Blue Cross Blue Shield of Michigan and Blue Care Network to offer new individual health plans for 2016

When the Health Insurance Marketplace opens Nov. 1, Blue Cross Blue Shield of Michigan and Blue Care Network will offer a total of 44 plans — 18 Blue Cross plans and 26 BCN plans, including nine new ones.

Some ID cards for 2016 will have a new Group ID number (00282189). Providers should note that members who have the same Group ID don’t necessarily have the same coverage.

The new Platinum, Silver and Bronze plans are designed for simplicity. The new Platinum plan has a simple design: 10 percent coinsurance on all approved medical benefits packaged with all ages dental and vision.

The new Silver Saver will appeal to members eligible for cost-sharing subsidies and the Advanced Premium Tax Credit. It is designed to attract healthy members.

The new Bronze Saver plan is offered as a buy-down option for current Bronze members. The deductible equals the out-of-pocket maximum and approved services are covered 100 percent after the out-of-pocket maximum is met.

You can refer your patients to HealthCareReformBasics.com, a website designed by Blue Cross to help consumers understand how the Affordable Care Act will affect their current health insurance status. All individual plans will have Blue Cross names. Members can tell which plans are BCN plans by the logo on the ID card or their names: Partnered, Metro Detroit HMO, Select and Preferred are BCN plans. Blue Cross Blue Shield of Michigan plans are identifiable by the logo on the ID card or their names: Metro Detroit EPO, Premier and Multi-State.

Please see New plans, continued on Page 2
New plans, continued from Page 1

The most significant changes to the offerings include the following:

- All Bronze Extra plans, except the Premier Bronze Extra, must be closed because we are unable to modify them to bring the plans back into the Bronze actuarial value range.
- Premier Bronze Extra will be modified to pay only primary care visits before the deductible and be renamed as Premier Bronze with Primary Care Visits.
- Platinum Extra with Dental and Vision will be closed and redesigned as a simple-to-understand zero deductible and flat coinsurance plan.
- Plan deductible and out-of-pocket maximum modifications were required on some existing plans to meet actuarial value requirements.

BCN-specific changes for 2016

- BCN is closing all Bronze Extra plans (they do not meet the CMS required actuarial value range).
- We have removed Jackson County from the PCP Focus provider network. The preferred provider network will be the only option for Jackson County for individual members.
- We are moving deductible and out of-pocket maximum from aggregate to embedded. This means for a two-person or family contract, one member cannot contribute more than the individual amount for covered services that apply to the deductible / out-of-pocket maximum.

Please see New plans, continued on Page 3
New BCN plans
Here are some details about the new BCN HMO plans.

• Bronze Saver Plan
  - Deductibles equal the out-of-pocket maximum.
  - The plan is HSA eligible.
  - It eliminates cost-sharing complexity inherent in benefit designs.
  - Offers the same portfolio of benefits as a Basic or Extra Plan.

• New Silver Saver plan
  - Offers same portfolio of benefits as a Basic or Extra plan.
  - Attracts healthy consumers who choose lower-priced plans.

BCN Basic and Saver plans offer the following benefits before the deductible:

• Preventive services
• Office visits provided by the member’s primary care physician
• Laboratory and pathology tests
• Urgent care visits
• Routine prenatal benefits
• Benefits before the deductible doesn’t apply to Bronze since it’s a high-deductible health plan

BCN Extra plan offers the following benefits before deductible:

• Preventive services
• Office visits provided by the member’s PCP
• Laboratory and pathology fees
• Urgent care visits
• Routine prenatal visits
• First four specialist office visits
• Tier 1A and Tier 1B generic prescription drugs

Blue Care Network will transition members from closing a plan into another BCN plan based on CMS guidelines. The Advanced Premium Tax Credit amount will be determined in the same plan effective Jan. 1, 2016.

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.

How we’re helping members navigate health care choices
The Health Insurance Marketplace offered some challenges that could potentially inconvenience our members. So Blue Care Network has taken steps to make it easier for members to understand network descriptions and choose a primary care physician.

The marketplace does not allow members to select a PCP. We are doing the following to make it easier for members:

• We are allowing members to select a PCP through the member portal of [bcbsm.com](http://bcbsm.com) before their effective date.
• We will make automated phone calls to members to remind them to select a PCP.
• ID carrier, a new member handbook and benefit change kit, includes the importance of selecting a PCP, along with instructions on how to make a selection.

The marketplace does not allow network descriptions online. We are doing the following to address this challenge.

• Keep [bcbsm.com](http://bcbsm.com) updated with the most current information about our networks and how they work
• Updated the provider directory drop down with [healthcare.gov](http://healthcare.gov)
• Created a Network Guide to describe the differences in the networks
Web MD launches in January for Blue Care Network

Key changes to Healthy Blue Living

The new Blue Cross® Health & Wellness platform, powered by WebMD®, will be launching on Nov. 1, 2015 for Blue Cross Blue Shield of Michigan members and on Jan. 1, 2016 for Blue Care Network members. This new wellness platform will bring enhancements to both of our wellness products – Healthy Blue Achieve PPO and Healthy Blue Living℠ HMO. Enhancements will include a new online health assessment, tobacco cessation program and walking program.

Here’s a list of key changes to Healthy Blue Living.

<table>
<thead>
<tr>
<th>Health assessment provider</th>
<th>Current product</th>
<th>Updated product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health assessment provider</td>
<td>Wellness and Prevention</td>
<td>WebMD Health Services</td>
</tr>
<tr>
<td>Compliance tracking</td>
<td>Included with product and administered by BCN</td>
<td>Included with product and administered by BCN</td>
</tr>
<tr>
<td>Continuous engagement requirements</td>
<td>• BMI ≥ 30: Weight Watchers, Premier Health Network Weight Coaching or Walkingspree until end of plan year or until BMI falls below 30 • Tobacco users: Quit the Nic tobacco cessation program until end of plan year or until negative cotinine test received</td>
<td>• BMI ≥ 30: Weight Watchers, WM Coaching (PHN only) or Steps walking program until end of plan year or until BMI falls below 30 • Tobacco users: Tobacco Cessation Coaching until end of plan year or until negative cotinine test received</td>
</tr>
</tbody>
</table>

Healthy Blue Living groups will remain with their current activity tracking program vendor until renewal. The WebMD-powered Tobacco Cessation and Lifestyle Coaching plans will begin Jan. 1, 2016 and participating members will transition to the new vendor at that time. (Eighty-five percent of groups renew on Jan 1.)

Healthy Blue Living members will link to WebMD to complete their health assessment and select the walking program, if needed.

Members will continue to use the Blue Cross member portal for compliance tracking and to select Weight Watchers, if needed.

All BCN HMO members will have access to the tobacco cessation coaching program and the health assessment.
Value Partnerships program saves $1.4 billion

Over the last 10 years, Blue Cross Blue Shield of Michigan’s partnerships with hospitals, physicians and care providers have saved lives and prevented $1.4 billion in health expenses.

These successes come from the Blue Cross Value Partnerships suite of clinical quality initiatives and value-based payment programs, which include more than 19,000 physicians and 75 hospitals in Michigan that participate and collaborate to improve care processes and outcomes.

“We are a national leader in advancing health care quality and developing a high-performing, value-based, cost-effective health care system,” said president and CEO Daniel J. Loepp. “And we have achieved success through collaboration, which isn’t easy. Value Partnerships has improved care and value, both for our customers and others.”

Value Partnerships efforts have directly saved $1.4 billion in health care expenses by achieving safer, higher quality care and reduced complications. It’s the unique collaborative model that catalyzes such progressive change. Because physicians and care providers statewide are working together to share and implement best practices, quality and safety improvements occur quicker and on a larger scale than similar initiatives that involve only one site or group.

“These initiatives are improving and saving lives through prevented complications, higher quality of care, improved outcomes and improved processes of care,” said Dr. David Share, senior vice president, Value Partnerships. “Together with our provider partners, we are moving from a fee-for-service to a value-based payment model. Michigan is a safer, higher quality state for health care as a result.”

Please see Value Partnerships, continued on Page 6
Value Partnerships, continued from Page 5

Nearly 2 million Blue Cross Blue Shield of Michigan members are cared for by providers who participate in the Value Partnerships programs. However, the cost savings and care improvements benefit all patients. Value Partnerships participants have changed their processes, so that all patients receive the benefit of these improved care models, regardless of their insurance type, or whether they have insurance. All Value Partnerships programs are based on cooperation, collaboration and information sharing.

The Michigan academic community has secured several million dollars in research funding so that others can study and learn from our model and resulting outcomes.

The University of Michigan Health System has collaborated with Blue Cross to serve as the clinical coordination center for nearly all of the Collaborative Quality Initiatives within the Value Partnerships portfolio. U-M Medical School faculty physicians lead most of the CQIs. Each CQI focuses on a specific type of care, from trauma care to prostate cancer to minimally invasive heart procedures.

Ten years ago, leaders from the Michigan State Medical Society provided input and guidance as the Value Partnerships program was being developed.

“If improving patient outcomes while maintaining physician decisions have been foundational to the success of the program. Blue Cross and Michigan physicians are leading the nation in health care reform,” says Rose M. Ramirez, M.D., president, Michigan State Medical Society.

The Value Partnerships team also works closely with the Michigan Health and Hospital Association.

Value Partnerships at a glance

The Value Partnerships portfolio of initiatives includes the nation’s largest Patient-Centered Medical Home designation program, with more than 4,345 physicians designated in 78 of 83 Michigan counties. Additional initiatives include:

- **Collaborative Quality Initiatives** — 22 initiatives, each aimed at improving specific medical or surgical procedures and processes
- **Physician Group Incentive Program** — Care process and quality improvement initiatives for physician organizations
- **Provider Delivered Care Management** — Care management services offered through the primary care practice
- **Organized Systems of Care** — A community of providers that coordinate care across all settings for a shared population of patients
- **Hospital Value-Based Payments** — Improves individual patient and population-based quality of care and payments based on outcomes
- **National Solutions** — Coordinating Michigan’s quality and value programs with similar programs in other Blues plans

For more information about Value Partnerships, go to [valuepartnerships.com](http://valuepartnerships.com).
Providers must report practice location and office hours changes to comply with CMS requirement

Beginning 2016, the Centers for Medicare & Medicaid Services is requiring health plans to contact providers monthly, to ascertain their availability and, specifically, whether they are accepting new patients. This is part of an effort to improve the information found on the online directories. CMS is also requiring contracted providers to inform the plan of any changes to street address, phone number, office hours or other changes that affect availability.

While Blue Cross Blue Shield of Michigan and Blue Care Network are working on a solution to be compliant, all professional organizational providers (groups) are strongly advised to use self service on bcbsm.com to identify any discrepancies in their addresses and affiliated providers’ information.

To add or remove practice locations, mailing or remittance address use Provider Enrollment and Change Self-Service. This is an online application in the Provider Secured Services section of our website that allows practice group administrators to electronically submit requests for updating group information with Blue Cross and Blue Care Network.

To use the Provider Enrollment and Change Self-Service, you must register for Provider Secured Services. Go to bcbsm.com/providers. Select Help, then FAQs, then Provider Enrollment and Change Self-Service for professional groups and allied providers and follow the instructions.

Group practice administrators should continue to use the self-service option monthly to ensure all changes are submitted to their records on a timely basis.

Submissions increase for Blue Care Network tobacco cessation office staff contest after reward doubled

Blue Care Network is seeing the early results from doubling the monthly reward given to the winning office staff starting this past July, from $500 previously to $1,000 per winning staff.

Congratulations to the office staffs of Providence Medical Center in South Lyon and Sparrow Medical Group – North, in East Lansing.

Starting last fall, BCN has sent Quit Guides and tobacco use surveys to primary care physician offices to help members quit using tobacco. The office staff contest was recently enhanced to provide $1,000 in gift cards to office staff. See the PDF to the right for details. The staff at Providence South Lyon was the first to win the $1,000 in Visa gift cards.

Extra surveys and Quit Guides are available from your provider consultant. Or you may call 248-799-6959 to request these supplies. Although we only sent these to PCP offices, all offices are welcome to join if their leadership allows. BCN members may also complete the survey online at bcbsm.com/bcnquit.

View our new Web-based presentation to learn more about the office staff contest.
24/7 online health care through American Well expanded to all BCN members

We announced in the Sept-Oct. issue that Blue Cross Blue Shield of Michigan and Blue Care Network contracted with American Well®, an independent telehealth company, to provide HIPAA-compliant online health care for some of our members and self-funded groups, effective Jan. 1. BCN is expanding this opportunity to all BCN members. Please note this option is not available to BCN AdvantageSM members. In addition, self-funded groups can opt out of the program.

BCN encourages members to coordinate care through their primary care physicians. However, when a primary care physician is not available, this service offers members the ability to connect with a doctor by online video 24 hours a day, seven days a week for common illnesses. Members with this benefit can talk to one of American Well’s extensive practice group of board certified doctors from their laptop, tablet or smartphone. Members will be encouraged to follow up with their primary care physician and will have the option to send a report about the online consultation to their doctor.

We will be communicating our online visit policy for BCN providers in a future issue.

Remember to refer BCN members only to providers contracted with BCN

Before you refer a BCN HMO℠ or BCN Advantage℠ member to another provider for services, double check to make sure the provider is contracted with BCN or BCN Advantage.

In addition, if the member has coverage through a product with a designated local network of providers, check to make sure you’re referring the member to a provider who belongs to that network.

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

Referring members to providers who are not contracted with BCN or who do not belong to the local provider network for the member’s plan or failure to obtain clinical review for services from those providers may result in denial of the provider’s payment. The provider cannot balance-bill the member.
Licensed professional counselors can learn more about enrolling with Blue Cross and BCN in upcoming webinars

Blue Cross Blue Shield of Michigan and Blue Care Network participating licensed professional counselors will receive direct reimbursement for covered mental health services within the scope of their licensure starting Jan. 1, 2016.

To learn more about this important change, we’re inviting LPCs to attend one of our LPC Update Webinars on Tuesday, Dec. 1, Thursday, Dec. 3, and Tuesday, January 12. The webinars will take place at 10 a.m. and 1 p.m. each day. They will include information about:

• The change to direct reimbursement
• Billing requirements
• How to enroll with Blue Cross and BCN
• Signing up to use our electronic systems

To register, download the invitation at right, complete the information requested and respond via email or fax. Please respond by Nov. 25 for the December webinars and by Jan. 8 for the January webinars.

Enroll now

LPCs can find Practitioner Agreements and enrollment forms on bcbsm.com/providers. Click on Enrollment and Changes under Join the Blues Network to find enrollment information. Specific qualification requirements are identified within each agreement. Qualified LPCs may apply for a Blue Cross provider identification number by completing the enrollment applications available on the same Web section. BCN individual enrollment requests will only be accepted until Feb. 1, 2016.

BCN offices closed for holiday

Blue Care Network offices will be closed on Nov. 26 and Nov. 27 for Thanksgiving.

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.
Blue Cross recognizes Blue Distinction Center+ designations for bariatric surgery

Thirteen Michigan facilities received distinction in the area of bariatric surgery this year. As you may recall from previous articles, a facility can earn the designation of either a Blue Distinction® Center — for delivering quality care resulting in better overall outcomes for bariatric patients — or a Blue Distinction® Center+ for delivering the same quality care as a Blue Distinction Center while also meeting key requirements for cost-efficiency. See a list of designated facilities at the end of this article.

To receive a Blue Distinction Center for bariatric surgery designation, a health care facility must:

- Demonstrate success in meeting patient safety measures.
- Demonstrate success in meeting bariatric-specific quality measures, including complications and readmissions for gastric stapling or gastric banding procedures.
- Have earned national accreditations at both the facility level and the bariatric care-specific level.

To receive a Blue Distinction Center+ for bariatric surgery designation, a health care facility must:

- Demonstrate quality. Only those facilities that first meet Blue Distinction’s nationally established, objective quality measures will be considered for Blue Distinction Center+ designation.
- Meet the criteria for a Blue Distinction Center for bariatric surgery.
- Demonstrate better cost-efficiency compared to its peers.

This year’s bariatric surgery designation includes facilities that are recognized for gastric banding, in addition to those recognized for gastric stapling.

Please see BDC+, continued on Page 11
Blue Cross Blue Shield of Michigan recognizes Spectrum Health Zeeland Community Hospital as one of the first health care facilities in the state to receive a Blue Distinction® Center+ designation for bariatric surgery by the Blue Distinction® Centers Specialty Care program.

From left: Ryan J. Powers (vice president of finance and system services, Spectrum Health Zeeland Community Hospital); Jane Czerew (vice president Nursing Services and Quality Services, Spectrum Health Zeeland Community Hospital); Lori Wolters (Bariatric Program coordinator, Spectrum Health Zeeland Community Hospital); Jawwad Baig (Blue Distinction Center administrator, Blue Cross Blue Shield of Michigan); Beth Mehall (provider consultant, Blue Cross Blue Shield of Michigan and Blue Care Network)

### Designated bariatric facilities

**Michigan facilities that received distinction in the area of bariatric surgery as of Oct. 1, 2015.**

<table>
<thead>
<tr>
<th>Facility name</th>
<th>Designated Blue Distinction Center+</th>
<th>Designated Blue Distinction Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borgess Medical Center, Kalamazoo</td>
<td>Gastric stapling</td>
<td>Gastric banding</td>
</tr>
<tr>
<td>Covenant Medical Center, Saginaw</td>
<td>Gastric banding</td>
<td>Gastric stapling</td>
</tr>
<tr>
<td>Henry Ford Hospital, Detroit</td>
<td>Gastric stapling</td>
<td>Gastric banding</td>
</tr>
<tr>
<td>Hurley Medical Center, Flint</td>
<td>Gastric stapling</td>
<td>Gastric banding</td>
</tr>
<tr>
<td>Marquette General Hospital, Marquette</td>
<td>Gastric banding</td>
<td>Gastric stapling</td>
</tr>
<tr>
<td>McLaren Flint, Flint</td>
<td>Gastric banding</td>
<td>Gastric stapling</td>
</tr>
<tr>
<td>MidMichigan Medical Center – Gratiot, Alma</td>
<td>Gastric banding</td>
<td>Gastric stapling</td>
</tr>
<tr>
<td>Mercy Health Mercy Muskegon Campus, Muskegon</td>
<td>Gastric stapling</td>
<td>Gastric banding</td>
</tr>
<tr>
<td>Sparrow Hospital, Lansing</td>
<td>Gastric stapling</td>
<td>Gastric banding</td>
</tr>
<tr>
<td>Spectrum Health Blodgett</td>
<td>Gastric banding</td>
<td>Gastric stapling</td>
</tr>
<tr>
<td>Spectrum Health Zeeland Community</td>
<td>Gastric banding</td>
<td>Gastric stapling</td>
</tr>
<tr>
<td>St John Macomb Oakland Hospital, Madison Heights</td>
<td>Gastric banding</td>
<td>Gastric stapling</td>
</tr>
<tr>
<td>William Beaumont Hospital, Royal Oak</td>
<td>Gastric banding</td>
<td>Gastric stapling</td>
</tr>
</tbody>
</table>
J&B Medical Supply enhances phone system to better serve providers

J&B Medical Supply has made enhancements to its phone system to improve service to providers

**Automatic call back** – If customer service representatives are helping other callers, providers will be able to enter a call-back number so customer reps can follow up. J&B can be reached at 1-888-896-6233.

**Improved call routing** – An automated system now routes callers to the right department or can offer self-service options to the caller.

**Coming soon**

**Network provider Web portal** – J&B plans to introduce a new secure Web portal so providers can update information, send questions, download documents and submit authorizations.

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**New Find a Doctor Web application makes it easier than ever to find network providers**

Later this year, we’ll be launching our new provider search at [bcbsm.com](http://bcbsm.com). The new Find a Doctor Web application will allow members to search for a person, place, condition or treatment all from one page. Members will be able to:

- Search with or without entering a specific plan
- Locate plans more easily
- Identify a plan when searching to see only in-network providers
- Filter on information like specialty, provider type and quality recognitions
- View episodic costs for treatment
- Read patient reviews and log in to leave a review of their own

Members who access Find a Doctor from their mobile devices will see everything available from the desktop version.

These features make finding a doctor easier and more convenient because members can find care based on criteria that are important to them, while bringing your office additional patients. These enhancements also give members the confidence and information they need to make more informed health care decisions.

Stay tuned for more information at [bcbsm.com](http://bcbsm.com).
BCN Advantages makes plan changes for 2016

BCN Advantage℠ members will see some increases in copayments for 2016. In addition, we have expanded our service area to include Luce, Schoolcraft and Mackinac counties as well as some St. Joseph ZIP codes.


We will continue to offer the following plans:
- BCN Advantage℠ Elements
- BCN Advantage℠ Basic
- BCN Advantage℠ Classic
- BCN Advantage℠ Prestige
- BCN Advantage℠ My Choice Wellness HMO
- BCN Advantage℠ HMO ConnectedCare

The following are changes for specific plans:
- BCN Advantage℠ Prestige — Specialist copay increased to $30
- BCN Advantage℠ Basic — Medical deductible increased to $405
- BCN Advantage℠ Basic — Skilled nursing facility copay increased to $160, days 21-100.
- BCN Advantage℠ Basic — Specialist copay increased to $50
- BCN Advantage℠ Basic — Inpatient acute copay increased to $285, days 1-6, $0 days 7-90. The inpatient mental health copay increased to $260, days 1-6 and $0 days 7-90.
- BCN Advantage℠ Classic — Gap coverage was removed

Please see 2016 BCN Advantage plan changes, continued on Page 14
2016 BCN Advantage plan changes, continued from Page 13

Other benefit changes that apply to all products included slightly higher copayments and tier changes for prescription drug coverage:

- Increased inpatient copay (hospital and mental health) by $25. (Higher copay change for BCN Advantage Basic – see previous page for specific plans).
- Increased emergency copay to new limit of $75 for all products
- Increased the ambulance copay to $150 for all products
- Increased outpatient hospital copay to $150 for all products
- Clarified chiropractic X-rays and office call as mandatory supplemental on all products
- Placed preferred insulin brand on tier 2 for all plans; leaving nonpreferred on tier 3
- Pharmacy deductible increased to $360 for Basic product
- CMS annual mandated Part D changes for the initial coverage limit, maximum true out-of-pocket (TROOP), and catastrophic on all Medicare Advantage Prescription Drug plans

BCN AdvantageSM HMO MyChoice Wellness benefit changes

- Increased emergency copay from 2015 limit of $65 to new 2016 limit of $75
- Increased the ambulance copay to $150 (all plans $25 increase)
- Increased outpatient hospital copay to $150 (all plans $50 increase); ambulatory outpatient remains at lower copay for less expensive place of service
- Increased inpatient hospital (acute medical and mental health) by $25 to $225
- Increased Part D tier 3 and tier 4 from $45/$95 to $47/$100
- Placing preferred insulin brand on tier 2 for all plans; leaving nonpreferred on tier 3
- Gap coverage removed for 2016
- Increased coverage limit copay to $47 and $100 for tier 3 and tier 4
- Updated Part D mandated changes for initial coverage limit, true out-of-pocket and catastrophic

Effective Jan. 1, 2016, the emergency/urgent care copay will not be subject to any plan-level deductible, if applicable. The $75 copay will also not reduce the plan deductible, if applicable. As required by the Centers for Medicare & Medicaid Services, the emergency room/urgent care copayments will still apply to the maximum out of pocket.
Year-end submission dates nearing for Diagnosis Closure Incentive Program

Blue Care Network and Blue Cross Blue Shield of Michigan 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 Blue Cross Medicare Advantage patients. Here are the details you need to know.

**Schedule patient visits by end of year**

Be sure to see your Blue Care Network and Blue Cross Medicare Advantage patients before the end of the calendar year to document and close diagnosis and treatment opportunity gaps. Information about gap closures should be submitted via Health e-BlueSM under Panel – Diagnosis Evaluation and Treatment Opportunities by Condition/Measure by Jan. 28, 2016. You may also submit a claim as part of your documentation.

**Diagnosis Closure Incentive Program**

All the diagnosis gaps included in the 2015 Diagnosis Closure Incentive for Jan. 1 through Sept. 30, 2015, are listed on Health e-BlueSM under Panel – Diagnosis Evaluation. To earn incentives, physicians must close all the diagnosis gaps (identified through Sept. 30, 2015) that exist for a patient through a face-to-face visit before the end of 2015. Physicians can also notify Blue Care Network or Blue Cross that the patient doesn’t have the suspected or previously reported diagnosis.

Diagnosis gaps will continue to appear on Health e-Blue from Oct. 1 through Dec. 31, 2015. 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 2015 Diagnosis Closure Incentive Program. An FAQ and fact sheet can also be found on web-DENIS. Go to BCN Provider Publications and Resources and click on Patient Care Reporting for Risk Adjustment in the Resources section.

Diagnosis and treatment opportunity closures must be submitted to Blue Care Network and Blue Cross by the following dates:

<table>
<thead>
<tr>
<th>Method</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim submission</td>
<td>Received by Feb. 29, 2016</td>
</tr>
<tr>
<td>Health e-Blue</td>
<td>Entered by Jan. 28, 2016</td>
</tr>
</tbody>
</table>

If you don’t have access to Health e-Blue, [sign up today](#).

If you have questions, contact your provider consultant.

The Diagnosis Closure Incentive program will continue in 2016. 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.

**Important note about closing diagnosis gaps**

When using Health e-Blue’s Diagnosis Evaluation panel to confirm or deny a patient’s condition, 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 confirmed by you as no longer having the condition or the suspected condition does not exist.

Keep in mind that if a prior year service date is entered for a 2015 diagnosis gap, the diagnosis gap will open with the next refresh and the gap closure won’t count toward your 2015 incentive payment.
Select insulin products moved to generic copay tier

Effective Jan. 1, 2016, BCN AdvantageSM will move certain insulin products to our generic copayment tier (Tier 2) to make it easier for Medicare members to save money and manage their diabetes. Our goal is to increase access and improve compliance with these drugs by reducing the members’ out-of-pocket costs.

Patients who switch to a generic-tier insulin from preferred brand (Tier 2) insulin product could have lower out-of-pocket copayments before they reach the coverage gap. Members who use two Tier 3 insulin products may save twice as much by switching. Individual savings will vary depending on the patient’s benefit.

<table>
<thead>
<tr>
<th>Members pay a Tier 2 (generic) copay for these insulin products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lantus®</td>
</tr>
<tr>
<td>Novolin® N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 3 (preferred brand copay) insulin products</th>
</tr>
</thead>
<tbody>
<tr>
<td>These insulin products remain on Tier 3 and the member’s copay stays the same.</td>
</tr>
</tbody>
</table>

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

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

BCN Advantage℠ has developed a new Patient Assessment Form that can help you identify treatment needs for your BCN Advantage patients. The form is located in e-referral.

Here’s how you can use the form to save time and improve communication.

What is it for?

The Patient Assessment Form helps you identify a BCN Advantage member’s care needs at each visit. It contains 10 questions that the Centers for Medicare & Medicaid Services believes are essential for practitioners to ask at each visit. The member fills out the form at the time of the visit and you can see the member’s answers at a glance. This allows you to focus on anything of concern without needing to ask the member each question.

BCN Advantage does not need the answers to these questions; the form is merely a tool you can choose to use in your office. This form is also not a replacement for the more comprehensive Medicare Advantage member health assessment form that we mail to every new BCN Advantage member and annually to all BCN Advantage members.

How does it work?

Your office staff gives the Patient Assessment Form to the member when he or she arrives for an appointment. The member completes the form while waiting to be seen. You review the member’s answers during the visit and ask the member about anything of concern.

Makes your job easier

The Patient Assessment Form is designed to make your job easier and help you enhance communication with your BCN Advantage patients.

Additional information

CMS surveys BCN Advantage and other Medicare Advantage members to assess the adequacy and quality of the health care they receive. The surveys CMS uses focus on the topics that are included in the Patient Assessment Form. When you use this form with your patients, those patients will be in a position to report that you’ve discussed these key topics with them during their visits.
Smoking cessation is part of the Million Hearts initiative

Our Chronic Care Improvement program helps to prevent cardiovascular disease in BCN Advantage™ members. Our program emphasizes member self-management strategies and partnerships with physicians. Prevention of cardiovascular disease will help us meet our other important goals to decrease heart attacks, strokes and related deaths in BCN Advantage members.

Previous articles have focused on the clinical interventions championed by Million Hearts™, a public initiative led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services to prevent 1 million heart attacks and strokes in the U.S by 2017. The Million Hearts clinical interventions focus on improved management of the “ABCs” – A spirin for high-risk patients, B lood pressure control, C holesterol management and S moking cessation.

In this issue, we focus on smoking cessation. We all know that smoking cigarettes is one risk factor for heart disease and stroke that is controllable and preventable. Reducing this risk factor in our BCN Advantage members requires efforts from all of us. Here are some facts about smoking that you can share with your patients who smoke.

Tobacco use remains the single largest preventable cause of death and disease in the United States. Cigarette smoking kills more than 480,000 Americans each year, with more than 41,000 of these deaths from exposure to secondhand smoke. In addition, smoking-related illness in the United States costs more than $300 billion a year, including nearly $170 billion in direct medical care for adults and $156 billion in lost productivity.
Smoking cessation, continued from Page 18

In 2013, an estimated 17.8 percent (42.1 million) adults in the United States were current cigarette smokers. Of these, 76.9 percent (32.4 million) smoked every day, and 23.1 percent (9.7 million) smoked some days.

Here are some facts about secondhand smoke:

- During 2011–2012, an estimated 58 million nonsmokers in the United States breathed other smokers’ tobacco smoke.
- Secondhand smoke exposure among nonsmokers decreased from 52.5 percent during 1999–2000 to 25.3 percent during 2011–2012.
- During 2011–2012, secondhand smoke exposure was highest among:
  - Children aged 3 to 11 years (40.6 percent)
  - Non-Hispanic Blacks (46.8 percent)
  - People living below the poverty level (43.2 percent)
  - People living in rental housing (36.8 percent)
- Each year, more than 41,000 nonsmoking adults die from exposure to secondhand smoke.
- Nearly 34,000 from coronary heart disease
- About 7,300 from lung cancer
- Nonsmokers who are exposed to secondhand smoke at home or work increase their lung cancer risk by 20 to 30 percent.

BCN has a tobacco cessation program for your BCN Advantage patients who smoke:

- **Tobacco Cessation – Quit the Nic®** The Blue Cross tobacco cessation efforts include the free telephone-based Quit the Nic® program. Quit the Nic emphasizes a members’ readiness to change. The program consists of four outgoing calls and unlimited inbound calls. This program will be available until Dec. 31, 2015. Effective Jan. 1, 2016, we will be transitioning to WebMD’s tobacco cessation program. We’ll provide more details on this program in an upcoming issue of the BCN Provider News.

BCN has a performance recognition program for physicians:

- **Performance Recognition:** BCN’s Million Hearts Incentive Program for BCN Advantage rewards physicians who counsel their patients on the importance of quitting smoking. Report CPT II code 4000F or 4004F for each patient identified as a tobacco user and who received tobacco cessation counseling.

Preventing 1 million heart attacks and strokes in the next five years will require the work and commitment to change from all of us. We look forward to working with you. Look for more information about our Chronic Care Improvement Program in future editions including the results of our chart audits that we conducted earlier this year.

References


What you need to know about Medicare fraud, waste and abuse

Medicare pays doctors, hospitals, pharmacies, clinics and other health care providers to take care of children and adults who need help getting medical care. Sometimes, providers and patients misuse Medicare resources, leaving less money to help people who need care. This misuse is called fraud, waste and abuse.

Definition of fraud

Fraud occurs when someone intentionally deceives or misrepresents the truth, knowing that it could result in some unauthorized benefit to himself or herself or some other individual.

Fraud schemes range from those committed by individuals acting alone to broad-based activities by institutions or groups of individuals. Seldom do these schemes target only one insurer or the public or private sector exclusively.

Most are simultaneously defrauding several private and public sector victims, including Medicare. Medicare health care fraud is defined in Title 18, United States Code (U.S.C.) § 1347, as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Definition of abuse

Abuse occurs when provider practices are inconsistent with sound business or medical practices, resulting in an unnecessary cost to the Medicare program. Abusive practices involve payment for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Differences between fraud and abuse

Fraud is distinguished from abuse in that there is clear evidence that the fraudulent acts were committed knowingly and intentionally. Abusive billing practices, on the other hand, may not be intentional or it may be impossible to show that intent existed. Although these types of practices may initially be classified as abusive, they may develop into fraud if there is evidence that the provider was intentionally conducting an abusive practice.

Please see Fraud, continued on Page 21
Fraud, continued from Page 20

Definition of waste
Waste involves payment or billing for items or services when there was no intent to deceive or misrepresent, but the outcome of poor or inefficient billing or treatment methods causes unnecessary costs.

Minimizing fraud, waste and abuse means the federal government can provide more care to more people and make the Medicare program even stronger.

Together, all of us can work to find, report and investigate fraud, waste and abuse.

Fraud, waste and abuse prevention
See our policy and applicable laws on web-DENIS under BCN Provider Publications and Resources. Click on Policies and Information and then Detection and Prevention of Fraud, Waste and Abuse Policy. Information on fraud, waste and abuse can also be found in the BCN Provider Manual.

BCN Advantage HMO-POS℠ and BCN Advantage℠ HMO providers and members can report fraud and abuse to the anti-fraud hotline for Blue Cross Blue Shield of Michigan at 1-888-650-8136.

Providers and vendors are required to take CMS training on Medicare fraud

Providers are required by the Center for Medicare & Medicaid Services to take CMS-specific training about fraud, waste and abuse and compliance. Training is available at cms.gov.

Providers and vendors should make sure that governing body members and any employees (including volunteers and contractors) providing health or administrative services in connection with the BCN Advantage℠ program or the Blue Cross Blue Shield of Michigan Medicare Advantage program complete the training within 90 days of being hired and annually thereafter. Be sure to keep the certificate generated by the website as proof that you took the training and retain evidence of training for 10 years from the end date of your contract with BCN or Blue Cross. You need to be able to provide proof to BCN, Blue Cross or CMS if requested.
New diabetes self-management and education recommendations

The American Diabetes Association, American Association of Diabetes Educators and the Academy of Nutrition and Dietetics issued a joint statement that offered new guidance on diabetes self-management education and support.

New recommendations encourage those living with diabetes to receive diabetes self-management education and support, also called DSME/S. Diabetes self-management education and support refers to information and skills a person with diabetes needs for appropriate self-care and the support they need to perform those skills.

People with diabetes should receive this self-management education and support at four critical times in their lives — at diagnosis; yearly; when changes in health occur that affect self-management; and any change in care, including changes in insurance that could affect treatment.

The Michigan Department of Health and Human Services has recommended that people with diabetes and their caregivers speak to their doctors about referrals to one of Michigan’s 93 DSME/S programs which offer a Certified Diabetes Educator. The educator works with patients to develop an individual education plan and to set goals.

The joint statement is available on the American Diabetes Association website.
How to contact Blue Cross Complete utilization management staff

Blue Cross Complete provides the following communications services for members and practitioners:

- Staff is available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding utilization management issues.
- Staff can receive inbound communication regarding utilization management issues after normal business hours.
- We offer TDD/TTY services for members who need them.
- Language assistance is available for members to discuss utilization management issues.

Providers can contact Blue Cross Complete’s Utilization Management department for plan notification or clinical review at 1-888-312-5713 (press 1) during normal business hours, 8:30a.m. to 5:00p.m., Monday through Friday.

For urgent or emergent requests after normal business hours and 24 hours on weekends and holidays, a physician and nurse are available to review requests and authorize medically appropriate services. Providers should call 1-888-312-5713 (press 1). The call will be forwarded to the reviewer on call.

Certified translation services are available to all Blue Cross Complete providers and to eligible Blue Cross Complete members whose primary language may not be English or who have limited English proficiency. Providers are encouraged to use these services to ensure all information is accurately communicated to members.

Members who access care in any setting (ambulatory, outpatient or inpatient) can call Blue Cross Complete Customer Service at 1-800-228-3354 for assistance with any or all of the following:

- Translating health plan documents
- Obtaining health plan documents in alternative formats
- Translation and interpretive services are available in more than 200 languages. Providers and members can call 1-800-228-3354 to:
  - Obtain these services immediately over the telephone
  - Schedule an appointment for services to be delivered either by telephone or in person

TTY and TTD services are also available for both providers and members who are sensory impaired. To obtain these services, providers and members should call 1-800-987-5832.

Providers can request criteria for utilization management decisions

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

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

Providers have the right to request the information used to make a decision. This includes benefit guidelines or other criteria. To request this information, providers should write to the Appeals Coordinator at the following address:

Appeals Coordinator
Blue Cross Complete of Michigan
Suite 210
100 Galleria Officentre
Southfield, MI 48034
Member rights and responsibilities outlined in *Blue Cross Complete Member Handbook*

Members can review their rights and responsibilities, information on benefits and coverage, how to obtain services, and how to voice a complaint or appeal at any time by reading the *Blue Cross Complete member handbook* on MiBlueCrossComplete.com.

To get a printed copy, call Blue Cross Complete Customer Service at 1-800-228-8554.

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**Pharmacy resources available for Blue Cross Complete**

Throughout the year, the Blue Cross Complete Pharmacy and Therapeutics Committee approves formulary changes.

These changes are published as a *Pharmacy Update* document, which can be found in the Pharmacy section at MiBlueCrossComplete/providers.

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

By Robert Goodman, D.O.

The medical policy department, although located at Blue Care Network, develops policies for the entire enterprise, both Blue Cross Blue Shield of Michigan and BCN. I’m discussing medical policies in this column to give providers a better understanding of how we write policies, determine criteria for coverage and the outside resources we use to make these decisions.

The primary focus of the medical policy department is the development and maintenance of the more than 450 joint Blue Cross and BCN, as well as some BCN-only, medical policies that provide information on specific medical technologies that include procedures, equipment and services, as well as the coverage determination and any applicable criteria for coverage.

Policies may be written for a number of reasons:

- Reviewing new technologies to determine coverage status (for example, established or investigational)
- Defining specific criteria which must be met for a service or technology to be covered
- Determining the status of new CPT and HCPCS codes
- Providing support for coverage decisions

Policy requests, or re-reviews of current policies, are prioritized according to the need identified. When issues are presented that require an urgent review, every effort is made to move these policy topics up in the review cycle. Policies are authored by the medical policy coordinators, working in close concert with our enterprise physician team, and include a thorough review of medical literature and input from specialty physicians as needed. Input from professional societies is also regularly requested. The policies are then presented at the enterprise Joint Uniform Medical Policy (JUMP) committee, or BCN Clinical Quality Committee for BCN-only policies. The JUMP committee meets a minimum of four times a year, usually every other month. The physician voting members (two BCN physician employees, two Blue Cross physician employees and one external physician) make recommendations to the Chief Medical Officers of Blue Cross and BCN as to whether or not the enterprise will consider the procedure in question to be established with any specific criteria for coverage, or not established (experimental or investigational).
From the medical director, continued from Page 25

Most procedures (including labs, radiology, surgery and obstetrics) can usually be represented by either a CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) code. These codes are formatted by either a five-digit number or five-place alphanumeric character. The procedure codes are listed on the medical policy to which they refer.

The following sources are used in the development and revision of JUMP medical policies:

- Policies and technology assessments published by the Blue Cross Blue Shield Association and the Blue Cross Blue Shield Association Technology Evaluation Center
- Medicare (local or national) determinations
- Hayes Technology Assessments
- Current published peer-reviewed medical literature
- Evidence-based guidelines developed by national organizations and recognized authorities (for example, specialty societies and organizations)
- Generally accepted standards of medical practice
- External practicing physician review
- Government approval status (for example, the U.S. Food and Drug Administration)

Medical policies are published on line and available to providers. Significant policy changes are communicated through our provider newsletters, BCN Provider News and The Record. (See Medical policy updates, Page 31.)

Providers can find medical policies online

To view medical policies on bcbsm.com, log in to web-DENIS and go to BCN Provider Publications and Resources. Then click on Medical Policy Manual under Resources.

Medical policy updates are published in each issue of BCN Provider News.
New postpartum checkup program available for BCN members

Postpartum care is a critical part of a healthy pregnancy. As a convenience for our members, Blue Care Network of Michigan now offers eligible BCN members their six-week postpartum checkup in their homes.

Although members are encouraged to follow up with their obstetrics provider first, the home visit program can be used as a secondary alternative to be sure members get the care they need from the 21st through the 56th day after the delivery date. This service began on Sept. 15, 2015, and is available to BCN members with commercial plans and helps improve a HEDIS® measure aimed at the compliance rates for postpartum visits.

Michigan Community Visiting Nurse Association nurse practitioners conduct the in-home postpartum visit with permission from the member’s obstetrician. The visit includes:

- A physical exam, including a breast exam
- Measurement of weight and vital signs, including blood pressure
- Contraceptive options
- Education on sexually transmitted infection prevention
- Screening and assessment for postpartum depression

Nurse practitioners can also answer any questions the patient may have. The exam will be documented on a postpartum exam form and sent to the OB provider for their records. The postpartum visit is a covered benefit, but copayments will apply.

For more information about the in-home postpartum program, please call Belinda Bolton at 1-800-392-4247.

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

Immunizations included in requirement to report national drug code number on professional drug claims beginning Nov. 1

Please see full article on Page 49.
Blue Care Network does not cover digital breast tomosynthesis

It has come to our attention recently that there has been an increase in appeals related to digital breast tomosynthesis, which is not a covered benefit by Blue Care Network or Blue Cross Blue Shield of Michigan.

This is a reminder that BCN doesn’t cover digital breast tomosynthesis. The procedure is considered investigational for both the screening and diagnosis of breast cancer. BCN doesn’t provide coverage for investigational services or procedures.

Digital breast tomosynthesis uses modified digital mammography equipment to obtain additional radiographic data to reconstruct cross-sectional “slices” of breast tissue. Conventional mammography produces 2-D images of the breast.

Digital breast tomosynthesis was developed to improve the accuracy of mammography by capturing three-dimensional images of the breast, further clarifying areas of overlapping tissue. Developers proposed that its use would result in increased sensitivity and specificity, as well as fewer recalls due to inconclusive results.

Currently, BCN has determined that digital breast tomosynthesis is experimental for both screening and diagnosis of breast cancer as there is insufficient clinical evidence supporting that it improves health outcomes. Additional studies are pending.

Medicare does allow coverage for digital breast tomosynthesis, when reported in addition to a screening or diagnostic mammogram. Therefore, this service will be covered for BCN AdvantageSM members.

Providers encouraged to use evidence-based recommendations to make decisions about care

Choosing Wisely® is an initiative of the ABIM Foundation (American Board of Internal Medicine) that aims to promote conversations between physicians and patients to think and talk about medical tests and procedures that may be unnecessary and, in some instances, can cause harm.

To assist in these conversations, several specialty societies have created lists of “Things Physicians and Patients Should Question” — evidence-based recommendations that should be discussed to help make wise decisions about the most appropriate care based on a patient’s individual situation.

We’ll be publishing a series of articles on Choosing Wisely initiatives in upcoming issues of BCN Provider News.

For additional information, providers can visit choosingwisely.org.
Help us improve our services to you by taking our Care Management survey

Now is your chance to let us know how satisfied you are with Care Management services from Blue Care Network. Take our Care Management survey and you could win a $250 gift card.

Your feedback is important to us because it will help us improve our Care Management processes. Please complete the survey and encourage the physicians, nurses, referral coordinators and others in your office to take it, too.

Responses must be submitted no later than Dec. 31, 2015 to be eligible for the random drawing. Two winners will be selected from all eligible entries approximately one week after the close of the survey. The winner will be notified by telephone or email.

You can find the survey at http://tinyurl.com/2015BCNCM.

Note: This drawing is open to all contracted BCN providers. If you do not wish to participate in the survey but wish to be included in the drawing, you may enter by emailing BCNPhysicianSurvey@bcbsm.com with your entry request. Please include your name, office name, NPI and address. All requests must be emailed no later than Dec. 31, 2015.
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:
Under the IQ criteria for appendectomy it doesn’t specify laparoscopic or open procedure. Would you clarify whether it would be appropriate to use laparotomy when reviewing for an open appendectomy?

Answer:
Based on clarification from McKesson, the reviewer cannot use laparotomy when reviewing for an open appendectomy. There is a listing for "laparotomy" on the inpatient list, under the General heading. The listing for laparotomy refers to a laparotomy performed as an isolated procedure, most often as an exploratory laparotomy.

A simple noncomplicated appendectomy is an outpatient procedure. Open or laparoscopic appendectomy is considered outpatient per BCN Local Rules even if the appendix is suppurative, gangrenous or ruptured.

Question:
A member went in for an outpatient procedure and on postop day 1 returned to surgery for an exploratory laparoscopy. Following surgery, there was an inability to void which required a straight cath. An inpatient setting was requested with documentation stating that the member meets the InterQual Adult Level of Care criteria found under General Surgery Page 703: Post-OP Day 1, Acute: Inability to void requiring catheterization. Was this the correct criterion to use?

Answer:
Upon clarification from McKesson, the inpatient criterion was not the correct setting to use. The surgery would have to be approvable for inpatient in order to use this criterion. Post Op Day 1 Observation criteria page 701 would be the appropriate selection. The criteria point of postambulatory surgery or procedure found under the bullet point of Unable to void and requiring urinary catheter would be the correct selection.
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 (annually, or every two years in absence of retinopathy)
- Consider TSH and LFTs

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

The level of HbA1c may be reduced with lifestyles choices of 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 from 8:30 a.m. to 5 p.m., Monday through Friday.

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:

Covered services

- Chromosomal microarray analysis and next-generation sequencing panels, for the evaluation of children with developmental delay/intellectual disability, autism spectrum disorder, and/or congenital anomalies
- Chromosomal microarray testing for the evaluation of early pregnancy loss and intrauterine fetal demise
- Genetic testing for carrier status of genetic diseases
The Great American Smokeout is Nov. 19

The American Cancer Society marks the Great American Smokeout on the third Thursday of November each year by encouraging smokers to use the date to make a plan to quit, or to plan in advance and quit smoking that day. By quitting even for one day smokers will be taking an important step toward a healthier life, one that can lead to reducing cancer risk. This is also a time for users of smokeless tobacco as well, since there is no safe alternative to smoking.

Tobacco use remains the single largest preventable cause of disease and premature death in the United States, yet approximately 42 million Americans or one in every five adults still smokes cigarettes, according to the American Cancer Society. As of 2012, there were also 13.4 million cigar smokers in the U.S., and 2.3 million who smoke tobacco in pipes.

Secondhand smoke
According to the 2014 Surgeon General’s Report, there have been more than 20 million smoking-related deaths in the United States since 1964; 2.5 million of those deaths were among nonsmokers who died from exposure to secondhand smoke. Secondhand smoke is also known as environmental tobacco smoke. SHS is a mixture of two forms of smoke that come from burning tobacco:

1. **Side stream smoke**: Smoke from the lighted end of a cigarette, pipe or cigar
2. **Mainstream smoke**: The smoke exhaled by a smoker

Even though we think of these as the same, they aren’t. Side stream smoke has higher concentrations of cancer-causing agents (carcinogens) and is more toxic than mainstream smoke. It has smaller particles than mainstream smoke. These smaller particles make their way into the lungs and the body’s cells more easily. When nonsmokers are exposed to SHS it’s called involuntary smoking or passive smoking. Nonsmokers who breathe in SHS take in nicotine and toxic chemicals by the same route smokers do. Quitting smoking alleviates exposure to second hand smoke that is harmful to others.

Blue Care Network offers Quit the Nic, a smoking cessation program to help members successfully end the use of tobacco products. Members can call 1-800-811-1764 to schedule a time to speak with a health coach. Effective January 1, 2016, BCN has partnered with WebMD for the tobacco cessation coaching program.

We encourage physicians to counsel all patients who smoke (or use smokeless tobacco) at each visit.

Sources: Cancer Facts & Figures 2014; and US Surgeon General Report 2014 American Cancer Society
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
- Measure height and weight and calculate body mass index
- Obtain blood pressure measurement at age 3 and then yearly if normal
- Lipid screening, if indicated
- Review child’s diet and daily physical activity
- Inquire about tobacco use by parents and by the child (beginning at age 12) including secondhand smoke exposure and 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. Your patients 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)
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 respiratory syncytial virus 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 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 high-risk infants are no longer at such a risk, AAP has developed new criteria to identify those high-risk infants:

- 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 for:

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

- Infants younger 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 Native American 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 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/index.html

References:

BCN Policy, Palivizumab.

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
Type 2 diabetes in children can be prevented

While type 2 diabetes is usually diagnosed in adults, it’s increasingly diagnosed in children and adolescents, particularly in Native Americans, African-Americans, and Hispanics and 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 and 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.
- Assessing dietary patterns (for example, frequency of eating away from home, consumption of breakfast, frequency of fruit and vegetable intake, portion sizes)
- Assessing physical activity level

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. Studies in adults have indicated that if an individual can reduce his or her body weight by 5 to 7 percent and maintain at least moderate activity for 30 minutes most days of the week, the risk of diabetes is reduced.

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 is obtained.
Reminder: CDC guidelines for pneumococcal vaccination of those 65 years of age and older

Physicians should be aware of recent Advisory Committee on Immunization Practices recommendations for routine pneumococcal conjugate (PCV 13, Prevnar) vaccination of those 65 years of age and older. The interval between the PCV13 and PPSV23 was changed to ≥ 1 year only for those 65 years of age and older, as reported in the Sept. 4, 2015 edition of the Morbidity and Mortality Weekly Report.

The three specific recommendations for those 65 years of age and older are:

1. **Pneumococcal vaccine-naïve persons** — Adults age 65 and older who have not previously received the pneumococcal vaccine or whose vaccination history is unknown should receive a dose of PCV13 first, followed by a dose of pneumococcal polysaccharide vaccine (PPSV23, Pneumovax). The dose of PPSV23 should be given ≥ 1 year after a dose of PCV13. If PPSV23 cannot be given during this time window, the dose of PPSV23 should be given during the next visit. The two vaccines should not be given at the same time. The minimum acceptable interval between PCV13 and PPSV23 is eight weeks. Adults age 65 years or older with immunocompromising conditions, functional or anatomic asplenia, cerebrospinal fluid (CSF) leaks, or cochlear implants are recommended to receive PCV13 first, followed by PPSV23 ≥8 weeks later to faster cover this at-risk population from the most strains possible. If a dose of PPSV23 is inadvertently given earlier than the recommended interval, the dose need not be repeated.

2. **Previous vaccination with PPSV23** — Adults age 65 years and older who have previously received at least one dose of PPSV23 also should receive a dose of PCV13 if they have not yet received it. A dose of PCV13 should be given no sooner than one year after the patient’s most recent PPSV23 dose. For those for whom an additional dose of PPSV23 is indicated, this subsequent PPSV23 dose should be given six to 12 months after PCV13 and at least five years after the most recent dose of PPSV23.

3. **Potential time-limited utility of routine PCV13 use among adults age 65 and older** — The recommendations for routine PCV13 use among adults age 65 and older will be reevaluated in 2018 and revised as needed. The guidance for other adults is unchanged. ACIP recommends routine use of PCV13 only in adults age 19 to 64 with immunocompromising conditions, functional or anatomic asplenia, cerebrospinal fluid leak or cochlear implants.

Medicare may not be able to implement this two-dose rule until 2016, because coverage rules have already been published for 2015, but Blue Care Network has already updated its policies to match the recommendations. Watch for updated information from the Centers for Medicare & Medicaid Services when treating Medicare members who do not have BCN AdvantageSM coverage.
Re-evaluation of ABA autism treatment every three years required only for some members

After careful consideration, Blue Cross Blue Shield of Michigan and Blue Care Network have decided that a re-evaluation of applied behavior analysis autism treatment after every three years will be required only in the following instances:

- When a member has shown only minimal progress in autism treatment
- When there is a significant question about the continued accuracy of a member’s diagnosis or treatment plan

Background
A component of the state’s autism mandate is that insurance companies may require a re-evaluation for members at three-year intervals of ABA autism treatment. Because the mandate began three years ago, in 2012, many of our members are now approaching the time that the re-evaluation would be required.

Blue Cross and BCN have decided that the mandatory review is not needed for many members who are in ABA autism treatment. We expect that the members who do need re-evaluation and redirection of their ABA treatment will come to our attention through the continuous monitoring, evaluation and utilization management that providers are doing together with our behavioral health care managers. In addition, Blue Cross and BCN may require that a member undergo annual developmental testing as a standardized method of measuring treatment progress.

Blue Cross and BCN also rely on providers to identify a member’s potential additional needs during the utilization review process, which may include various evaluations (psychiatric, pediatric, neurological, speech therapy, occupational therapy, physical therapy or other types) and services. These needs should be discussed by the providers and the behavioral health care managers as part of the ongoing utilization management process for a member in ABA autism treatment.

What’s in the literature?
The literature has shown that the most rapid benefit from ABA treatment comes in the first two years, followed by slower, continued improvement. O. Ivar Lovaas, Ph.D., an autism researcher, and others included in Christina M. Corsello’s large meta-analysis1,2 of the research have identified that approximately one-third of individuals getting ABA interventions experience good improvement; another third experiences moderate improvement and the remaining third experiences only minimal improvement.

Research also shows that approximately 10 percent of members with autism reach stable remission of symptoms, which is the ultimate goal of successful intervention.

In light of this evidence-based information, Blue Cross and BCN have determined that the members in need of the more thorough re-evaluation are likely those showing minimal or no improvement in ABA treatment.

This decision is consistent with the behavioral health medical necessity criteria used by New Directions (the Blue Cross behavioral health care manager) and by BCN. These criteria require that when treatment fails to result in the member’s continued improvement, the treatment plan and interventions must be evaluated and adjusted. This is standard practice in learning-theory-based interventions.

Collaboration is key
Blue Cross and BCN appreciate the collaborative relationship we have with our autism treatment providers and their treatment teams. We also know how critical this collaboration is to our members achieving enhanced functioning within their family and social networks.

References
Direct reimbursement available to licensed professional counselors beginning Jan. 1, 2016

Starting Jan. 1, 2016, licensed professional counselors will have the opportunity to participate as Blue Care Network providers. Participating LPCs can receive direct reimbursement for covered mental health services within the scope of their licensure. Licensed professional counselors who currently bill BCN under a fully licensed psychologist supervisor will no longer be able to bill that way starting Jan. 1, 2016.

BCN is allowing LPCs to enroll as individual practitioners between Oct. 1, 2015, and Jan. 31, 2016. Beginning Feb. 1, 2016, LPCs who want to enroll in BCN can do so only as part of a group practice.

Enrollment opens on October 1. On that date, the enrollment forms and contract documents will be available at bcbsm.com/providers. To enroll, LPCs must complete the following steps:
1. Click Join our network.
2. Click Provider enrollment form.
3. Click Physicians and professionals and Next.
4. Click Enroll a new provider and Next.
5. Click Licensed Professional Counselor under the Behavioral Health heading, and Click Next
6. Make your additional selections as appropriate and submit the required documents. See the sidebar for additional instructions.

All applicants must pass a credentialing review prior to participation, regardless of whether they enroll as individuals or as part of a group practice. We’ll notify applicants in writing of their approval status.

Licensed professional counselors who practice in a substance abuse/outpatient psychiatric clinic (OPC) setting may continue to do so and do not have to go through any additional application process.

The document Requirements for providing behavioral health services to BCN members will be updated and available on the Web by Jan. 1, 2016. This document provides guidelines for various types of BCN behavioral health providers. It is available at ereferrals.bcbsm.com. Click Behavioral Health.
Quality corner: Follow-up after hospitalization

What is the follow-up after hospitalization for mental illness (seven days) measure, according to the Healthcare Effectiveness Data and Information Set guidelines?
The percentage of members 6 years or older who were hospitalized for treatment of a selected mental disorder and who had an outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within seven days of discharge.

Why is it important?
Getting a follow-up in a timely manner may:
- Lower the chance of re-hospitalization
- Detect adverse responses to medications early on
- Ensure progress made during hospitalization is retained
- Provide continued support

How can I ensure my patients are getting follow-up visits?
- If you are the discharging hospital, make sure the patient has a follow-up visit scheduled before leaving your facility.
- If you are the mental health practitioner accepting the patient for follow-up, make sure that your office has capacity to see the patient within seven days, so that the patient’s appointment is not delayed or rescheduled

Please remember that patients are very vulnerable during the time after discharge. Continued care after stabilization in the hospital setting is exceptionally important for them to maintain stability as they transition back into their environment.

Resources for you
Have questions? Contact your provider consultant by going to bcbsm.com/providers.

Blue Care Network is offering an incentive for this measure, as part of its Behavioral Health Incentive Program. Each time an office completes the measure according to HEDIS® guidelines, they are qualified to receive $125.

To learn more about the incentive program, please see the article on Page 41.

References:
1. https://www.harvardpilgrim.org/portal/page?_pageid=253,277266&_dad=portal&_schema=PORTAL

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Providers can help patients manage seasonal affective disorder

Seasonal affective disorder or seasonal mood disorder is a type of depression that tends to occur and recur as the days grow shorter during the fall and winter months. Seasonal affective disorder is considered a subtype of major depression or bipolar disorder. Even with a thorough evaluation, it can sometimes be difficult to diagnose SAD because other types of depression or other mental health conditions can cause similar symptoms.

The DSM-5 criteria for diagnosing depression with a seasonal pattern include having these experiences for at least the last two years:

- Depression that begins during a specific season every year
- Depression that ends during a specific season every year
- No episodes of depression during the season in which the patient experiences a normal mood
- Many more seasons of depression than seasons without depression over the lifetime of the patient’s illness

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 depressed mood, lack of energy; carbohydrate cravings and increased appetite with weight gain; decreased interest in work or significant activities of daily living; increased sleep and excessive daytime sleepiness; social withdrawal; decreased energy and concentration; and slow, sluggish, lethargic movement.

Recent research by the National Alliance on Mental Illness has found that some people may experience “reverse SAD”, where symptoms occur in the summer rather than winter. The symptoms may include insomnia, decreased appetite, weight loss, agitation or anxiety.

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

According to NAMI, SAD is sometimes misdiagnosed as hypothyroidism, hypoglycemia, chronic fatigue syndrome, infectious mononucleosis and 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.
SAD, continued from Page 40

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 re-evaluation of the member’s status by a physician at regular intervals
- Monitoring diet, especially carbohydrate intake
- Exercise therapy. Staying active helps the brain release chemicals to improve mood and decrease stress. A goal would be to complete 30 minutes of aerobic exercise three to five times weekly.
- Stress management and relaxation techniques
- Getting enough sleep, at least eight hours per night
- Talk therapy to help identify and change negative thoughts and behaviors that might be playing a part in presenting symptoms

As the seasons change, the symptoms usually resolve or decrease. Some people may have the disorder throughout their lives, but the outcome can be positive with continuous treatment.

BCN patients don’t need a referral from their primary care physician to access their mental health and substance abuse benefits. If you need assistance in identifying a referral for a BCN member, please contact the behavioral health department at 1-800-482-5982. This number is listed on the back of the patient’s insurance card.

Sources:
MQIC Guidelines, Depression Management mqic.org
National Health Institute, www.nih.gov
National Alliance on Mental Illness, www.nami.org
Diagnostic and Statistical Manual of Mental Disorders (DSM-5), June, 2013

Blue Care Network Behavioral Health Incentive Program 2015 updates

Self-reported submissions have increased significantly for the Behavioral Health Incentive Program. In just the first six months of 2015, submissions are nearly triple that of 2014.

We are continuing to streamline the self-reported submission process. For example, we have launched an electronic option for the self-reported form submissions. It is not a mandated approach, but simply an option in place of faxing or e-mailing individual forms.

Instructions on how to submit forms electronically, as well as documents regarding the program in general, can be accessed on web-DENIS.

Go to BCN Provider Publications and Resources
Click on Behavioral Health under Resources
Scroll down to Behavioral Health Incentive Program

Lastly, we are trying to ensure that payments are released in a timely manner. In the past, the second six months self-reported payment would go out with the BCN-assessed annual payment. Moving forward, the second six months self-reported payment will be released independently, so that providers can receive that portion of the incentive sooner.

Again, thank you to all the behavioral health providers who participated. We appreciate your efforts to improve members’ health.
Blue Care Network has submitted its Healthcare Effectiveness Data and Information Set measures to the National Committee for Quality Assurance for the accreditation process.

HEDIS® is the most widely used set of performance measures in the managed care industry, and 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.

Areas of improvement were noted in the following measures:

**Commercial**
- Childhood Immunizations
- Colorectal cancer screening
- Comprehensive diabetic care – Eye exam
- Comprehensive diabetic care – Nephropathy screening
- Comprehensive diabetic care – HbA1c poorly controlled
- Controlling high blood pressure
- Postpartum care
- Adult BMI
- Weight assessment and counseling for nutrition and physical activity – BMI-nutrition and physical activity
- HPV vaccine for female adolescents
- Antidepressant medication management – acute and continuation phase
- Appropriate testing for children with pharyngitis
- Appropriate treatment for children with upper respiratory infection
- Avoidance of antibiotic treatment in adults for acute bronchitis
- Breast cancer screening (age 50-74)
- Cervical cancer screening
- Persistence of beta-blocker treatment after a heart attack
- Chlamydia screening® — Total
- Follow-up for children with ADHD — Continuation
- Use of spirometry testing in the assessment and diagnosis of COPD
- Well-child visits - 3 to 6 years
- Follow-up after hospitalization for mental illness — 7 days
- Pharmacotherapy management of COPD — Systemic corticosteroids and bronchodilators

**Medicare**
- Comprehensive diabetic care — Eye exam
- Comprehensive diabetic care — HbA1c testing
- Comprehensive diabetic care — HbA1c poorly controlled
- Comprehensive diabetic care — Nephropathy
- Controlling high blood pressure
- Adult BMI
- Annual monitoring for patients on persistent medications
- Antidepressant medication management — Acute and continuation phase
- Breast cancer screening (age 50-74)
- Follow-up after hospitalization for mental illness — 7 day
- Osteoporosis management in women who had a fracture
- Persistence of beta-blocker treatment after a heart attack
- Use of high-risk medications in the elderly — 1 prescription
- Use of high-risk medications in the elderly — 2 prescriptions
- Initiation of alcohol and drug dependence treatment — Initiation and engagement
- Pharmacotherapy management of COPD — Systemic corticosteroids and bronchodilators
- Disease modifying anti-rheumatic therapy in rheumatoid arthritis
- Advising smokers to quit

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

Please see HEDIS, continued on Page 43
Primary care practitioners can still find opportunities to provide aggressive intervention in the management and care of our members with diabetes, and controlling high blood pressure, and in ordering procedures for breast, cervical and colorectal cancer screening.

BCN is 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-Blue™ Web
- Member interactive reminder telephone calls and cards
- Member and physician education
- Member health fairs
- Disease management programs
- Care management follow-up telephone calls and letters
- Member incentive programs
- HEDIS/CAHPS Summit Meeting
- MedXM at home services (bone mineral density tests)

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

If you would like more information about HEDIS®, contact the Blue Care Network STARS & HEDIS Operations & Data Management department at 248-350-7405.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Controlling high blood pressure and A1c testing

Hypertension and diabetes are two of many HEDIS® accreditation measures for health plans.

The Controlling High Blood Pressure measure looks at members 18 to 85 years of age with a diagnosis of hypertension and a blood pressure reading of:

<table>
<thead>
<tr>
<th>Reading</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>138/89 mmHg or less</td>
<td>18 to 59</td>
</tr>
<tr>
<td>138/89 mmHg or less</td>
<td>60-85 with diabetes</td>
</tr>
<tr>
<td>149/89 mmHg or less</td>
<td>60 to 85 without diabetes</td>
</tr>
</tbody>
</table>

Blood pressure readings

- A representative blood pressure is the most recent BP reading taken during the measurement year (by Dec. 31) and it occurs after the date of service in which the diagnosis of hypertension occurred. If multiple readings occur in a single visit, the lowest systolic and lowest diastolic is the representative BP and determines BP control.
- Reported blood pressures taken by your patient are not considered accurate in diagnosing hypertension.
- Record all blood pressures taken during a visit and if initial BP is high (140/90 or 150/90 or higher for age/condition range), make sure to record second BP reading, if taken.
- Do not round up blood pressure readings.
- Do document lifestyle modifications and treatment changes in member’s medical record (for example, changes in medication dosage, diet, exercise and smoking cessation.)

- Initiate pharmacologic anti-hypertensive treatment that includes angiotensin-converting enzyme inhibitor (ACEI), or angiotensin receptor blocker (ARB), if lifestyle changes are not effective.
- Make sure the correct cuff size is used.

<table>
<thead>
<tr>
<th>Indications</th>
<th>Arm Circumference (inches)</th>
<th>Arm Circumference (CM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Adult</td>
<td>9-10</td>
<td>22-26</td>
</tr>
<tr>
<td>Standard Adult</td>
<td>11-13</td>
<td>27-34</td>
</tr>
<tr>
<td>Large Adult</td>
<td>14-17</td>
<td>35-44</td>
</tr>
<tr>
<td>Adult Thigh</td>
<td>18-21</td>
<td>45-52</td>
</tr>
</tbody>
</table>

- Calibrate blood pressure device regularly according to manufacturer’s recommendations.

Diabetic HbA1c testing

- For the Comprehensive Diabetes Care measure, members age 18 to 75 identified as having diabetes should have a HbA1c test every six months with a goal of at least 8.9 or below.
- Follow-up visits and testing needs to be done every three months until the goal is reached.

If you would like more information about HEDIS®, contact the Blue Care Network STARS & HEDIS Operations & Data Management department at 248-350-7405.

References:

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

Ann Arbor physician uses quality improvement projects to increase childhood immunization rates

How do you get doctors and patients excited about something as routine as childhood immunizations? The answer is passion, according to Dr. Heather Burrows, who practices at the University of Michigan Pediatrics in Ann Arbor. For Dr. Burrows and her staff, immunizations are an important part of the practice. She has implemented several strategies to increase immunization rates and continues to look for ways to educate parents and new doctors as well.

The office has completed a large quality improvement project looking at adolescent immunization to identify ways to offer vaccines at every possible visit. That project has expanded to childhood immunizations. “Nurses and medical assistants print out the MCIR for every patient scheduled and highlight when vaccinations are due,” says Dr. Burrows. They follow that procedure for both scheduled visits and sick visits. “This way there are fewer missed opportunities,” she says. “It helps us stay on track and get patients back on schedule.”

The doctors in Dr. Burrows’ practice give the registry results to patients and highlight the vaccines that are required. “It’s another reminder for families that this is important,” says Dr. Burrows. “There are times when people come in for sick visits and it’s not the right time to vaccinate. If we know they’re coming back we may wait. But we would vaccinate a teenager at a visit for a sprained ankle because they may not come in as often for well visits.”

Dr. Burrows’ office also uses electronic medical records to run gap reports to identify children scheduled for vaccines. “We also reach out to families who are due for vaccines. We sometimes have to contact them to make sure they come in for well care,” she says.

In addition, a new pilot project with the University of Michigan reminds parents about the importance of vaccines and well visits with a birthday letter reminder. “We still spend a lot of time with families who still have questions about the safety of vaccines,” Dr. Burrows says. “Most of the time, we can get families to understand the importance of vaccines. Other times it takes a while. It’s sobering to share stories about children who have succumbed to childhood diseases because they weren’t vaccinated. That is a powerful message,” she says.

Please see Best Practices, continued on Page 46
To help in their efforts, the office has outreach posters in the exam rooms about vaccines. “When nurses meet with women for prenatal visits, we always mention vaccines,” says Dr. Burrows.

The office has also worked with residents to develop a curriculum so they can communicate a consistent message about vaccinations to patients and to learn how to talk to families about vaccines. “We’ll be expanding that to the medical school to develop those skills before they do their residency,” says Dr. Burrows.

There’s a lot to know about vaccinations. You have to be up to date on the correct information, says Dr. Burrows. “You also have to know what your parents are reading and hearing to be able to give them correct information.”

Consistency of message is also important. “Everyone in the practice, including six faculty and 16 residents, hears the same message,” says Dr. Burrows. “To be effective in improving vaccination rates, everyone has to be on board and passionate.”

Although the practice’s rates have improved, they’re not yet at 100 percent. “It’s easier to fix the process and identify patients and missed opportunities,” says Dr. Burrows. “So we’re always looking for new ways to pass on our message in the most effective way.”

Dr. Burrows and Amber Glasgow, medical assistant-specialist.
### Medicare Part D prescribers must be enrolled in Medicare in an approved status

The Centers for Medicare and Medicaid Services requires physicians and other eligible professionals who write prescriptions for Part D drugs to be enrolled in Medicare in an approved status or to have a valid opt-out affidavit on file in order for their prescriptions to be covered under Part D.

Recently CMS has announced that it will delay enforcement of the requirements in 42 CFR § 423.120(c)(6) until June 1, 2016. Prescribers of Part D drugs must submit their Medicare enrollment applications or opt-out affidavits to their Medicare administrative contractors before Jan 1, 2016. This ensures that Medicare administrative contractors have sufficient time to process the applications or opt-out affidavits and avoid their patients’ prescription drug claims from being denied by their Part D plans beginning June 1, 2016.

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

### Aspirin covered for prevention of preeclampsia

Effective Sept. 30, 2015 Blue Care Network began covering low-dose aspirin at no cost-sharing for the prevention of morbidity and mortality from preeclampsia. This recommendation comes from the U.S. Preventive Services Task Force.

Daily low-dose aspirin (81 mg/day), when initiated between 12 and 28 weeks of gestation, reduces the risk for preeclampsia, preterm birth and intrauterine growth restriction in women at high risk for preeclampsia. Pregnant women are at high risk for preeclampsia if they have at least one of these risk factors:

- History of preeclampsia, especially when accompanied by an adverse outcome
- Multifetal gestation
- Chronic hypertension
- Diabetes
- Renal disease
- Autoimmune disease (such as lupus or antiphospholipid syndrome)

Coverage is provided for low dose, over-the-counter aspirin and requires a prescription.
Price Watch feature helps manage drug costs

Blue Care Network strongly encourages the use of generic drugs. As we noted in the September – October issue, prices for some generic drugs are increasing rapidly, which can increase costs for patients. BCN continues to monitor changes in the market and highlight alternatives to high-priced generics.

Look for this Generic Price Watch feature in upcoming issues. We’ll identify generics that have experienced price jumps, and offer lower-cost alternatives for consideration.

Generic Price Watch

<table>
<thead>
<tr>
<th>High-cost generic</th>
<th>Average cost per Rx*</th>
<th>Recent price jump</th>
<th>Lower-cost alternatives</th>
<th>Average cost per Rx for alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dibenzyline® (g)</td>
<td>$8,063 - $16,127</td>
<td>28%</td>
<td>Alpha-1 adrenergic receptor blocker combined with a preferred calcium channel blocker</td>
<td>$64</td>
</tr>
<tr>
<td>Glumetza® (g)</td>
<td>$3,700 - $8,000</td>
<td>1,799%</td>
<td>Glucophage®/XR (g)</td>
<td>$155</td>
</tr>
<tr>
<td>Thiola® (g)</td>
<td>$10,000</td>
<td>2,242%</td>
<td>Increased fluid intake, restriction of sodium and animal protein, and therapy with Urocit®-K (g)</td>
<td>$205</td>
</tr>
</tbody>
</table>

*As of 2nd quarter, 2015

BCBSM and BCN drug lists updated, available online

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

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

Blue Cross Blue Shield of Michigan and Blue Care Network regularly update their drug lists. For the most recent updates, go to bcbsm.com/rxinfo.
Immunizations included in requirement to report national drug code number on professional drug claims beginning Nov. 1

Web-based training available on web-DENIS

In the last issue, we announced that Nov. 1, 2015 will be the date Blue Care Network will align with Blue Cross Blue Shield of Michigan by pricing and reimbursing medical professional drug claims at the national drug code level for BCN commercial patients. NDC-level pricing will also include claims for immunizations beginning Nov. 1. NDC-level pricing does not apply to BCN AdvantageSM claims.

Beginning Nov. 1, 2015, you must include the NDC and the appropriate NDC quantity on your BCN commercial drug claims. Once BCN begins processing claims using the NDC codes and quantities, if you do not include the appropriate NDC code and quantity, you will not receive the payment you expect.

- A medical claim for a specialty drug submitted by a professional provider will be paid at the lowest NDC fee for that HCPCS/CPT code if the claim does not include the NDC code.
- A medical drug claim submitted by a home infusion therapy provider or specialty pharmacy that does not include an NDC code will be denied.
- A medical drug claim will also be denied if it is billed with an invalid NDC and HCPCS/CPT code combination.

Please refer to the article on Page 43 of the July-Aug issue for more information.

Please note the following correction on units of measure.

Units of measure

Please do not use milligrams (ME) as a unit of measure on your BCN or Blue Cross professional drug claims. You can use these units of measure:

- Weight – grams (GR)
- Volume – milliliter (ML)
- Count – unit (UN)

Injections reimbursement

BCN will use the Blue Cross Blue Shield of Michigan Injections Minimum Fee Schedule to pay most professional medical drug claims, including immunizations. Refer to the BCN Professional Fee Schedule for pricing on the following drugs:

- Aranesp® (darbepoetin alfa) J0881-J0882
- Avastin® (bevacizumab) for ophthalmic diagnoses J9035
- Intra-articular hyaluronic acid J7321-J7327

The Blue Cross Injections Minimum Fee Schedule is available on web-DENIS; contact your provider consultant for a copy of the BCN Professional Fee Schedule.

Please see Immunizations, continued on Page 50
Immunizations, continued from Page 49

Immunization reimbursement
Effective Nov. 1, 2015, BCN will no longer have a separate immunization fee schedule for BCN commercial members. Instead, BCN commercial reimbursement for immunizations will be similar to that of Blue Cross.

• If the NDC code is not included on the claim, BCN will reimburse the minimum fee listed on the BCN professional fee schedule. In most cases, this will be the same as the fee listed on the Blue Cross Injections Minimum Fee Schedule.

• If the NDC code is included on the claim, BCN will reimburse the average wholesale price less a specific discount. In most cases this is the same as the fee listed on the Blue Cross Injections Minimum Fee Schedule.

Contact your provider consultant for a list of the NDC discounts.

Web-based training
We are offering Web-based training to help you understand this change and code your claims correctly. The training can be found at brainshark.com/bcbsm/ndc-billing. It is also available in web-DENIS. Go to BCN Provider Publications and Resources and then go to the Learning Opportunities tab.

Specialty Drug Visit Summary form
In addition, a new Specialty Drug Visit Summary form is available for your use. The form asks for the specialty drug name, dosage and unit of measure. It can be completed to help you gather the information you need before calling Provider Inquiry with any questions about using NDC codes. This form may also be helpful in your office for sharing information with your biller. You do not need to share this form with BCN or Blue Cross.

Remember to submit BCN claims status inquiries using the CMS-1500 (02/12) form
To submit a status inquiry for a Blue Care Network claim, providers should use the CMS1500 (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.

As a reminder, BCN announced we would stop accepting the Status Claim Review Form as of Jan. 1, 2015. BCN providers who are still submitting status inquiries using the Status Claim Review Form should stop using that form and immediately begin to use the CMS-1500 (02/12) form to submit their status inquiries.

References to the Status Claim Review Form are being removed from BCN’s published documents.
Question:
When a Blue Care Network patient is having additional meds infused >30 minutes and there are several charged in one day, we charge 96376 but are getting some of the units denied. When we look up the HCPC Payment Rule, this code does not have a limit. It seems like only six are getting paid. For Traditional and Trust we are not having this issue. What do we have to do to get these claims reimbursed correctly? Rejection reasons are N123, M86, MA02.

Answer:
Procedure code 96376 has a limit of six for BCN. This code is an add-on code, for an additional sequential infusion of up to one hour. Any quantities reported above six will receive an edit and must be submitted to BCN for review. To do this, submit the documentation supporting all infusion services provided to the patient, along with the completed clinical editing appeal form.

BCN has different business rules than Blue Cross Blue Shield Michigan. Limits to codes are assigned based on various criteria, including but not limited to the nomenclature of the procedure code, standards of medical practice, and various clinical sources, such as peer reviewed literature.

Question:
I work for an Indiana community mental health center and we have many members who have Blue Cross Blue Shield Michigan plans through the UAW. When we bill for a 99211 – 99215 with a place of service of 53, the claim is denied most of the time, stating we did not have an authorization. I have to send an inquiry or call for nearly every claim we submit for these members. I am told authorization for these services is not required. Is there anything that can be done to ensure these claims process properly the first time?

Answer:
Behavioral health services, including medication management, provided to Michigan members by out-of-state providers do require preauthorization. Team members will be reminded of the correct process for out of-state providers. If you have any cases pending due to lack of an authorization, you can contact BCN Customer Service at 1-800-482-5982 to resolve those.
Billing Q&A, continued from Page 51

Question:
Does BCN Advantage require the reporting of the non-payable functional G codes for physical, occupational and speech therapy following the Centers for Medicare & Medicaid Services guidelines?

Answer:
As of now, the G codes are not required by BCN Advantage for reporting therapy services, but will be accepted on claims if reported.

Question:
What is the current process for submitting an appeal?
I submitted an appeal and have not heard anything. When I call Provider Inquiry, I am told it is pending. Should I resubmit it so it can be reviewed?

Answer:
To answer your last question first, please do not resubmit your appeal if we have it. Submitting duplicate appeals bogs down the system and creates extra work for you, as well as for our analysts. You are following the correct process.

The clinical editing appeal process is located in the BCN Provider Manual on web-DENIS. Clinical editing appeals must be submitted as follows:

- With a completed Clinical Editing Appeal form:
  - Use the most current form from the website.
  - Complete all required fields as indicated by an asterisk.
  - Make sure information on the form is legible (preferably typed) and accurate.
- Within 180 days of original clinical editing denial
- With all supporting and relevant documentation for an appeal
  - There is only one level of appeal.
  - Ensure documentation is included and legible.
  - Flag or mark key parts of documentation, but avoid highlighter, especially if faxing.

We typically load appeals into our system within three to five days of receipt. If you want to check the status of your appeal, you can contact Provider Inquiry at 1-800-255-1690. Do not resubmit an appeal without checking if we already have it.

Our goal is to provide a response to providers within 30 to 45 days. Currently, we are exceeding that timeframe but are taking measures to provide you with the service you deserve. By following the above process, and avoiding duplicate submissions, you will help us meet our timeframes.

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.
Blue Care Network follows the Centers for Medicare & Medicaid Services’ ICD-9-CM coding guidelines and American Hospital Association coding clinics to identify supporting documentation for alcohol use. The medical record documentation for alcohol-related conditions isn’t always clear to the reader.

Complete documentation is crucial to accurately report the medical condition, status, severity, and any other conditions that affect or are affected by the abuse or dependence. Medical conditions submitted to CMS are based solely on provider documentation.

It’s important to be specific, too. Complete documentation is essential to determine whether the condition is alcohol abuse or alcohol dependence, known as alcoholism. The following are examples from progress notes that don’t include the diagnosis:

- Patient is aware his drinking is causing problems with family relationships.
- Patient needs a drink to get going in the morning or to unwind after a long day.
- Patient admits to drinking every Friday to get drunk with friends.
- Patient drinks a beer but finds it difficult to stop at one.

It’s critical that providers take it one step further and identify the status of alcohol use in their documentation. For example, providers should note if it’s continuous, episodic or in remission. Here are sample situations where additional documentation is needed to identify the status of the condition:

- Patient needs a drink every day to unwind.
- Patient only drinks on Friday to get a high.
- Patient hasn’t had a drink in a week, two weeks, a month or two months.

A review of the past medical history is a critical part of the patient encounter. It’s important to remember the following:

- The progress note must be current and updated with each office visit.
- Actively treating conditions recorded in past medical history must be addressed and documented in the face-to-face encounter.
- When both “abuse” and “dependence” have been recorded, the notes should clearly describe which one is actively being treated. Without this clarification, neither diagnosis can be reported. Note: This differs from the ICD-10-CM coding guidelines. See details on the next page under ICD-10.

“History of” means the condition no longer exists and the patient is no longer receiving any treatment. Providers often use “history of” to signify “ongoing” or “continual” conditions. Without supporting documentation, the status of the condition is unclear and may default to a personal history. The following are examples of the two scenarios:

- Patient has a history of consuming a minimum of six cans of beer daily since age 18. Patient has been sober now for five years and continues with Alcoholics Anonymous program.
- Patient has a history of consuming a minimum of six cans of beer daily since age 18. We discussed in today’s visit how the patient’s drinking continues to affect his overall health.

Please see Coding Corner, continued on Page 54
Coding Corner, continued from Page 53

It’s equally important to review associated medical conditions in the face-to-face encounter. For example:

- Patient is present for annual visit. He’s alcohol dependent and drinks a minimum six cans of beer daily and has done so continuously over the past five years. In today’s visit, it was stressed that his liver damage will worsen if he doesn’t stop drinking.
- Patient is an alcoholic who quit drinking three days ago. He’s complaining of shakiness and anxiety. It was explained that his body has developed a physical dependence and he’s experiencing withdrawal symptoms.

ICD-10

As we look at the conversion to ICD-10-CM coding guidelines that was effective Oct. 1, it’s important to remember that ICD-10-CM includes a more comprehensive index to capture a complete diagnosis, such as alcohol, delirium, with intoxication, in abuse.

Both ICD-10-CM and ICD-9-CM coding guidelines allow only one code to be assigned when referring to alcohol use, abuse and dependence. However, with ICD-10-CM, a hierarchy is followed. For example:

- When both “use” and “abuse” are documented, only a code for “abuse” can be reported.
- When both “abuse” and “dependence” are documented, only a code for “dependence” can be reported.

Alcohol documentation should read as “use,” “abuse” or “dependence.” It’s equally important to identify the pattern of use. For example, “uncomplicated,” “intoxication” or “remission.”

<table>
<thead>
<tr>
<th>ICD-9-CM DOCUMENTATION</th>
<th>ICD-10-CM DOCUMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol abuse episodic use specified</td>
<td>Alcohol abuse uncomplicated</td>
</tr>
<tr>
<td>Alcohol dependence in remission</td>
<td>Alcohol dependence in remission</td>
</tr>
<tr>
<td>Alcohol dependence continuous use specified</td>
<td>Alcohol dependence and intoxication</td>
</tr>
<tr>
<td>with alcoholic cirrhosis of the liver</td>
<td>with alcoholic cirrhosis of the liver</td>
</tr>
<tr>
<td></td>
<td>F10.229/K70.30</td>
</tr>
</tbody>
</table>

This issue’s billing tips include the following:

- Correct use of modifiers
- Reporting more than one evaluation and management service on a date of service for BCN AdvantageSM members
- Clinical editing for evaluation and management services

Documentation is key to a complete progress note. The written documentation in a face-to-face encounter will determine the diagnosis.
Using in-network laboratories

As a contracted Blue Care Network physician, you should always use a JVHL-contracted laboratory for testing. You may not be aware that commonly ordered laboratory tests referred to out-of-network laboratories can actually be performed in network by many of the JVHL-participating laboratories.

There are many benefits to using in-network laboratories. Here are some:

- There is no member cost-sharing on authorized laboratory tests provided by JVHL laboratories.
- Out-of-network laboratories can balance-bill members when services are not paid at 100 percent of charges or are not authorized by JVHL.
- Results reporting to BCN is enhanced, which improves physician achievement on HEDIS® and CMS Stars measures and results in better incentive performance.
- Health care expenses and variability in costs are more controlled.

Joint Venture Hospital Laboratories and BCN have provided a list of tests (see next page) commonly referred out of network and their cost impact. These data are based on paid claims for BCN HMO® (commercial) members.

Here’s what we ask: When your patients require molecular testing or other laboratory services, please refer them to a JVHL-participating laboratory.

Please also contact JVHL at 1-800-445-4979 for prior authorization for molecular testing and for help finding in-network laboratories. Their business hours are Monday through Friday from 8 a.m. to 4:30 p.m.

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Use only ICD-10 codes in BCN’s e-referral system

Since Oct. 1, 2015, the health care industry has been required to use ICD-10 procedure and diagnosis codes. With this change, Blue Care Network providers should be aware of the following when entering referrals and authorization requests into e-referral:

- Authorization requests and referrals submitted into e-referral for dates of service Oct. 1 and later should include an ICD-10 code.
- Authorization requests and referrals submitted into e-referral for dates of service Oct. 1 and later with an ICD-9 code will see the warning message: “You have selected an inactive (retired) code. Would you like to continue?” Please choose ‘no’ and choose an ICD-10 code.
- If you are using your e-referral bookmarks that contain an ICD-9 code, you will not see the warning message. Please delete any ICD-9 codes from your bookmarks.
## Laboratories, continued from Page 55

<table>
<thead>
<tr>
<th>Test type</th>
<th>Out-of-network lab</th>
<th>Cost impact of using these noncontracted laboratories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakpoint cluster region / Abelson (BCR/ABL1)</td>
<td>Accupath Diagnostic Laboratories Genoptix Medical Laboratory</td>
<td>89% higher</td>
</tr>
<tr>
<td>Breast cancer susceptibility (BRCA 1 and BRCA 2)</td>
<td>Ambry Genetics Genoptix Medical Laboratory Myriad Genetics*</td>
<td>up to 95% higher</td>
</tr>
<tr>
<td>Comparative genomic hybridization / single nucleotide polymorphism (CGH/SNP) microarray</td>
<td>GeneDx LabCorp Lineagen Natera Molecular Health Myriad Genetics*</td>
<td>up to 91% higher</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td>Courtagen Life Sciences Good Start Genetics Natera Progenity Sequenom Laboratories</td>
<td>95% higher</td>
</tr>
<tr>
<td>Fragile X</td>
<td>Good Start Genetics Lineagen Natera Progenity Sequenom Laboratories</td>
<td>97% higher</td>
</tr>
<tr>
<td>Lynch syndrome</td>
<td>Ambry Genetics bioTheranostics GeneDx Molecular Health Myriad Genetics*</td>
<td>up to 98% higher</td>
</tr>
</tbody>
</table>

* Out of network as of Jan. 1, 2016

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Use these tips to transition PT, OT, ST cases continuing into 2016

Blue Care Network has implemented a year-end transition plan for the physical, speech and occupational therapy authorization process. This process worked well for therapy providers and members in 2015; therefore, the same strategy will apply for 2016.

Care that starts in November or December

All 2015 treatment authorizations for PT, OT and ST will end December 2015 for members whose coverage follows a calendar year plan. If an episode of care begins in 2015 and is expected to continue into 2016, the following apply:

- An initial evaluation or re-evaluation for therapy isn’t necessary to continue an active episode of care into 2016.
- You must enter a new referral either through e-referral or by calling BCN Care Management before the first treatment in 2016.
- 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 2016

Physical, occupational and speech therapy providers should enter their own referrals for therapy services for all patients receiving therapy in December that will carry over into January 2016. The referral begin date should be the date of the first appointment in 2016. You may enter the 2016 referral into e-referral in December 2015. 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 provider consultant.

Approvals for 2016 must meet these requirements:

- The member is an eligible BCN member on the date services are provided.
- 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 Transition, continued on Page 58

Reminder: eviCore health care expanded reviews was effective Oct. 1

Effective, Oct. 1, 2015, eviCore healthcare (formerly CareCore National) began performing clinical review of additional radiology services and for select cardiology and radiation therapy services.

This applies to select nonemergency outpatient services when performed on or after Oct. 1, 2015, in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices for BCN HMO (commercial) and BCN Advantage members.

See the article in the Sept.-Oct. issue for details.
Transition, continued from Page 57

Therapists should enter the 2016 referral in e-referral with the following information:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Submit applicable procedure code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Procedure code</td>
<td></td>
</tr>
<tr>
<td>Start date</td>
<td>Enter date of the first visit for 2016</td>
</tr>
<tr>
<td>Count</td>
<td>1</td>
</tr>
<tr>
<td>Date span</td>
<td>60 days</td>
</tr>
</tbody>
</table>

- 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, 2016. 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, 2016, new referrals revert to the established policy of one evaluation and one visit for all new patients seen by Category C providers.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>*92506</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Speech Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Procedure code</td>
<td></td>
</tr>
<tr>
<td>Start date</td>
<td>Enter date of the first visit for 2016</td>
</tr>
<tr>
<td>Count</td>
<td>1</td>
</tr>
<tr>
<td>Date span</td>
<td>60 days</td>
</tr>
</tbody>
</table>

- 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 2016. Landmark will review for medical necessity and send a determination letter. BCN Care Management accepts requests for transition cases by phone or by e-referral. 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 (formerly CAREN). If you identify a member with a plan year other than January 1, adjustments to the start and end date of an authorization is subject to the benefit year renewal date. BCN and Landmark work together to administer benefits accordingly.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>*92506</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Procedure code</td>
<td></td>
</tr>
<tr>
<td>Start date</td>
<td>Enter date of the first visit for 2016</td>
</tr>
<tr>
<td>Count</td>
<td>1</td>
</tr>
<tr>
<td>Date span</td>
<td>60 days</td>
</tr>
</tbody>
</table>

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

*CPT codes, descriptions and two-digit modifiers only are copyright 2014 American Medical Association. All rights reserved.
## Referral Roundup
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- Year-end submission dates nearing for Diagnosis Closure Incentive Program
- Select insulin product moved to generic copay tier
- Patient Assessment Form saves time and enhances communication
- Smoking cessation is part of the Million Hearts initiative
- What you need to know about Medicare fraud, waste and abuse
- Providers and vendors are required to take CMS training on Medicare fraud

## Behavioral Health
- Re-evaluation of ABA autism treatment every three years required only for some members
- Direct reimbursement available to licensed professional counselors beginning Jan 1, 2016
- Quality corner: Follow-up after hospitalization
- Providers can help patients manage seasonal affective disorder
- Blue Cross Network Behavioral Health Incentive Program 2015 updates

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- Immunizations included in requirement to report national drug code number on professional drug claims
- Remember to submit BCN claims status inquiries using the CMS-1500 (02/12) form
- Coding corner: Improve medical record documentation for alcohol abuse vs alcohol dependence
- Clinical editing billing tips

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- New diabetes self-management and education recommendations
- How to contact Blue Cross Complete utilization management staff
- Providers can request criteria for utilization management decisions
- Member rights and responsibilities outlined in Blue Cross Complete Member Handbook
- Pharmacy resources available for Blue Cross Complete

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- Blue Cross Blue Shield of Michigan and Blue Care Network to offer new individual health plans for 2016
- How we’re helping members navigate health care choices
- Web MD launches in January for Blue Care Network
- Value Partnerships program saves $1 billion
- Providers must report practice location and office hours changes to comply with CMS requirement
- Submissions increase for Blue Care Network tobacco cessation office staff contest after reward doubled

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- Price Watch feature helps manage drug costs
- Use only ICD-10 codes in BCN’s e-referral system
- Use these tips to transition PT, OT, ST cases continuing into 2016
- Reminder: eviCore healthcare expanded reviews was effective Oct. 1

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- HEDIS 2015 results
- Controlling high blood pressure and A1c testing
- Ann Arbor physician uses quality improvement project to increase childhood immunization rates

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- New postpartum checkup program available for BCN members
- Blue Care Network does not cover digital breast tomosynthesis
- Providers encouraged to use evidence-based recommendations to make decisions about care
- Help us improve our services to you by taking our Care Management survey
- Criteria corner
- Diabetes patients require certain tests
- Medical policy updates
- The Great American Smokeout is Nov 19
- Screen kids early to avoid cardiovascular disease
- American Academy of Pediatrics updates
- Synagis guidelines
- Type 2 diabetes in children can be prevented
- Reminder: CDC guidelines for pneumococcal vaccination of those 65 years of age and older

## Price Watch
- Medicare Part D prescribers must be enrolled in Medicare in an approved status
- Aspirin covered for prevention of preeclampsia
- New postpartum checkup program available for BCN members
- Blue Care Network does not cover digital breast tomosynthesis
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