Vital signs: prevalence, treatment, and control of high levels of low-density lipoprotein cholesterol. United States, 1999–2002 and 2005–2008. *MMWR*. 2011;60(4):109–14.

² – Roger VL, Go AS, Lloyd-Jones DM, et al. Heart disease and stroke statistics—2012 update: a report from the American Heart Association. *Circulation*. 2012;125(1):e2–220.

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What to do when a service is not covered and your patient still wants it

When a service is not covered or may not be covered by Blue Care Network HMOSM or BCN AdvantageSM but your patient is still interested in getting it, you can submit a clinical review request to us. Submit the request through the normal channels, either through the e-referral system or by calling BCN Care Management.

If the request is approved by BCN Care Management, you're all set to provide the service and bill BCN or BCN Advantage. If the request is denied, Care Management sends written notification of the denial to both you and your patient. You can also see the denial in the e-referral system.

Once you have the denial, take the following steps:

1. Let the patient know the service is denied.
2. Ask whether the patient wants to appeal the denial or is willing to pay for the service out of pocket.

Ultimately, if the patient agrees to pay and you provide the service, it's important that you keep the following denial notices in the member's file:

- The denial notice sent by BCN Care Management to you as the provider
- The copy you receive of the denial letter BCN sent to the member

These documents confirm that the request was denied before the service was rendered and that the denial was communicated to the member.

With these steps completed and assuming the member's agreement to pay, you should feel comfortable billing the patient for the service.

Previously, BCN and BCN Advantage offered the *Patient Advance Notice of Noncovered Service(s)* form for providers to use in these situations, to get written confirmation of the member's agreement to pay for services that were not covered by the plan. That form is no longer available because CMS guidelines restrict the use of this form by Medicare Advantage plans. Except for the *Notice of Medicare Non-Coverage*, other advanced beneficiary notifications involving written agreement from the member to pay for services to be performed are also not compliant.

Instead of using these forms, providers must follow the process described in this article and keep the denial letters from BCN or BCN Advantage in the member's record before performing a service not covered by the plan.



Provider Recognition Program changes coming for 2015

In 2015, Blue Cross Complete will be implementing changes to the Performance Recognition Program. These changes will focus on population-based care and offer greater incentives for managing populations.

We appreciate providers working with Blue Cross Complete to improve the quality of care for our members. More details will be provided in a future issue.

Blue Cross Complete offers incentives for preventive health services

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

Blue Cross Complete offers quality incentive payments for providing and reporting a number of preventive health services. Please visit the provider site at **Navinet** to access Care Gap reports.

Please call your provider consultant for more information or if you have questions.



State of Michigan requires providers to include BMI in registry

Family practice and pediatric providers need to include body mass index in the Michigan Care Improvement Registry when reporting immunizations. It is required by the State of Michigan. Enter this information on **mcir.org**.

Blue Cross Complete offers incentive program for postpartum and well-child visits

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In September, Blue Cross Complete of Michigan began offering a new incentive program for eligible members. Through this program, members who attend their postpartum visit between 21 and 56 days after delivery are eligible to receive a free pack of diapers. This postpartum visit is especially important to new mothers because it gives doctors the opportunity to assess the physical and emotional well being of the mother.

Additionally, parents who take their children for their six well-child visits before the age of 15 months are eligible for a free pack of diapers. Well-child visits start within days of a child's birth. Each visit provides important screenings and helps to educate parents on the developmental needs of their children.

We hope that this new diaper incentive will promote healthy behaviors among members and lead to an increase in the postpartum care and well-child visit, two important Health Effectiveness Data and Information Set® quality of care measures.

Currently, Blue Cross Complete ranks in the 50th percentile (63.99 percent) among other HMOs nationally for postpartum care. Blue Cross Complete is currently ranked in the 75th percentile (70.9 percent) among other HMOs nationally for well-child visits before 15 months of age. These measures have been steady since 2012. The goal is to move the postpartum visits into the 75th percentile (70.2 percent) and well-child visits into the 90th percentile (77.44 percent) and eventually sustain rates above Michigan's HMO average.

Research has found that parents experiencing material hardship are subject to increased parenting stress. Families without diapers may be unable to obtain child care and have limited parental activities such as attendance at school and work. In addition to parental stress, a lack of diapers may result in parents stretching diapers when the supply is running short. This may lead to diaper dermatitis and urinary tract infections in small children. Such infections are responsible for numerous pediatric office and emergency department visits per year.¹

Since diapers play such an important role in the well-being of the child and the mental health of parents, Blue Cross Complete projects that the new diaper incentive program will reduce unnecessary doctor visits ultimately improving overall health outcomes for mothers and children.



¹ Smith, M., Kruse, A., Weir, A., & Goldblum, J. Diaper Need and Its Impact on Child Health. *Pediatrics*, 132, 253-259. Retrieved June 6, 2014, from pediatrics.aappublications.org



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Complete a health risk assessment for members

Under the Healthy Michigan Plan, 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. The form is also available on mibluccrosscomplete.com/providers and on **NaviNet**.

Please follow these guidelines:

- Complete the HRA form legibly and in its entirety.
- Please **Note**: When completing Section 4 Member Results, be sure to include all required information if a diagnosis is checked “yes.” 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 2013 American Medical Association. All rights reserved.**

Where to locate pharmacy information and formulary changes

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

Please visit the site regularly to keep up to date with the latest changes. You can also access the **Online Drug Search Tool** and prior authorization documents in this section.



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Reminder: In some instances, Blue Cross Complete combines two admissions into one for DRG reimbursement

Blue Cross Complete's Utilization Management department reviews inpatient readmissions that occur within 15 days of discharge from a facility that is reimbursed by diagnosis related groups, when the member has the same or a similar diagnosis for each admission. Blue Cross Complete reviews each readmission to determine whether it resulted from one or more of the following:

- A premature discharge or a continuity of care issue
- A lack of a discharge plan or inadequate discharge planning
- A planned readmission
- Surgical complications

In some instances, Blue Cross Complete will combine two admissions into one for the purposes of the DRG reimbursement. The facility's discharge planning process is a key factor in determining whether the two admissions can be reimbursed separately. More information is included in the *Blue Cross Complete Provider Manual*.

Note: For dual-eligible members (those with Original Medicare, BCN AdvantageSM or BCBSM's Medicare Plus Blue PPO as their primary plan and Blue Cross Complete as their secondary plan), inpatient readmissions will be reviewed according to the requirements of the member's primary plan.

The 15-day readmissions policy is a Medicaid policy that is implemented by all Medicaid health plans. We have an appeals process in place for providers who disagree with our determination to combine admissions for payment.

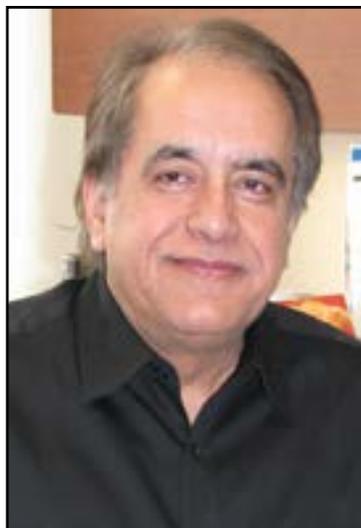
BCN commercial and BCN Advantage have a 14-day policy. Those guidelines can be found in the Claims and Care Management chapters of the *BCN Provider Manual*.

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.

Help Blue Care Network reduce childhood obesity

By Hashim Yar, M.D.



Obesity affects 17 percent of all children and adolescents in the United States, according to the 2007-2008 National Health and Nutrition Examination Survey. That's triple the rate from just one generation ago.

Rates of overweight and obese children worldwide rose by nearly 50 percent between 1980 and 2013. In 2013, more than 22 percent of girls and nearly 24 percent of boys in developed nations were

overweight or obese. The rates in developing nations were nearly 13 percent for both boys and girls

The financial cost of childhood obesity tops \$3 billion annually. Obese and overweight children are at risk for elevated blood pressure, cholesterol, diabetes, sleep apnea, fatty liver disease, gallstones and gastroesophageal reflux. What's more, these children are vulnerable to social and psychological problems, such as discrimination and poor self-esteem and to becoming obese adults.

Beside genetic factors, childhood obesity is the result of eating too many calories and not getting enough physical

activity. American children are exposed to environments that promote increased consumption of less healthy food and physical inactivity in their homes, child care centers, schools and communities.

Blue Care Network has taken an active role to try to reduce childhood obesity. Here are a few of the initiatives we're taking to address childhood obesity endemic:

- BCN is supporting the "We Are For Children" program, a primary care obesity prevention and treatment program in 2 to 5 year old children in West Michigan. The program assesses changes in the health behaviors of the child and the family, including dietary, physical activity and sedentary habits, as well as changes in the child growth patterns.
- BCN will start a pilot program with the University of Michigan Pediatric Outpatient Weight Evaluation and Reduction Program. It offers a comprehensive range of evidence-based pediatric obesity treatment programs for families with obese adolescents (BMI>95 percentile) who are 12 to 18 years old. This is a multidisciplinary program with the goal of reducing BMI in this age group and alleviating the complications associated with childhood obesity.
- Incentives are included in the BCN 2014 Physician Recognition Program to provide specific codes that demonstrate BMI, nutritional counseling and counseling for physical activity were completed by the provider.

We strongly believe that the providers have a critical role in combating this epidemic by educating and counseling their pediatric patients and families for a healthier and productive life.

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



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Screen kids early to avoid cardiovascular disease

Atherosclerosis begins in childhood and progresses slowly into adulthood, leading to coronary heart disease. Children are also at risk for developing hypertension, metabolic syndrome and type 2 diabetes.

The American Academy of Pediatrics recommends that all children be screened for high cholesterol at least once between the ages of 9 and 11 years, and again between ages 17 and 21 years.*

Michigan Quality Improvement Consortium guidelines recommend screening for children older than 2 who are at increased risk for genetic forms of hypercholesterolemia. The best method for testing is a fasting lipid profile. If the child has values within the normal range, testing should be repeated in three to five years.

Children 8 years and older with abnormal cholesterol readings may be considered for cholesterol-reducing medications. Younger children with abnormal readings should focus on weight reduction, healthy eating habits and food selection, and an active exercise program.

For younger patients who are overweight or obese and have a high triglyceride concentration or low HDL concentration, weight management is the primary treatment.

During the office visit, the primary care physician should address the following risk factors with the child and his or her family:

- Family history of heart disease
- Family history of obesity
- Family history of high blood pressure
- Family history of diabetes
- Height and weight measurement; body mass index calculation
- Blood pressure measurement at age 3; then yearly if normal
- Lipid screening if indicated
- Diet and daily physical activity review
- History of tobacco use by parents and by the child (beginning at age 12); offer counseling for smoking cessation

Blue Care Network’s Care Management team provides parents and caregivers of overweight children with information about hypertension, nutrition and other factors related to cardiovascular disease. You may call the Care Management nurse line at 1-800-392-4247 and ask to speak with a nurse.

*Guidelines sponsored by the National Heart, Lung and Blood Institute (NHLBI)



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Type 2 diabetes in children can be prevented

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While type 2 diabetes is usually diagnosed in adults, it's increasingly diagnosed in children and adolescents, particularly in American Indians, African-Americans and Hispanic or Latinos, according to the Centers for Disease Control and Prevention.

Obesity is a major risk factor for type 2 diabetes in children. Type 2 diabetes mellitus can remain asymptomatic for a long time. According to the National Institutes of Health, obesity in children may be attributed to the following modifiable habits:

- High-calorie food choices
- Lack of physical activity
- Parental obesity
- Irregular eating habits that include skipping meals and overeating
- Parents with poor nutritional habits and sedentary lifestyles

The Michigan Quality Improvement Consortium guidelines recommend that children be assessed at each periodic health exam. These key components should be addressed:

- Education of parents with children under 2 years old about obesity risk and prevention
- Assessment of body mass, risk factors for overweight and excessive weight gain relative to linear growth in children age 2 or older
- Prevention to promote healthy weight in children age 2 years or older with a body mass index less than the 85th percentile for age

For children 2 years or older, guidelines recommend that the general assessment include:

- Performing a history (including focused family history) and physical exam
- Measuring and recording weight and height on CDC BMI-for-age growth chart
- Assessing risk factors, including pattern of weight change. Watch for increases of three to four BMI units/year.

For additional information about prevention and identification of childhood overweight and obesity refer to the updated **MQIC guidelines**.

Overweight or obese children may benefit from weight loss supervision from their health care practitioners.

Young people and their families should receive counseling about nutrition, weight control and physical activity, as well as an individualized plan of care. The child may also need treatment for hypertension and hyperlipidemia, including follow-up every three months. Pharmacologic therapy for weight loss isn't recommended for children until more safety and efficacy data have been obtained.

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

- Negative oral pressure therapy for the treatment of obstructive sleep apnea
- Continuous subcutaneous insulin infusion (insulin pumps) and transdermal insulin delivery systems

Covered services

- Genetic testing of CADASIL syndrome
- Light therapy for vitiligo
- Genetic testing for alpha-1 antitrypsin deficiency



[Medical Policy Updates PDF](#)



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Criteria corner

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

Question:

Why does the criteria for deep vein thrombosis or pulmonary embolism exclude medications like Xarelto (rivaroxaban) or Pradaxa (dabigatran) in the criteria for the treatment of DVT or PE?

Answer:

InterQual's inpatient admission criteria for deep vein thrombosis are limited to those patients who are experiencing a complication or are at risk for a complication. The only published study of rivaroxaban for the treatment of DVT specifically excluded patients at high risk for complications, including bleeding. The use of rivaroxaban or dabigatran in this patient population is further complicated by the risk of bleeding and the lack of any agent to reverse the anticoagulant effect. McKesson consultants don't recommend oral agents for the initial treatment of pulmonary embolism. As these medications are relatively new to the market and randomized control trials may be ongoing regarding their use in specialized populations, McKesson will continue to evaluate them for inclusion in the criteria for future releases.

Question:

How can I apply the criteria point "Comorbid pneumonia in a hospitalized patient"?

Answer:

The criteria point "Comorbid pneumonia in a hospitalized patient" can only be applied to patients who have developed pneumonia as a complication of their current inpatient stay in an acute care facility. The criteria points can't be applied for patients who have been either discharged to home or transferred to a post-acute facility.

Diabetes patients require certain tests

Blue Care Network is commemorating American Diabetes Month in November by reminding physicians about the assessment and treatment of their diabetic patients.

The Michigan Quality Improvement Consortium guidelines recommend periodic medical assessments, laboratory tests and education to guide effective self-management in patients with type 1 and type 2 diabetes mellitus. The following tests are recommended:

- Hemoglobin A1C (two to four times annually based on individual therapeutic goal)
- Urine microalbumin measurement (annually)
- Serum creatinine and calculated glomerular filtration rate (annually)
- Fasting lipid profile (annually)
- Dilated eye exam by ophthalmologist or optometrist or digiscope evaluation

For more information about treating diabetic patients, refer to the **MQIC guidelines**.

The level of HbA1c may be reduced with lifestyle choices including diet, weight loss and physical activity. Members that continue to be challenged with HbA1c levels >9 percent may benefit from working with a BCN nurse case manager.

Blue Care Network's Chronic Condition Management program provides members with tools they need to make informed health choices and manage their conditions. To refer members to the diabetes chronic condition management program, call Chronic Condition Management at 1-800-392-4247, TTY 1-800-257-9980. Our chronic condition management specialists are available Monday through Friday, from 8:30 a.m. to 5 p.m.



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Blue Care Network partners with Alere management for CHF and COPD members

Blue Care Network, in partnership with Alere Health, continues to offer members and practitioners an innovative approach to the management of commercial and BCN AdvantageSM members with congestive heart failure. Alere Health also offers disease management services to BCN Advantage members with chronic obstructive pulmonary disease.

Alere Health program

The Alere Health program identifies problems early and alerts the treating physician with timely information on changes in the patient's symptoms while they are at home.

Key features include:

- Home biometric monitoring with DayLink[®] Monitor technology
- Nurse review of symptom information 365 days a year and comparison of this information to parameters preset for each patient
- Notification to the member's practitioner by fax when the patient's symptoms exceed the preset parameters

BCN identifies members who are eligible to participate in Alere programs through a predictive model database using claims and demographic data. Alere contacts the members directly to engage them in the program. If the member accepts the program, Alere notifies providers of their enrollment.

Members with congestive heart failure may have a DayLink Monitor placed in their home to record their weight and heart failure symptoms. This information is transmitted to Alere Health through a telephone line and reviewed daily by licensed professional staff.

Alere Health staff monitors members' adherence with daily weights, medications, blood pressure, tobacco cessation, alcohol use, and flu and pneumonia vaccinations. Alere also monitors member outcomes related to inpatient and ER visits, medication use and quality of life surveys.

Members with COPD may also receive a DayLink Monitor to transmit symptoms once a day. Alere staff also provides education to members to help them understand their COPD symptoms, use self-management techniques, adhere to physician's care plan and medication regimen, learn about the use of spacers for metered dose inhalers and monitor sputum. Smoking cessation is emphasized for those members who smoke.

Member satisfaction

NCQA's disease management standards for health plans require that the organization annually measure satisfaction with its disease management program by obtaining feedback from members. In an effort to improve member satisfaction, Alere implemented an enhancement called *The Healthcard*. The tool allows Alere to measure clinical effectiveness monthly, helps evaluate the impact of interventions and provides a mechanism to provide and focus clinical care. Alere's 2013 member satisfaction survey aggregate overall score was 95.6 percent, an increase from the 2012 overall score of 88.1.

To learn more about Alere Health programs or to refer one of your members, contact BCN's case management team at 1-800-392-2512. They are available 8 a.m. to 5 p.m., Monday through Friday.



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Great American Smokeout is in November

The American Cancer Society marks the Great American Smoke out on the third Thursday of November each year by encouraging smokers to use that date to make a plan to quit using tobacco.

In the United States, tobacco use is responsible for nearly one in five deaths; this equals about 480,000 early deaths each year, according to the American Cancer Society. This includes both tobacco users and those exposed to the second hand smoke. Quitting smoking alleviates exposure to second hand smoke that is harmful to others. Tobacco contains more than 7,000 chemicals, including hundreds that are toxic and about 70 that cause cancer.

Blue Care Network offers Quit the Nic, a smoking cessation program to help members to successfully quit smoking cigarettes or using smokeless tobacco. Members may call 1-800-811-1764 to schedule a time to speak with a health coach.

We encourage physicians to use each visit to counsel all patients who smoke (or use smokeless tobacco) to quit. You can also refer to the article, [Blue Care Network to kick off smoking cessation campaign this fall](#), in the **Sept.-Oct. issue** for information about BCN's tobacco cessation campaign.



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

Blue Care Network's Behavioral Health Incentive Program launched in January of 2014 and is 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

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

| Measure | Provider type | Intake period | Payment | Projected payout | Provider action |
|--|---|-------------------|-------------------|---|--------------------|
| Follow – up after hospitalization | All qualified mental health providers | 1/1/14 – 10/31/14 | Flat fee \$100 | Second quarter of 2015 | None – Claims data |
| Anti – depressant medication management – Acute | Prescribing providers | 1/1/14 – 4/30/14 | Flat fee \$40 | Second quarter of 2015 | None – Claims data |
| Anti – depressant medication management – Continuation | Prescribing providers | 1/1/14 – 4/30/14 | Flat fee \$60 | Second quarter of 2015 | None – Claims data |
| Generic substitution rate | Prescribing providers | 1/1/14 – 12/31/14 | Per script \$1.50 | Second quarter of 2015 | None – Claims data |
| Pharmacotherapy adherence for bipolar disorder | Prescribing providers | 1/1/14 – 12/31/14 | Flat fee \$80 | Second quarter of 2015 | None – Claims data |
| Therapeutic alliance | Non-prescribing providers | 1/1/14 – 12/31/14 | Flat fee \$10 | Third quarter of 2014; second quarter of 2015 | Submit forms |
| Primary care physician contact | Prescribing and non-prescribing providers | 1/1/14 – 12/31/14 | Flat fee \$20 | Third quarter of 2014; second quarter of 2015 | Submit forms |

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

Please understand that if you are not participating in the self-reported measures at this point, you are forgoing incentive money from a large allocated budget.

BCN would like to know your thoughts regarding BHIP. Please complete the following **survey**, which addresses familiarity with the program, any barrier to participating and general feedback. If you have already responded to the survey, please do not complete it again. The survey will close on January 15. We look forward to your feedback.

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ABA limit to be removed in 2015 for treatment of autism

Effective Jan. 1, 2015, BCN will remove the hourly limit for the treatment of autism utilizing applied behavior analysis, but will continue to apply medical necessity criteria when authorizing these services. This will be effective for all non-grandfathered individual, small group and large group plans with effective dates beginning on or after Jan. 1.

Psychiatric and psychological services are already without limits but are managed using medical necessity criteria.

BCN clarifies behavioral health provider requirements

As a behavioral health provider for Blue Care Network, you can refer to the new document *Requirements for providing behavioral health services to BCN members* for information related to your work in solo and group practices and in substance abuse and outpatient psychiatric clinic settings.

This document is available on BCN's e-referral website. Visit ereferrals.bcbsm.com, click *Behavioral Health* and then click ***Requirements for providing behavioral health services to BCN members.***



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Feedback

Seasonal affective disorder can be treated

Seasonal affective disorder is a type of depression that tends to occur and recur as the days grow shorter during the fall and winter months. SAD can seriously affect work and relationships. The disorder may have its onset in adolescence or early adulthood and like other forms of depression, occurs more frequently in women than men. The cause of SAD is unknown, but it's thought to be related to numerous factors such as heredity, age, body temperature, hormone regulation and the availability of sunlight.

The symptoms include depression, carbohydrate cravings, increased appetite with weight gain, decreased interest in work or significant activities of daily living, increased sleep, social withdrawal and decreased energy and concentration.

Recent research by the National Alliance on Mental Illness has found that some people may experience "reverse SAD", where a relapse of symptoms occurs in the summer rather than winter. The symptoms may be insomnia, decreased appetite, weight loss, agitation or anxiety.

Barriers to detection and treatment may include time constraints, competing demands from other medical problems, social stigma, family dysfunction, patient attitude, community factors and clinician and practice factors.

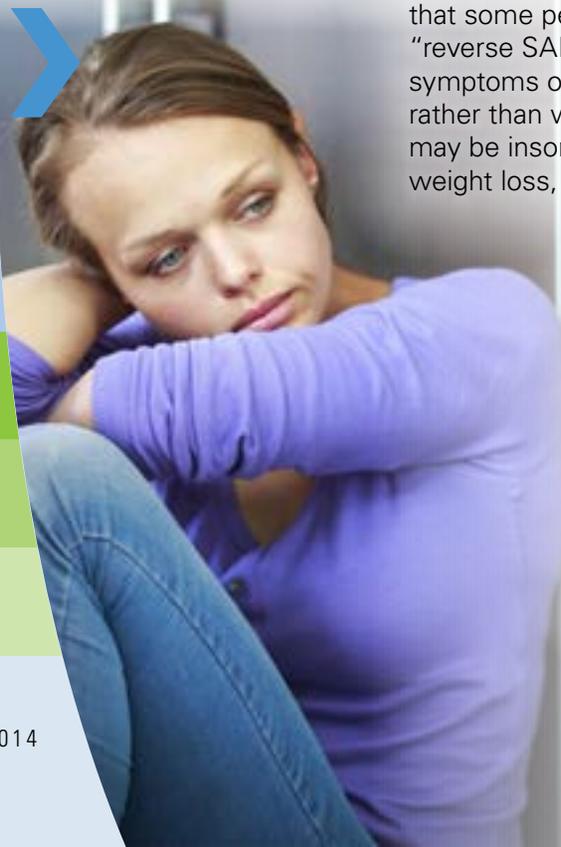
According to NAMI, SAD is sometimes misdiagnosed as hypothyroidism, hypoglycemia, infectious mononucleosis or other viral conditions because of the similarity of some of the symptoms, such as fatigue, lack of energy, problem concentrating or memory loss. All of these can affect patient presentation and detection by the primary care physician.

It's often possible to successfully manage SAD with early intervention, treatment and lifestyle changes which may include:

- Early assessment using a depression screening tool to clarify diagnosis
- Antidepressant medication with observation of behavior by physician
- Diet monitoring, especially carbohydrate intake
- Exercise therapy to help the brain release chemicals to improve mood
- Stress management and relaxation techniques
- Adequate sleep
- Talk therapy to help identify and change negative thoughts and behaviors that may exacerbate symptoms

As the seasons change the symptoms usually resolve. Although some people may have the disorder indefinitely, continuous treatment usually improves outcomes.

If you have any questions about SAD, you may contact Quality Management by emailing BCNQIQuestion@bcbsm.com or by calling Quality Management at 248-350-6263.





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HEDIS 2014 results

The Healthcare Effectiveness Data and Information Set®, the most widely used set of performance measures in the managed care industry, was submitted to the National Committee for Quality Assurance® accreditation process.

HEDIS® is part of an integrated system to establish accountability in managed care organizations. It was originally designed to address private employers’ needs as purchasers of health care and now has been adopted for use by public purchasers, regulators and consumers.

Significant improvement was noted in the following measures:

Commercial HMO

- Weight assessment and counseling for nutrition and physical activity
 - Nutrition only
- Follow-up after hospitalization
 - 7 day
- Follow-up for children with ADHD
 - Initiation phase
- Follow-up for children with ADHD
 - Continuation phase

Medicare

- Colorectal cancer screening
- Comprehensive diabetic care
 - Eye exam
- Follow-up after hospitalization
 - 7 day
- Glaucoma screening for older adults
- Osteoporosis management in women who had a fracture
- Use of high-risk medications in the elderly
 - 1 prescription
- Use of high-risk medications in the elderly
 - 2 prescriptions
- Use of spirometry testing for COPD

A significant decrease was noted in the following measures:

Commercial HMO

- Comprehensive diabetic care
 - Nephropathy monitoring
- Antidepressant medication management
 - Acute phase
- Antidepressant medication management
 - Continuation phase
- Advising smokers to quit

Medicare

- Comprehensive diabetic care
 - HgA1c poorly controlled >9.0 percent
- Controlling high blood pressure
- Antidepressant medication management
 - Continuation phase
- Persistence of beta blocker treatment after heart attack
- Pharmacotherapy management of COPD
 - Bronchodilators
- Disease modifying anti-rheumatic therapy in rheumatoid arthritis

We would like to thank all of our practitioners for their contribution toward providing quality care to our members and allowing the BCN staff to conduct the medical record reviews.

Primary care practitioners can still find opportunities to provide aggressive intervention in the management and care of our members with diabetes, controlling high blood pressure, and in ordering procedures for breast, cervical and colorectal cancer screening. It’s important that members are brought in for needed services and tests, and that the information is documented in the member’s medical record.



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HEDIS 2014, continued from Page 39

We are actively involved in activities throughout the year that positively impact our HEDIS® rates including:

- Physician Performance Recognition Program which is tied to some of the HEDIS® measures
- Health e-BlueSM Web
- Member reminder telephone calls and cards
- Member and physician education
- Member health fairs
- Chronic condition management programs
- Care Management follow-up telephone calls/letters
- Member incentive programs
- HEDIS®/CAPHS Summit Meeting

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

If you would like more information about HEDIS® contact our Quality Management department:

- By phone at 248-350-6263
- By email at BCNQIQuestion@bcbsm.com

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

NQA revises HEDIS measure for blood pressure

In 2015, the *Cholesterol Management for Patients with Cardiovascular Conditions* measure will be retired. Also in 2015, the *Controlling High Blood Pressure* measure will be changed to include the following for members with a diagnosis of hypertension before June 30, 2014:

- Age 18-85 years old whose BP is <140/90
- Age 60-85 years old with a diagnosis of diabetes whose BP is <140/90
- Age 60-85 years old *without* a diagnosis of diabetes whose BP is <150/90 who has a diagnosis of hypertension and whose blood pressure is adequately controlled during 2014



[2014 Commercial HMO HEDIS® Results PDF](#)



[2014 BCN Advantage HEDIS® Results PDF](#)



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Chantix and Nicotrol products require authorization for coverage

As the New Year approaches, some of your patients may be thinking about giving up tobacco and may ask for your guidance and help.

Blue Care Network strongly supports members who are trying to quit. We provide coverage for many different tobacco cessation therapies. Members must have a prescription for these therapies – including over-the-counter versions – before we'll provide coverage.

As a reminder, BCN now requires prior authorization before we'll cover prescriptions for Chantix, Nicotrol and Nicotrol NS. Members must try one of these therapies that are covered at no member cost share: generic Zyban, Nicoderm CQ or Nicorette gum or lozenges.

For members who meet criteria, BCN will cover Chantix, Nicotrol and Nicotrol NS at no member cost share.

BCN's criteria follow U.S. Department of Health and Human Services practice guidelines on treating tobacco use and dependence. The recommendations don't support the use of one agent over another. In addition, the guidelines show no significant difference in quit rates between the seven first-line medications for smoking cessation.

When prescribing smoking cessation products for BCN members, please help our members manage their out-of-pocket costs by first prescribing a therapy that doesn't require prior authorization.

Quit rates for first-line smoking cessations therapies

| Product | Quit rate |
|--------------------------------------|-----------|
| Chantix (varenicline) | 25 – 33% |
| Generic Nicoderm CQ (nicotine patch) | 24 – 27% |
| Generic Nicorette (nicotine gum) | 19 – 26% |
| Generic Nicorette (nicotine lozenge) | 24% |
| Nicotrol (nicotine inhaler) | 25% |
| Nicotrol NS (nicotine nasal spray) | 27% |
| Generic Zyban (bupropion) | 24% |

References

1. Tobacco Use and Dependence Guideline Panel. Treating tobacco use and dependence: 2008 update. Rockville, MD. US Department of Health and Human Services. May 2008 Available from: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/treating_tobacco_use08.pdf

BCBSM and BCN drug lists updated, available online

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



[Comprehensive Formulary Updates PDF](#)



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Switch to generic Norco helps members save

In October 2013, Blue Care Network launched prior authorization requirements for hydrocodone combination products that contain 300 mg of acetaminophen due to the high cost of the new formulations. Since this change went into effect, more than 99 percent of members who use these products are being prescribed the lower-cost generic Norco, which contains 325 mg of acetaminophen.

BCN appreciates the support we have received from our providers. Thank you for helping keep costs low for our members.

As a reminder, the Drug Enforcement Agency moved hydrocodone combination products to Schedule II from Schedule III on Oct. 6, 2014. Any prescriptions for hydrocodone combination products issued before Oct. 6, 2014 and authorized for refilling may be dispensed before April 8, 2015.

BCN Pharmacy Clinical Help Desk to handle BCN Advantage drug requests, grievances

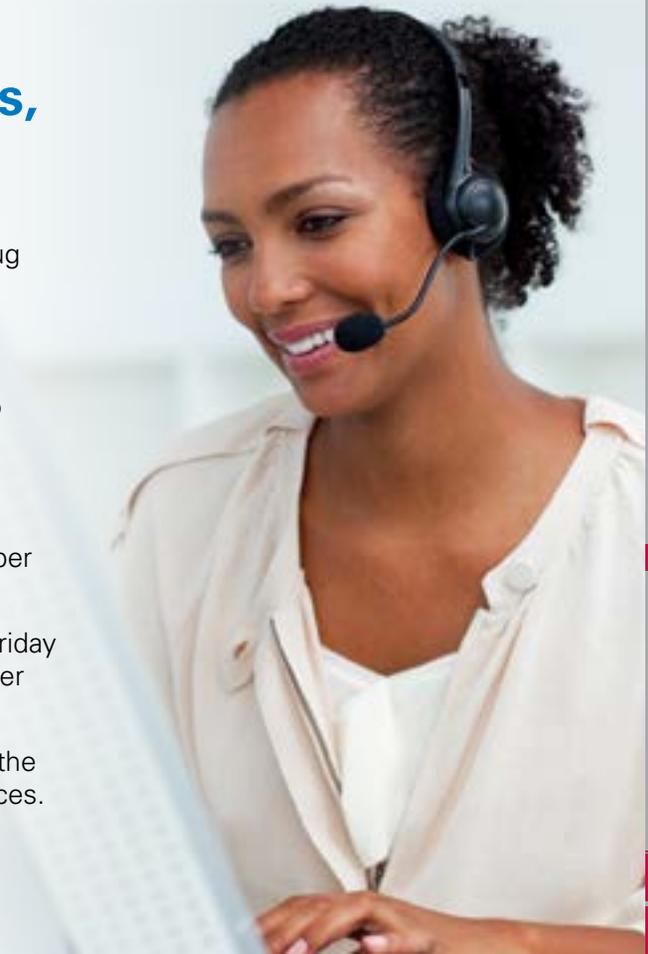
Starting Jan. 1, 2015, BCN Pharmacy Clinical Help Desk will process BCN AdvantageSM Part D appeals and grievances. This move allows all Part D drug requests and grievance work to be processed by one centralized staff.

Once the change is in effect, prescribers can initiate appeals by telephone. Prescribers may also provide clinical information over the phone. With the appropriate clinical information available, the Help Desk staff may be able to provide a determination during the initial call, unless review by a pharmacist is required.

When calling the BCN Pharmacy Clinical Help Desk, remember to have all pertinent information available. This includes the enrollee's name and member ID number, medication name, diagnosis and rationale for the request.

The BCN Pharmacy Clinical Help Desk is available for providers Monday – Friday from 8 a.m. to 8 p.m. The phone number is 1-800-437-3803. The fax number for BCN Advantage is 1-800-459-8027.

Members will continue to contact the Customer Service phone number on the back of their member ID card for information regarding appeals and grievances.



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American Academy of Pediatrics updates Synagis guidelines

Blue Care Network follows guidelines from the American Academy of Pediatrics for the use of Synagis (palivizumab). Palivizumab was approved in 1998 and has reduced RSV hospitalizations. AAP recently updated its Synagis guidance for prevention of respiratory syncytial virus. The guidance was developed to implement palivizumab in the most cost-effective way.

Palivizumab is a monoclonal antibody given monthly to prevent RSV during the RSV season in pre-term or high-risk infants. RSV season in Michigan generally starts around December 1 and continues for four to five months.

High-risk infants were previously defined as infants with bronchopulmonary dysplasia, those born at or before 35 weeks' gestation age and children with hemodynamically significant congenital heart disease. In addition, it was indicated for children undergoing cardiopulmonary bypass.

Due to the immense advancement in neonatal care since 1998, there has been a steady decline in RSV hospitalization both with and without prophylaxis. This has changed the need for palivizumab. Because those previously high-risk infants are no longer at such a risk, AAP has developed new criteria to identify infants at high risk simply due to gestational age:

- Palivizumab is recommended for infants born before 29 weeks, 0 days' gestation, who are younger than 12 months at the start of RSV season.

Palivizumab is no longer recommended for infants born at 29 weeks, 0 days' gestation or later, but may be indicated if they meet any of the following conditions:

- Infants younger than 12 months with hemodynamically significant congenital heart disease
- Infants younger than 12 months with chronic lung disease — defined as birth at before 32 weeks, 0 days, and less than 21 percent oxygen for at least 28 days after birth

- Infants less than 24 months who are profoundly immunocompromised during the RSV season, children who required at least 28 days of oxygen supplementation after birth and those who require medical intervention (oxygen, chronic corticosteroids, diuretic therapy)
- Children younger than 12 months with pulmonary abnormalities or neuromuscular disease that impairs the ability to clear secretions from upper airways

The AAP also emphasizes that the risk of RSV disease is higher in Alaskan Native American patients, and use has been broadened in these individuals as well as other selective American Indian populations.

The guidance states a maximum of five monthly doses may be given to infants in the first year of life. This differs from the previous recommendations, where certain infants required fewer doses. Although those born within the season may require fewer doses, palivizumab is no longer recommended for infants in their second year of life as it was in certain populations in the past. It is no longer recommended for prevention of health care-associated RSV disease and is to be discontinued in any child who has a breakthrough RSV hospitalization.

RSV surveillance data information is available at the CDC at the following links:

<http://www.cdc.gov/features/dsRSV/index.html>

<http://www.cdc.gov/surveillance/nrevss/rsv/>

References

1. BCN Policy, Palivizumab.
2. Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection. *Pediatrics* 2014; 134:415; originally published online July 28, 2014



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Feedback

Correction: Implementation for Walgreens Infusion moved to 2015

In the Sept.-Oct. 2014 issue, we said that Walgreens Infusion had been named the preferred provider of immunoglobulin services for Blue Care Network and BCN AdvantageSM members, effective Oct. 1, 2014. Implementation of this program has been moved to 2015. We apologize for any confusion this may have caused.

Are your patients protected from measles?

Measles is making a comeback.

In 2014, 592 cases of measles have been confirmed in the United States. This may seem low; however, it's the highest number of cases here in 20 years. No cases have been reported in Michigan as of June, but our neighbor to the south, Ohio has the largest outbreak in the nation.

The Centers for Disease Control and Prevention says two things are fueling this dramatic increase in cases: outbreaks in foreign countries and the disease spreading through groups of people who are not vaccinated.

The disease was officially eliminated in 2000 from the United States, but 20 million cases occur around the world every year. There's currently a large outbreak in the Philippines.

Almost all current cases can be traced to travelers who were exposed in another country and brought the virus back home. Ninety percent of the U.S. cases this year were among unvaccinated people. Because of the high risk of importing the disease, vaccination recommendations for those planning international travel differ from the standard recommendations.

- Travelers 6 months or older should have evidence of immunity or be vaccinated before leaving the US.
 - 6 to 11 months: One dose is recommended (a two-dose revaccination is recommended after the child's first birthday)
 - 12 months and older: Two doses are recommended
- Space two-dose vaccinations at least 28 days apart.

The full vaccination schedule is available on the CDC's [website](#). Please remind your patients to allow enough time for vaccination when they're planning to travel.

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1. Gastañaduy PA, Redd SB, Fiebelkorn AP, et al. Measles – United States, January 1–May 23, 2014. MMWR [Internet]. 2014 Jun 6 [cited 2014 Jun 16]:63(22):496-9. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6322a4.htm?s_cid=mm6322a4_w
2. McLean HQ, Fiebelkorn AP, Temte JL, et al. Prevention of Measles, Rubella, Congenital Rubella Syndrome, and Mumps, 2013: Summary Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR [Internet]. 2013 Jun 14 [cited 2014 Jun 16]:62(RR04):1-34. Available from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm>
3. US Centers for Disease Control and Prevention website – <http://www.cdc.gov/measles/cases-outbreaks.html>; accessed Sept. 8, 2014.



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BCN launches approval requirements for generic Skelaxin

Beginning Nov. 1, 2014, Blue Care Network requires prior authorization before we will cover metaxalone (generic Skelaxin) for commercial members. Before BCN will approve coverage for metaxalone, the member must experience treatment failure or intolerance to three of four alternative generic agents: chlorzoxazone, cyclobenzaprine, methocarbamol or orphenadrine.

On average, generic Skelaxin costs about 43 times as much as a prescription for other generic skeletal muscle relaxants. Metaxalone accounts for just 7 percent of skeletal muscle relaxant use among BCN members but represents 91 percent of dollars spent annually on this drug class.

Several cost-effective skeletal muscle relaxants are available to provide appropriate therapy to members while helping to manage drug costs and keep premiums in check.

| Drug | Average Plan Cost/Prescription |
|--|--------------------------------|
| Generic Flexeril (cyclobenzaprine) | \$0.44 |
| Generic Robaxin (methocarbamol) | \$2.41 |
| Generic Parafon Forte (chlorzoxazone) | \$7.11 |
| Generic Norflex (orphenadrine citrate) | \$16.19 |
| Generic Skelaxin (metaxalone) | \$279.50 |

A systematic review of comparative studies found no difference in clinical efficacy among the medications in this class. Because most of the drugs in this class cause sedation and some pose a serious risk of liver toxicity and addiction, selection of an agent should be based on factors associated with the specific skeletal muscle relaxant.

Due to metaxalone’s high cost and failure to demonstrate greater efficacy over other products, we encourage you to try more cost-effective agents first. Please consider prescribing an alternative skeletal muscle relaxant when your patient requires one of these agents.

References

1. Chou, R and Peterson, K. Drug class review: skeletal muscle relaxants. Oregon Health & Science University; May 2005.
2. See, S and Ginzburg, R. Choosing a skeletal muscle relaxant. Am Fam Physician. 2008 Aug; 78(3): 365 - 70.

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Question:

If I have an appeal or inquiry on a BCBSM claim, can I use the BCN clinical editing appeal form, submit it to your address, and receive a response?

Answer:

No, Blue Care Network does not process Blue Cross claims. The clinical editing form in the *BCN Provider Manual* referring to the Grand Rapids address is strictly for edits related to BCN or BCN AdvantageSM claims. If you have an appeal for a Blue Cross claim or an inquiry regarding an edit, it should be submitted to Blue Cross. The appeal should be complete and submitted in writing. The address for Blue Cross clinical editing appeals is:

Providers Appeals Unit – Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette
Detroit, MI 48226-2998

Have a billing question?

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

Question:

Where do I find information on BCN's clinical edits and the appeal process?

Answer:

The *BCN Provider Manual* contains a section on clinical editing. That section provides basic information on clinical editing, as well as links to tools that can be used if there are questions on edits. It is located in the Claims section of the manual. There are other links under the *Billing* section of web-DENIS that also may be useful. These links will take you directly to information about modifiers, EX codes or to forms such as the *Clinical Editing Appeal Form*. The links also provide recommendations if an appeal is needed or if a corrected claim may be sufficient.

BCN publishes regular updates in *BCN Provider News* and on web-DENIS. While changes may occur at any time due to updates in billing and coding rules, they are most prevalent at the time of code updates.

BCN maintains its commitment to correct coding and works to ensure that accurate updates are in its system on a timely basis.



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BCN will reject old CMS 1500 (08/05) claim forms starting Jan. 1, 2015

Claims for services to Blue Care Network members submitted on the old paper CMS-1500 (08/05) form will be rejected starting Jan. 1, 2015. The *Status Claim Review Form* will also be rejected starting on that date.

As a reminder, BCN providers were asked to change to the new CMS-1500 (02/12) form starting April 1, 2014.

If you are one of the few providers still using the old CMS-1500 (08/05) form and the *Status Claim Review Form*, you'll need to switch to the new CMS-1500 (02/12) form by Jan. 1, 2015, or risk having your claims and status inquiries rejected. To submit a status inquiry for a BCN claim using the CMS-1500 (02/12) form, complete Field 22 by entering the original reference number for the resubmitted claim and the appropriate bill frequency code — either a "7" (to replace a prior claim) or an "8" (to void or cancel a prior claim). For BCN claims, providers do not need to complete Field 19.

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:

- Documentation of E&M services
- Use of anatomic modifiers
- Use of the most specific code



[Clinical editing
billing tips PDF](#)

Locating negative balances online

Negative balance reports for facility claims are available online effective immediately. Negative balance reports for professional claims will be available online by Dec. 1, 2014.

See the PDF below for instructions on how to locate these reports.



[Locating negative
balances PDF](#)

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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 <p>Note: If you need assistance locating a network provider, contact Northwood at 1-800-393-6432.</p> | <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 | — |
| 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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positive airway pressure devices, continued from Page 48

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.

New e-referral system is live

Please see news, information and training about the new e-referral system on the e-referral [website](#).

2015 BCN Referral and Clinical Review Program effective January 1

The 2015 BCN Referral and Clinical Review Program will be effective Jan. 1, 2015. The document applies to BCN HMOSM (commercial), BCN AdvantageSM HMO-POS and BCN AdvantageSM HMO products.

There are no changes to the program effective Jan. 1, 2015. However, the program is updated as needed throughout the year. The most current program is always available on the Web.

To access the 2015 program starting Jan. 1, please go to ereferrals.bcbsm.com and click on **Clinical Review & Criteria Charts**.

Use these tips to transition PT, OT, ST cases continuing into 2015

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Blue Care Network has implemented a year-end transition plan for the physical, speech and occupational therapy clinical review process. This process worked well for therapy providers and members in 2014; therefore, the same strategy will apply for 2015.

Care that starts in November or December

All 2014 treatment authorizations for PT, OT and ST will end December 2014 for members whose coverage follows a calendar-year plan. If an episode of care begins in 2014 and is expected to continue into 2015, the following apply:

- An initial evaluation or reevaluation for therapy isn't necessary to continue an active episode of care into 2015.
- You must enter a new referral either through e-referral or by calling BCN Care Management **before** the first treatment in 2015.
- A member does **not** need a new referral from the member's primary care physician to complete the active episode of care.

Care that continues into 2015

Physical, occupational and speech therapy providers should enter their own referrals for therapy services for all patients receiving therapy services in December that will carry over into January 2015. The referral begin date should be the date of the first appointment in 2015. You may enter the 2015 referral into e-referral in December 2014. If you are unable to use e-referral, you may contact Care Management at 1-800-392-2512. For more information or instructions on using e-referral, please contact your BCBSM/BCN provider consultant.

Approvals for 2015 must meet these requirements:

- The member is an eligible BCN member on the date services are rendered.
- Services received must be a benefit covered under the member's contract.
- Benefits must be available or remaining as defined by the member's contract.

Please see [Tips](#), continued on Page 51

Tell us what you think about BCN Care Management — you could win a prize!

We'd like to know how satisfied you are with BCN's Care Management services and learn what we can improve to better meet your needs and those of the BCN members you serve. Please take a few minutes to complete our **BCN Care Management Provider Survey**.

Participation in the survey is not necessary to win. The drawing is open to all active BCN providers. Enter by completing the survey no later than Dec. 31, 2014, or by sending an e-mail with your name, phone number and "Survey drawing" in the subject line to BCNPhysicianSurvey@cbbsm.com by Dec. 31, 2014.

All entries must be received by Dec. 31, 2014. Two winners will be selected in a random drawing from among all eligible entries. Each winner will receive a gift card in the amount of \$250. The drawing will take place approximately one week following the end of December. Winners will be notified by telephone or e-mail following the drawing.

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Therapists should enter the 2015 referral on e-referral with the following information:

Physical Therapy

| | |
|----------------|--|
| Procedure code | Submit applicable procedure code |
| Start date | Enter date of the first visit for 2015 |
| Count | 1 |
| Date span | 60 days |

- Category A and B therapy referrals are processed according to their tier level and therapists receive a determination letter.
- Category C providers who have patients currently under care or new patients who begin treatment in January will receive a letter approving three therapy visits. The three-visit approval will be granted through Jan. 31, 2015. Be sure to submit a treatment plan prior to the third visit to avoid the risk of lapse in treatment due to lack of authorization. Beginning Feb. 1, 2015, new referrals revert to the established policy of one evaluation and one visit for all new patients seen by Category C providers.

Occupational Therapy

| | |
|----------------|--|
| Procedure code | Submit applicable procedure code |
| Start date | Enter date of the first visit for 2015 |
| Count | 1 |
| Date span | 60 days |

- Landmark processes occupational therapy referrals according to the established process and therapy providers receive a determination letter.

Speech Therapy

| | |
|----------------|--|
| Procedure code | *92506 |
| Start date | Enter date of the first visit for 2015 |
| Count | 1 |
| Date span | 60 days |

- Requests automatically pend for speech therapy. Landmark processes speech provider referrals according to the established process and therapy providers receive a determination letter.
- Speech therapy providers should submit a treatment plan as soon as they determine that care is required for 2015. Landmark reviews for medical necessity and sends a determination letter.

BCN Care Management accepts requests for transition cases by phone or by e-referral. A transition case is a request for continued access to care for a member new to BCN and hasn't seen the primary care physician but needs to continue with ongoing therapy that was started while under a prior plan. Please call Care Management at 1-800-392-2512.

For members with plan year benefits

Most BCN plans apply benefits on a calendar year basis, but some groups administer benefits on a plan year with renewal dates other than January 1. Health care providers can verify this information when checking eligibility on web-DENIS or PARS (CAREN). If you identify a member with a plan year other than January 1, a new referral isn't needed until that plan year ends. BCN and Landmark work together to administer benefits accordingly.

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