Blue Care Network offers two new local networks in the Southeast and West regions, effective Sept. 1

Blue Care Network is offering two new local networks – BCN Local Network Southeast and BCN Local Network West. Both networks, effective Sept. 1, will be sold through GlidePath, Blue Cross Blue Shield of Michigan’s private exchange for group customers.

**BCN Local Network℠ Southeast**
- The network is offered in Wayne, Oakland and Macomb counties.
- The network includes Ascension Health-affiliated primary care physicians, specialists and seven hospitals:
  - Crittenton Hospital
  - Providence Park Novi
  - Providence Southfield
  - St. John Hospital and Medical Center, Detroit
  - St. John Macomb-Oakland Hospital, Madison Heights
  - St. John Macomb-Oakland Hospital, Warren
  - St. John River District Hospital, East China Township
- Members need to select a primary care doctor in this local network.
- Standard Southeast region referral and authorization requirements apply.

Please see BCN local networks, continued on Page 2

Tiffany Albert named president and CEO of Blue Care Network

Blue Cross Blue Shield of Michigan announced that Tiffany Albert, LifeSecure’s current president and CEO, will succeed Kevin Klobucar as president and CEO of Blue Care Network, the HMO-affiliate of Blue Cross and the state’s largest health maintenance organization. Klobucar was promoted in May to Blue Cross executive vice president, Health Care Value.

“Tiffany is a well-respected leader within our organization and has helped launch innovative solutions at LifeSecure,” said Daniel Loep, president and CEO of Blue Cross Blue Shield of Michigan. “Blue Care Network has a tradition of exceptional leadership. I’m confident Tiffany will add to this legacy and continue to advance Blue Care Network’s reputation as the leading HMO in Michigan.”

Please see Tiffany Albert, continued on Page 2
BCN local networks, continued from Page 1

This new network is **not** the same as Blue Cross Metro Detroit HMO, the local network individual product covering the same counties. This new product may not cover the entire county of Wayne.

Providers will need to submit a referral for specialists located within the BCN Local Network Southeast or in the broader BCN commercial network (as is standard in the Southeast region). All BCN authorization rules apply.

Except for emergencies, care is not covered outside the local network.

When you check eligibility on web-DENIS, through a 270/271 electronic transaction or by calling PARS, the Provider Automated Response System, there will be a message notifying you that the patient has this local network.

Providers will be able to check their network status for this new local network using BCN’s online provider search.

When submitting an authorization request in e-referral for a patient with this coverage, providers in BCN Local Network Southeast will show as “Preferred”.

There is no change for behavioral health providers. BCN Local Network Southeast follows BCN behavioral health network and authorization rules.

Please see **BCN local networks**, continued on Page 3

Tiffany Albert, continued from Page 1

Albert brings more than 20 years of insurance experience and a proven track record of execution and strategic leadership. Her broad experience includes new business development, customer management and retention, marketing, program implementation, operations, provider contracting, information technology and organizational development.

Prior to serving as CEO at LifeSecure, Albert was director, external sales distribution and strategic sales at Blue Cross Blue Shield of Michigan, and held executive positions at other major insurance companies. She is a graduate of the University of Michigan.
BCN Local Network℠ West

- This product is offered in Kent, Muskegon & Oceana counties
- The network includes Mercy Health-affiliated primary care physicians, specialists and four hospitals:
  - Mercy Health Hackley
  - Mercy Health Lakeshore
  - Mercy Health Muskegon
  - Mercy Health Saint Mary’s
- Members need to select a primary care physician in BCN Local Network West
- Care provided outside the local network requires a referral from the primary care physician.
- This new network will be similar to Blue Cross Partnered, the local network individual product covering the same counties with Mercy Health providers.
- Referrals within BCN Local Network West do not require submission of a referral to BCN (as is standard in the West region), but providers should keep a record of their referrals. All BCN authorization rules apply.
- Members must select a primary care doctor in the BCN Local Network West. Any care provided outside BCN Local Network West requires a referral from the primary doctor. If you receive a referral for a member with this product, look at the type of referral. The referral could be for a specific service or it could be a global referral covering a period of time.
- When you check eligibility on web-DENIS, through a 270/271 electronic transaction or by calling PARS, the Provider Automated Response System, there will be messaging to notify you that the patient has this local network and requires authorization to go outside the network.
- Providers will be able to check their network status for this new local network using BCN’s online provider search.
- When submitting an authorization request in e-referral for a patient with this coverage, providers in BCN Local Network West will show as “Preferred”.
- There is no change for behavioral health providers. BCN Local Network West follows BCN behavioral health network and authorization rules.

Make sure you are signed up for e-referral

If you don’t have an e-referral user ID sign up today.
If you don’t know how to use e-referral, please go to training tools on the e-referral website.
Remember, you must login at least once every 180 days to keep your user ID active. If your user ID is not working, fax a request on company letterhead to 1-800-495-0812 asking for the ID to be reconnected. Include the user ID, your name and email address, and have it signed by the authorized individual in the office. For additional help, call the Web Support Help Desk at 1-877-258-3932.

Check network status

- To check your network status or search for other providers in the network:
  - Visit bcbsm.com/find-a-doctor
  - Click on Get Started
  - In the Choose a heath plan drop-down, click on Employer Group Plans
  - In the Blue Care Network section under HMO Plans, click on BCN Local Network Southeast or BCN Local Network West
Clarification: For MSU plans, dependents do not need referrals, regardless of age

In the July-Aug issue of BCN Provider News we announced two new plans with unique referral requirements, effective Aug. 15.

- MSU Graduate Assistant Health Plan – Covers graduate assistants at Michigan State University
- MSU Student Health Plan – Covers students at Michigan State who don’t have other health coverage

These new products have unique referral requirements for medical services.

We want to remind providers that dependent children do not require referrals, regardless of the age of the child or whether the dependent is a young adult.

Please refer to the article in the last issue for complete details and referral rules.

Click on the PDF icon to see the product flier.

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Click on the PDF icon to see the product flier.
Blue Care Network offices will be closed Sept. 5 for Labor Day. When BCN 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 emergency home health care, home infusion services and in-home pain control
- Arranging for durable medical equipment
- Emergency discharge planning coordination and authorization
- Expedited appeals of utilization management decisions

Note: Clinical review 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 placement.

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

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

As a reminder, when an admission occurs through the emergency room, we ask that you contact the primary care physician to discuss the member’s medical condition and coordinate care before admitting the member.
New tools to help you find and use the BCN Provider Manual

We want to make it easier for you to find and use the BCN Provider Manual. That way, you can get what you need quickly so you can return to serving your patients without waiting on hold or waiting for a call back.

You can reach the BCN Provider Manual through the new Provider Manuals page. Here’s how:

1. Go to bcbsm.com/providers.
2. Click Login.
3. Log in to Provider Secured Services using your user ID and password.
4. Click Provider Manuals, in the lower right corner of the page that opens.

The Provider Manuals page will open. This page gives you access to four different provider manuals:

From the Provider Manuals page, you can click the BCN Provider Manual link to open BCN’s web-DENIS Provider Manual page:

On the web-DENIS Provider Manual page, you’ll see the tools you’ll need to find what you’re looking for in the BCN Provider Manual, including:

1. The About the BCN Provider Manual document, which gives a short overview about the manual and how it’s updated with Blue Dot changes on a regular basis.
2. Instructions for searching the BCN Provider Manual Portfolio, which is a collection of all the manual chapters in one package, and a link to open the portfolio.
3. The list of Blue Dot changes to the manual, which shows what’s changed in the manual since the beginning of the year.
4. A link to the Claims chapter, which contains most of the information you’ll need to know to bill BCN correctly for the services you’ve provided to our members.
5. A link to BCN’s web-DENIS Billing / Claims web page, where you’ll find links to many other documents useful in billing BCN, including clinical editing resources and instructions for billing specific type of claims.
6. A link to the Care Management chapter, which contains information on authorization and referral requirements, instructions for appealing denial decisions and much more.
7. A link to BCN’s web-DENIS Authorizations / Referrals web page, from which you can access many other documents that explain BCN’s authorization and referral requirements.

On the web-DENIS Provider Manual page, you’ll also find links to all the other chapters in the BCN Provider Manual.

Don’t forget about Ctrl+F. In the July-August 2016 issue of BCN Provider News, we shared how you can use the Ctrl+F keys on your keyboard (for Windows users, or Command+F for Mac users) to search the provider manual. In fact, you can use the Ctrl+F / Command+F shortcuts on any web page or PDF document to help you with a simple keyword search. Give it a try, to find what you need without having to read every word on a page. Just press the Ctrl (or Command) key and hold it down and then press F.
Register for the Provider Enrollment and Change Self-Service tool

Our Provider Enrollment and Change Self-Service tool makes it easier for professional group administrators to update group information and enroll new practitioners within their group.

Some of the benefits are the following:

- The application is electronic and makes it easy to keep your group records up to date.
- Your enrollment and change requests will be processed faster.
- Your data remains secure.

**Transactions that can be performed with self service**

- Group location maintenance: Update your practice, remit and mailing addresses
- Networks and demographics: Update your name, tax information and network participation
- Terminate groups: Terminate groups and remove them from our active rosters
- Group practitioner management: Enroll new practitioners, add and remove practitioners from your groups

Click on the PDF link to see our flier on this tool and information on how to register.
Chronic Care Improvement program focuses on smoking cessation

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.

You may remember from previous articles that we’re using 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 – Aspirin for high-risk patients, Blood pressure control, Cholesterol management and Smoking 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 and exposure to secondhand smoke you can share with patients:

- In 2014, nearly 17 of every 100 U.S. adults aged 18 years or older (16.8 percent) currently* smoked cigarettes. This means an estimated 40 million adults in the United States currently smoke cigarettes.¹
- Cigarette smoking is the leading cause of preventable disease and death in the United States, accounting for more than 480,000 deaths every year.¹
- More than 16 million Americans live with a smoking-related disease.²
- Current smoking has declined from nearly 21 of every 100 adults (20.9 percent) in 2005 to nearly 17 of every 100 adults (16.8 percent) in 2014.¹
- There is no risk-free level of secondhand smoke exposure; even brief exposure can be harmful to health.³,⁴,⁵
- Since 1964, approximately 2,500,000 nonsmokers have died from health problems caused by exposure to secondhand smoke.³

Please see Million Hearts, continued on Page 9

*Current smokers are those who reported smoking at least 100 cigarettes during their lifetime and who, at the time they participated in the survey about this topic, reported smoking every day or some days.
Million Hearts, continued from Page 8

One goal of the Chronic Care Improvement program is to improve the health of our members by getting more smokers to quit. Here are some resources available for you and your BCN Advantage patients who smoke:

**Tobacco cessation coaching**

We offer the Blue Cross® Health & Wellness Tobacco Cessation Coaching program, powered by WebMD® for your BCN and BCN Advantage patients. It’s a 12-week program for patients who are ready to set a quit date within the next 30 days. Eligible patients receive five calls from a health coach. Patients can schedule calls at a time convenient to them and if they need extra support, they have unlimited access to call their health coach at any time. To enroll, BCN Advantage or BCN members can call 1-855-326-5102 to schedule their first call.

**Quit Guide**

Blue Care Network’s tobacco cessation brochure, Quit Guide, is available for your patients who smoke. The printed brochure is a guide for patients who are ready to quit smoking. It contains strategies to help patients quit, medication recommendations and instructions on how to sign up for WebMD’s Tobacco Cessation Coaching program. Contact your provider consultant to find out how to get copies of the Quit Guide for your patients.

**2016 CMS Million Hearts provider incentive**

BCN’s Million Hearts Incentive program for BCN Advantage rewards physicians who counsel their patients on the importance of quitting smoking.

The incentive is available for members who have BCN Advantage as their coverage, are age 40 and over as of Dec. 31, 2016, who are smokers and have been counseled on the importance of quitting smoking. Physicians can report “Not a smoker” in Health e-Blue® as an exclusion reason/contraindication.

- Report CPT II code 4000F or 4004F for each patient identified as a tobacco user and received tobacco cessation counseling

The 2016 CMS Million Hearts Incentive Program document that explains this program in detail is available in BCN’s Health e-Blue®. The document is located in the Resources section under Incentive Documents. If you have any questions, contact your medical care group leadership or your provider consultant. We appreciate your continued support of our physician incentive programs.

Preventing 1 million heart attacks and strokes in the next five years will require work and commitment to change. As health care professionals, you play a key role in helping patients reduce their risk for heart disease and stroke and lead longer, healthier lives. We look forward to working with you to achieve these goals. Look for more information about our Chronic Care Improvement program in future issues of BCN Provider News.

References:


Educating patients about physical activity and falls

One in three older adults fall every year and these falls threaten the lives, independence and health of these adults. Between 20 and 30 percent of those adults who suffer moderate to severe injuries after experiencing a fall will find it harder to get around or live independently as well as an increase to their risk of an early death.

One out of every five falls causes a serious injury such as a broken bone or head injury. The most common cause of traumatic brain injury is a fall.

People who fall but don’t experience an injury may develop a fear of falling which may cause many to limit their activities, leading to reduced mobility and loss of physical fitness which will in turn increase their actual risk of falling.

One of the most important things an older adult can do for good health is physical activity. Even some physical activity is better than none. The health benefits increase as the physical activity increases.

There are four types of exercise that encompasses all the benefits of physical activity: Endurance, strength, balance and flexibility. It’s important to start out slowly and build up to more activity. Exercising shouldn’t cause pain or cause someone to become tired. Many local fitness centers, hospitals, churches, religious groups, senior/civic centers, parks, and recreation associations have exercise, wellness or walking programs.

The following list includes groups that distribute information for older adults regarding physical activity:

- American College of Sports Medicine
  1-317-637-9200
  [www.acsm.org](http://www.acsm.org)
- Centers for Disease Control and Prevention
  1-800-232-4636 (toll-free)
  1-888-232-6348 (TTY/toll free)
  [www.cdc.gov](http://www.cdc.gov)
- National Library of Medicine
  Medline Plus
  Exercise for Seniors
  Exercise and Physical Fitness
  [www.medlineplus.gov](http://www.medlineplus.gov)
- President’s Council on fitness, Sports and Nutrition
  1-240-276-9567
  [www.fitness.gov](http://www.fitness.gov)

For more information contact:

National Institute on Aging Information Center
1-800-222-2225 (toll-free)
1-800-222-4225 (TTY/toll-free)
[www.nia.nih.gov](http://www.nia.nih.gov)
[www.nia.nih.gov/espanol](http://www.nia.nih.gov/espanol)
[www.nia.nih.gov/Go4Life](http://www.nia.nih.gov/Go4Life)
Tips to share with older adults to prevent falls

- Exercise is a great way to reduce the risk of a fracture after sustaining a fall. Examples include walking, jogging, climbing stairs, dancing and playing tennis.
- Tai chi and Yoga programs are especially good for helping to improve balance and strength.
- Have a yearly eye exam and hearing test because even small changes in vision or hearing can cause someone to fall. Hearing aids should be properly fitted and worn.
- Get plenty of rest.
- Limit the amount of alcohol.
- Stand up slowly to avoid a drop in blood pressure.
- If a cane or a walker is recommended for use, make sure it is the right size and the wheels roll smoothly.
- Wear non-skid, rubber-soled, low-heeled shoes, or lace-up shoes with non-skid soles that fit and support the feet. Do not walk around the home or use the stairs in stockings or in shoes or slippers with smooth soles.
- Be careful when walking on wet or icy surfaces. Be safe by having sand or salt spread on the icy areas around the front and back doors of the home.
- Look carefully at floor surfaces in public buildings as many floors are made of highly polished marble or tile that can be very slippery.
- Use plastic or carpet runners on hard floors whenever possible.
- Have handrails on both sides of the stairs and make sure they are securely fastened. Be careful if carrying an item that it doesn’t block the view of the steps.
- Have good lighting and use the lights for long hallways and stairs. Use night lights to eliminate dark hallways and rooms.
- Don’t clutter walk areas. Keep the floor clear from books, magazines, papers, clothes, shoes and pets. Know where your pet is to avoid being tripped.
- Reduce tripping hazards and make the home safer by removing throw rugs and having all carpets firmly fixed to the floor so they don’t slip or turn up at the corners.
- Keep all electrical cords, telephone wires, computer cords or other electronic device cords near walls and away from walking pathways.
- Sofas and chairs should be the right height for getting in and out of easily.
- Keep items within easy reach and use an assist device such as a step stool with a handrail or a “reach-stick” for things too high. Best to have assistance than to use a step stool or have someone stand next to you. Do not stand on a chair or table.
- Mount grab bars inside and outside of tubs, showers and near toilets.
- Have emergency numbers in large print next to the telephone.
- Have the telephone close to the bed and within reach to avoid falling out of bed.
- Consider getting a home-monitoring system which can call for help if unable to do so. Medicare and most medical insurance companies don’t pay for these systems.
- Eat a healthy diet and get adequate calcium and vitamin D daily requirements to help with bone strength and health.
- Get screened for osteoporosis and treatment if needed to live a better and healthier life.
Physicians can help educate patients about osteoporosis

Osteoporosis often goes undetected until a person falls and breaks a bone. Falls increase as people age and can cause severe injury, huge medical bills and sometimes can even result in death.

Bone loss can occur without any cause, and Caucasian women are more likely to develop bone loss. The leading cause of bone loss in women occurs due to a drop in estrogen at the time of menopause. Other causes of bone loss are:

- Confinement to bed
- Certain medical conditions
- Taking of certain medicines

Other risk factors may include:

- Amenorrhea, or the absence of menstrual periods for long periods of time
- Family history of osteoporosis
- Consuming a large amount of alcohol
- Low body weight
- Smoking

We recommend that physicians perform a fracture risk assessment (FRAX) which should include the following: age, sex, weight (kg), height (cm), previous fracture, whether a parent fractured a hip, current smoking status, glucocorticoids, rheumatoid arthritis, Vitamin D deficiency or low dietary calcium intake, inadequate physical activity, loss of height (1.5 inches), family history of osteoporosis, Depo-Provera use, aromatase inhibitor therapy, androgen inhibitor therapy and Lupron therapy.

**Treatment**

Providers can educate patients about lifestyle changes, such as diet and exercise. Low calcium levels or intake appears to be associated with low bone mass, rapid bone loss and high fracture rates. A good source for obtaining calcium through diet is low-fat dairy products including milk, yogurt, cheese and ice cream; dark green, leafy vegetables such as broccoli, collard greens, bok choy and spinach; sardines and salmon; tofu; almonds; and foods fortified with calcium such as orange juice, cereals and bread.

Women over the age of 50 should consume 1,200 mgs of calcium daily and men between the ages of 51 and 70 should consume 1,000 mgs daily and increase that dose to 1,200 once 70 and older.

Vitamin D helps the body to absorb calcium. The body makes vitamin D when exposed to sunlight. As one ages the need for vitamin D increases. People 51 through 70 should consume at least 600 international units (IU) of vitamin D daily; after 70, people should consume 800 IUs per day. A few good sources for obtaining vitamin D in the diet are certain kinds of fish-herring, salmon, and tuna and low-fat milk fortified with vitamin D.

Regular physical activity has long been identified as having a positive impact on health and exercise definitely plays a key role in preserving bone density in older adults. Examples of weight-bearing physical activity are:

- Walking, jogging or running
- Tennis or racquetball
- Field hockey
- Stair climbing
- Jumping rope
- Basketball
- Dancing
- Hiking
- Soccer
- Weight lifting

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

Also, remember to counsel patients to stop smoking and help them find strategies, including prescriptions.

Counsel patients about excessive consumption of alcohol and the use of certain medications, such as glucocorticoids and anticonvulsants, which can increase the risk of bone loss and fractures.
Physicians can help increase colorectal cancer screening rates

By Hashim Yar, M.D.

Colorectal cancer affects men and women of all racial and ethnic groups, and is most often found in people aged 50 years or older. Colorectal cancer is the second leading cancer killer in the United States. The risk of developing colorectal cancer is influenced by both environmental and genetic factors.

The lifetime incidence of colorectal cancer in patients at average risk is about 5 percent. Incidence is about 25 percent higher in men than in women and is about 20 percent higher in African Americans than in whites. The incidence is higher in patients with specific inherited conditions that predispose them to the development of colorectal cancer.

In the United States, both the incidence and mortality have been slowly but steadily decreasing. Annually, approximately 134,490 new cases of large bowel cancer are diagnosed, of which 95,270 are colon and the remainder rectal cancers. Approximately 49,190 Americans die of colorectal cancer annually, accounting for approximately 8 percent of all cancer deaths in the United States,

While screening rates have increased in the U.S., not enough people are getting screened for colorectal cancer. In 2014, 65.7 percent of adults were up-to-date with colorectal cancer screening; 7 percent had been screened, but were not up-to-date, and 27.3 percent had never been screened.

Screening recommendations are modified for members of families with hereditary colon cancer syndromes, on the basis of personal or family history of CRC or adenomas in patients with inflammatory bowel disease, and in those who have been exposed to abdominal radiation.

Several potentially modifiable factors, including obesity, diabetes, tobacco use, excess consumption of alcohol, excess consumption of processed meat, and lack of physical activity, have been consistently identified as risk factors in observational studies, but at present, they do not alter screening recommendations.

The U.S. Preventive Task Force recommends screening for colorectal cancer using high-sensitivity fecal occult blood testing (annually), sigmoidoscopy (every five years, FOBT every three years), or colonoscopy (every 10 years) beginning at age 50 and continuing until age 75. The USPSTF does not recommend routine screening for colorectal cancer in adults 76 to 85 years of age, and recommends against screening for colorectal cancer in adults older than age 85.
From the medical director, continued from Page 13

People at higher risk of developing colorectal cancer should begin screening at a younger age, and may need to be tested more frequently. The decision to be screened after age 75 should be made on an individual basis.

The slow transition from polyps to colorectal cancer in most patients allows opportunities to prevent cancer by removing polyps and to prevent cancer death by finding and removing early cancers. While stool-based tests mostly improve disease prognosis by detecting early stage treatable cancers (and possibly advanced adenomas), endoscopic or radiologic tests that visualize the bowel mucosa have a greater potential to also prevent cancer by detecting polyps that can be removed prior to malignant transformation.

Most colorectal cancers arise from adenomatous polyps that progress from small to large (>1.0 cm) polyps and then to cancer. Most colorectal polyps are either adenomatous or hyperplastic. These cannot be distinguished reliably by gross appearance and therefore biopsy is required for diagnosis. Hyperplastic polyps usually do not progress to cancer.

Through our incentive program and communication efforts, Blue Care Network encourages network providers to reach out to our members and encourage them to test for colorectal cancer. We also communicate directly to members with reminders about the importance of colorectal cancer screening.

We are working on a new program through a vendor to mail a Fecal Occult Blood Test kit (FOBT) to members who are due for colorectal screening. Members mail the kits back to BCN contracted lab (JVHL) for testing. The results will be communicated to BCN and primary care physicians, so you can follow up with patients.

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, BCN provides clarification from McKesson on various topics.

Question:

In the InterQual criteria for 2015, General Medical – Hematology/Oncology under Malignant Disease, Acute page 563, there is nothing in the criteria that says “includes PO” next to the criteria. Can we apply a PO opiate to fulfill this criterion or is this only pertaining to parenteral routes? In addition, does there have to be an actual history of a malignancy to meet this criterion?

Answer:

There is nothing in this criteria that states includes PO, therefore you cannot apply a PO route with the opiates 4x/24 hrs for this criteria point. It must be parenteral. The rule at the top of the page states: “excludes PO medications unless noted”.

There must be a diagnosis of a malignancy in order to apply the opiates 4x/24hrs criteria point listed under the malignant criteria in the General Medical Hematology / Oncology criteria Pg 563.
Asthma Management program helps members manage illness

The prevalence of asthma increases each year in the United States. Approximately 17.7 million adults and 6.3 million children under 18 have asthma, according to statistics from the Centers for Disease Control and Prevention.

Blue Care Network’s Asthma Management program provides members with the information, tools and assistance needed to make informed health choices. Members learn about their condition, how it affects their lives and how to manage symptoms. The program is available for BCN members age 2 and older, and is consistent with the Michigan Quality Improvement Consortium Guideline for the Management of Asthma in both children and adults.

The chronic condition management team offers information that explains the importance of working with the health care team as well as the primary care physician. BCN sends members materials about required tests, as well as recognizing triggers and how to control them. We also provide information about medications that may be prescribed and how to self-administer medications. BCN offers education on how to use a peak flow meter and the purpose of the meter, as well as how to maintain an exercise program as an asthmatic patient. Children who have asthma receive age appropriate information on how to manage the disease while at school or away from parents’ supervision.

Both adults and children receive a management action plan that we recommend the patient use in cooperation with the physician to control their disease and prevent attacks and hospitalizations.

We offer members with severe disease enrollment in the Asthma Case Management program. In conjunction with the member’s physician, we develop an individualized plan of care and monitor outcomes.

The Chronic Condition Asthma program is a part of Blue Care Network’s Blue Cross® Health & Wellness benefit. It’s designed to help member’s stay healthy and get better when sick. Encourage members to use this program when appropriate. Current referral requirements apply. Registered nurses, who staff the chronic condition management team are available from 8:30 a.m. to 5 p.m., Monday through Friday and can be reached at 1-800-392-4247 or 1-800-257-9980 for TTY users.
Domestic violence, also referred to as intimate partner violence, is a repetitive pattern of behaviors to maintain power and control over an intimate partner. These are behaviors that physically harm, arouse fear, prevent a partner from doing what they wish or force them to behave in ways they don’t want. Abuse includes the use of physical and sexual violence, threats and intimidation, emotional abuse and economic deprivation. Many of these different forms of abuse can be going on at any one time.

Domestic violence is an epidemic affecting individuals in every community, regardless of age, economic status, sexual orientation, gender, race, religion or nationality. It can result in physical injury, psychological trauma and even death.

Domestic violence often intensifies gradually over time so it isn’t always easy to determine in the early stages of a relationship if a person is abusive. Often the abusive behaviors are dismissed or downplayed in the beginning of a relationship. It’s important to note that domestic violence doesn’t always manifest as physical abuse. Emotional and psychological abuse can often be just as damaging to the victim as physical abuse.

Many times, domestic abuse intensifies when the victim attempts to escape the abuser, terminate the relationship or seek help as the abuser feels a loss of control over the victim.

Anyone can be a victim of domestic violence — there is no typical victim. Victims of domestic violence come from all age groups and genders, all backgrounds and communities, all education and economic levels, all ethnicities and cultures, all religions and lifestyles.

Anyone can be an abuser — they also come from all age groups and genders, all backgrounds and communities, all education and economic levels, all ethnicities and cultures, all religions and lifestyles. It’s important to note that the majority of abusers are only violent with their current or past intimate partners. One study found that 90 percent of abusers don’t have criminal records and are generally law-abiding outside of the home.

Intimate partner violence screening is part of the Michigan Quality Improvement Consortium Adult Preventive Services (ages 18-49) Guideline, available at the MQIC website.

If you think one of your patients is a victim of domestic violence, encourage him or her to talk to someone they trust or encourage them to call the National Domestic Violence Hotline, available every day 24 hours a day, 365 days a year, at 1-800-799-7233 (SAFE).

For information about screening, download the Centers for Disease Control & Prevention brochure, Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings.
Flu vaccine recommendations for the 2016-2017 influenza season

The Food and Drug Administration’s Vaccines and Related Biologics Advisory committee endorsed the World Health Organization’s recommended vaccine for use in the U.S. during the 2016-2017 flu season. The recommendation was that a trivalent vaccine be used for the 2016-2017, and contain the following:

- An A/California/7/2009 (H1N1) pdm09-like virus
- An A/Hong Kong/4801/2014 (H3N2)-like virus
- aB/Brisbane/60/2008-like virus (B/Victoria lineage).

The committee also recommended that quadrivalent vaccines containing two influenza B viruses contain the above three viruses and a B/Phuket/3073/2013-like virus (B/Yamagata lineage).

The vaccine viruses recommended for inclusion in the 2016-2017 Northern Hemisphere influenza vaccines are the same vaccine viruses that were chosen in 2016 Southern Hemisphere seasonal flu vaccines.

More information is available on the Food and Drug Administration’s web page, Vaccines and Related Biological Products Advisory Committee and in the FDA’s summary minutes.

Who should get vaccinated

The Advisory Committee on Immunization Practices recommends that everyone 6 months and older get vaccinated every year. Everyone, even healthy people, is at risk for contracting the flu.

People at high risk of contracting the flu and serious complications include:

- Children 6 months through 4 years of age
- Adults 50 and older
- People with chronic pulmonary (asthma even if well controlled), cardiovascular (except hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders including diabetes
- Immunosuppressed individuals including those whose immunosuppression is caused by medications or by human immunodeficiency viruses
- Pregnant women or those women who may become pregnant during the influenza season
- Children 6 months through 18 who are on long-term aspirin therapy
- Those living in nursing homes or other long-term extended care facilities
- American Indians/Alaska Natives
- People with a body-mass index of 40 or greater
- Health care personnel
- Household contacts and out-of-home caregivers of children less than 6 months of age and adults 50 and older
- Household contacts and out-of-home caregivers of people with medical conditions that place them in a high risk category for complications from influenza

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

References:

Michigan Quality Improvement Consortium Guideline: Routine Preventive Services for Infants and Children (Birth-24 Months)
Michigan Quality Improvement Consortium Guideline: Routine Preventive Services for Children and Adolescents (Ages 2-21)
Michigan Quality Improvement consortium Guideline: Adult Preventive Services (Age>50)
http://www.cdc.gov/flu/about/season/flu-season-2016-2017.htm
HEDIS measure recommends two influenza vaccines before second birthday

The Childhood Immunization Status measure is one of many HEDIS® accreditation measures for health plans. One component of this measure is members who are ≥ 6 months of age who received two influenza vaccinations before their second birthday.

Two-dose vaccination instructions
According to the Centers for Disease Control and Prevention, the initial dose of the flu vaccine should be given as soon as it is available; the second dose should be given at least four weeks later. The first dose acts as a primer for the immune system and the second dose provides the actual immune protection. The child who receives only one dose remains at high risk for contracting influenza.

Providers are encouraged to discuss this initial influenza vaccination series with parents and remind them of second dosing with follow-up calls and letters. The ICD-10 code for “Encounter for immunization against influenza” is Z25.1 with CPT® codes for specific vaccination brand administered.

If you would like more information about HEDIS®, contact Blue Care Network, Population Health and Analytics department at 248-350-7405.

References:
http://www.cdc.gov/flu/professionals/vaccination/vax-summary.htm

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

*CPT codes, descriptions and two-digit modifiers only are copyright 2015 American Medical Association. All rights reserved.

Medical policy updates

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

Noncovered services
- Endovascular therapies for extracranial vertebral artery disease
- Extracorporeal liver support devices
- Peroral endoscopic myotomy for treatment of esophageal achalasia
- Aquablation of the prostate
- Genetic testing for retinal dystrophies

Covered services
- Genetic testing—BCR/ABL1 in chronic myelogenous leukemia and acute lymphoblastic leukemia
- Sacroiliac joint fusion for low back pain
National Lead Poisoning Prevention Week is October 23-29, 2016

It is important to reinforce the need to test children under six years for potential elevated blood lead levels.

Michigan Quality Improvement Consortium Guidelines recommend blood lead level testing at ages 9 and 18 months.

The Michigan Department of Community Health has a Lead Poisoning Prevention Program. The program offers information on the number of children with elevated blood lead levels and the percentage of children tested. The program also includes training on in-office lead level testing, and a questionnaire on lead exposure.
Help patients understand pneumonia vaccine recommendations

Protection against pneumococcal disease can be accomplished by administering two different pneumococcal vaccines, depending on age and underlying conditions.

One agent is the pneumococcal conjugate vaccine, called PCV 13 or Prevnar 13. PCV 13 protects against 13 types of pneumococcal bacteria. These 13 types of strains can cause the most severe infections in children and almost half of infections in adults. The Centers for Disease Control and Prevention’s recommendation for PCV 13 is to routinely give to children at 2, 4, 6, and 12-15 months of age. The CDC also recommends administration of PCV 13 to children and adults 2 to 64 years of age with certain health conditions. It is indicated also for all of those 65 years of age and older, no matter what the underlying conditions might be, unless there is a contraindication to the vaccine.

People who have had a severe allergic reaction to any of the components of PCV13, a life-threatening allergic reaction to a dose of PCV13, or an earlier pneumococcal vaccine called PCV7, or to any vaccine containing diphtheria toxoid (for example, DTaP), should not get vaccinated with PCV13.

The other vaccine is known as pneumococcal polysaccharide vaccine, commonly abbreviated PPSV23, and it contains 12 of the serotypes included in PCV13, plus 11 additional serotypes.

The CDC’s recommendations for those who should receive a pneumococcal vaccine are:

- Adults 65 years old or older, PPSV23 at least 1 year after PCV13 for immunocompetent
- Adults aged ≥65 years
- Anyone 2-64 years of age with certain long-term health problems such as diabetes: PPSV23
- Anyone 2-64 years of age with immunocompromising conditions: PCV13 followed by PPSV23 at least eight weeks later.
- Adults 19-64 years of age who smoke cigarettes or have asthma or COPD, PPSV23.

The recommended guidelines from the Michigan Quality Improvement Consortium state the following:

- Pneumococcal vaccine: Administer before age 65 if risk factors are present.
- Consult Advisory Committee on Immunization Practices website.
- Age 65 or older: Give PCV13 first and PPSV23 at least one year later.
- If patient has already received the PPSV23, give PCV13 at least one year later.

Risks and side effects

There are no side effects or only minor side effects from the pneumococcal vaccine. There may be some pain or redness at the site of the injection. Serious effects are rare and are due to an allergic reaction to a part of the vaccine. PPSV23 is an inactivated bacteria vaccine and therefore an infection cannot occur from the administration of this vaccine. If an adverse event occurs after the administration of any vaccine, it should be reported to the Vaccine Adverse Events Reporting System, or VAERS. Reporting can be done online, through facsimile or mail. Call 1-800-822-7967 for more information or online at vaers.hhs.gov.

Assistance programs are available to cover vaccine expenses for those who are uninsured. Since health care reform, all insurance plans are required to cover vaccines as recommended by the CDC.
October is National Breast Cancer Awareness Month

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

Blue Care Network follows these screening guidelines:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Ages 18–49</th>
<th>Ages 50–74</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography</td>
<td>Discuss with your doctor</td>
<td>Every two years</td>
</tr>
</tbody>
</table>

For additional screening information, refer to the Michigan Quality Improvement Consortium adult preventive services guidelines ages 18 to 49 and for age ≥50.

Preventive services guidelines

The Michigan Quality Improvement Consortium updated the adult preventive guidelines for ages 18 and older for 2016. Blue Care Network follows the MQIC guidelines that support several Healthcare Effectiveness Data and Information Set® measures. These HEDIS® measures are used by the National Committee for Quality Assurance and the Centers for Medicare and Medicaid Services to determine quality health care practices. The guidelines can be downloaded from the Michigan Quality Improvement Consortium website.

The following preventive care guidelines were updated in 2016:

- Adult Preventive Services Ages 18–49
- Adult Preventive Services Age ≥50

The updated recommendations for ages 18–49 include:

**Immunizations:**
- If risk factors are present, consult Advisory Committee on Immunization Practices website.

The updated recommendations for age ≥50 include:

**Immunizations:**
- Pneumococcal before age 65: If risk factors present, consult ACIP website.
- Pneumococcal age 65 and older: Give PCV13 first and PPSV23 at least one year later. If the patient already received PPSV23, give PCV13 at least one year later.

These guidelines are based on several sources with levels of evidence provided for the most significant recommendations. The grade definitions used for these guidelines are defined by the United States Preventive Services Task Force.

Other MQIC guidelines updated in 2016 include:

- Advance Care Planning
- Management of Acute Low Back Pain in Adults
- Management of Uncomplicated Acute Bronchitis in Adults
- Primary Care Diagnosis and Management of Adults with Depression
- Management and Prevention of Osteoporosis
- Prevention of Pregnancy in Adolescents 12-17 Years

BCN values its partnership with practitioners in promoting quality health care outcomes for its members. These guidelines were developed as a resource to assist practitioners and aren’t intended to be a substitute for medical judgment. Individual patient considerations and advances in medical science may supersede or modify these recommendations.
Tell us what you think about BCN Care Management services – You could win a prize!

Blue Care Network wants to know how satisfied you are with BCN Care Management services and how we can improve to better meet your needs.

Your feedback is important to us. Please complete the 2016 BCN Care Management Survey and encourage your office colleagues to do so as well, including physicians, nurses and referral coordinators. Your input will help us evaluate our efforts and determine other improvements we can make to enhance our Care Management processes.

The survey will be offered starting in October and remain available online through Dec. 31, 2016.

As a token of our appreciation, those who respond and provide their contact information following the survey will be entered in a drawing to win one of two $250 gift certificates.* All survey responses must be submitted no later than Dec. 31, 2016, in order to be eligible for the random drawing. Our winners from last year’s survey drawing were: Suzanne Baxter at Michigan Surgical Center in East Lansing and Jessica Jones at a pediatric office in Flint.

Thank you in advance for taking the time to complete the survey. If you have any questions, please contact your provider consultant.

*Two winners will be selected in a random drawing at the end of the survey from among all eligible entries. The winner will receive a $250 gift certificate. No participation is necessary. The drawing will take place approximately one month following the closure of the survey. The winner will be notified by telephone or email following the drawing.

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, phone number, office name and address. All requests must be emailed no later than Dec. 31, 2016.
Provider should discuss PSA screening risks and benefits with patients

The Michigan Quality Improvement Consortium Guidelines recommend against prostate-specific antigen based screening for prostate cancer. It’s recommended that men make an informed decision with their health care providers about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks and potential benefits of the screening. Men shouldn’t be screened unless they have received this information.

The discussion about screening should take place at:

• Age 50 for men who are at average risk of prostate cancer and are expected to live at least 10 more years
• Age 45 for men at high risk of developing prostate cancer. This includes African Americans and men who have a first degree relative (father, brother or son) diagnosed with prostate cancer at an early age (younger than age 65)
• Age 40 for men at even higher risk (those with more than one first degree relative who have prostate cancer at an early age)

As new information about the benefits and risks of testing becomes available, the discussion about the pros and cons of testing should be repeated. It’s also important to consider changes in the patient’s health, values and preferences. Overall health status, and not age alone, is important when making decisions about screening.

Advice from physicians is important to reducing SIDS deaths

Your contribution to reduce the risk of deaths from SIDS by sharing safe infant sleep messages is critical. Research shows that advice from health care providers positively affects parent and caregiver choices about infant sleep position and infant sleep environment.

While great progress has been made in reducing the SIDS rate by 50 percent since 1992, there is still much to do. In the United States, African American, American Indian/Alaska Native infants are at a higher risk for SIDS than are White or Hispanic infants.

Although the SIDS rates have dropped, the rates of other sleep related causes of infant death such as accidental suffocation have increased. Michigan Quality Improvement Consortium Guidelines recommend that the risk for accidental deaths in infants as well as SIDS related deaths be included in conversations with parents.

For materials about the Safe to Sleep campaign, visit the National Institute of Child Health and Human Development.
Well child visits are important through adolescence

A well child visit is the perfect opportunity to monitor not only the physical, but emotional and psychological well-being as a child grows and develops. From birth through early childhood, a child will have more frequent well child visits offering excellent opportunities for physicians to educate parents about normal growth and development, immunizations, safety, exercise and nutrition.

The child's weight, height and head circumference should be recorded on a growth chart and kept in the child's medical record. Other information that can be discussed and documented includes:

- BMI screening
- Nutrition
- Sleep
- Safety
- Physical activity
- Violence, bullying and abuse
- Sexually transmitted infection prevention
- Suicide threats
- Alcohol and drug abuse
- Behavioral and emotional problems
- Anxiety, stress and coping skills
- Immunizations
- Skin cancer prevention
- Tobacco use and second smoke exposure
- Poison and burn prevention
- Family relationships
- School and community services

Information about routine preventive services for infants, children and adolescents can be found at the [Michigan Quality Improvement Consortium](http://www.michiganquality.org) website.

Developmental screening

Developmental screening can be performed through a short test that can tell if a child is learning basic skills when he or she should or if there are any delays. The American Academy of Pediatrics advocates screening for developmental delays and disabilities during regular well-child visits at 9 months, 18 months and 30 months. However, if a child is at high risk for developmental problems due to preterm birth, low birth weight or other reasons, additional screenings may be needed.

Preventive health care schedule

A visit to a health care provider before the baby is born could be very beneficial for first time parents to discuss common issues such as feeding, circumcision, immunizations and immunization schedules.

After birth the first visit for breastfed babies should be two to three days after coming home or two to four days for all babies released from a hospital before they are two days old. After that, recommended visits should occur at the following ages:

- By one month
- Two months
- Four months
- Six months
- Nine months
- One year
- Fifteen months
- Eighteen months
- Two years
- Two and a half years
- Three years
- Each year after until the age of 21
Step treatment of depression: Where do the new treatments and medications fit in?

By William Beecroft, M.D., BCN medical director

Treatments for many illnesses have evolved and are changing with new strategies and interventions. In the area of depression treatment, new medications are available. And psychotherapies have been enhanced to add an equally effective intervention that is as good as medication alone to improve depressed mood. Psychotherapy when added together with medication, exercise, diet, spiritual resources and avoidance of stimulant or sedating substances has shown the best overall outcomes.

The Centers for Medicare & Medicaid Services has recommended screening for depression for everyone. Using the PHQ-9 screening tool is a Healthcare Effectiveness Data and Information Set measure. It’s a commonly found objective measure already embedded in electronic medical record systems and administered routinely in primary care physician offices.

There is a new quality measure through HEDIS®, called depression screening, that measures the efficacy of the treatment of patients. This is also a measure for primary care physicians for the Blue Cross Blue Shield of Michigan Physician Group Incentive Program. Success is measured by improvement in the PHQ-9 score, specifically a patient who had a PHQ-9 score of 10 or greater and has a 50 percent improvement within six months. This measurement schema conforms to the literature-supported definition of response to an intervention. However, remission is the goal of our treatments.

A 75 to 90 percent reduction of symptoms would be a closer approximation of remission and is achievable in most patients. Generally, with even very aggressive treatment using adequate trial of medications, psychotherapy, exercise, diet, spiritual resources and avoidance of stimulant or sedating substances, 25 percent of people don’t have a response to treatment and many people don’t achieve remission.

We know that measurement of depression using objective evidence-based measures is critical. Subjective assessment of a member’s mood is inaccurate and ineffective. PHQ-9, developed by Robert Spitzer, leader of the DSM taskforce through DSM-IV-TR, has a substantial evidence base for specificity and sensitivity (88 percent each). We know how to measure response and remission along with relapse as a percentage improvement in the scores, which helps objectively gauge progress.

Please see Step treatment depression, continued on Page 26
Behavioral Health

Step treatment depression, continued from Page 25

STAR-D trials in the 1980s showed the importance of changing medications and psychotherapy intervention if the treatment plan wasn’t showing improvement within four to six weeks (not months)\(^2\). Use of your first go-to treatment and remeasuring efficacy in four to six weeks is the current standard of care. When there isn’t a 50 percent improvement of the PHQ-9 score, you need to change interventions. With medications, that would include changing to a different class of medication. With psychotherapy, it would mean changing to a different style (cognitive behavioral therapy is shown to be the most effective) or referring the member to a psychiatrist for initiation of medication. More of the same intervention is bound to fail to produce improvement.

Remeasuring the second, new intervention at four to six weeks continues to be important because if there is no improvement (50 percent reduction of the PHQ-9), then the intervention would need to be changed again. Interventions might include changing to a different class of medication or adding more vigorous diet, exercise and restrictions on substance use.

Psychoeducation of members to continue to participate and adhere to recommendations is imperative as by now (12 to 18 weeks of treatment — likely four to six months of illness) members become tired of being depressed and lose hope that they will get any better.

By this time, the member should have at least three classes of medication trials and a course of cognitive behavioral psychotherapy. Assuming that a psychiatrist hasn’t been involved in the treatment, a consultation is in order to review the options of pharmacologic augmentation or referral for neuromodulation. Transcranial magnetic stimulus is an effective treatment of refractory individuals. Electroconvulsive therapy is also effective and done much differently today, minimizing the memory side effects. ECT is the first line treatment of depression with psychosis so it doesn’t need to be left as a last resort.

The newer antidepressant medications, such as Brintellex or Viibryd may provide better tolerance for individual patients but generally would fall into a broad definition of the main classes of medications we have: SSRIs, SSNRIs or Atypicals/Others. Viibryd would be very similar in action to SSRIs as a pharmacologic agent as would Brintellex, although being newer agents are much more expensive.

Because cost is a factor, the member has to deal with using lower cost generic agents. Physicians should consider the member’s copayments for treatment. This must be balanced with efficacy and evidence base of the interventions you are considering. Sometimes the patient needs psychotherapy twice a week for a short time to stabilize a crisis or therapeutic impasse. If more frequent interventions are indicated, considering a referral to a partial hospital program or intensive outpatient program for crisis intervention may be the best use of time and resources.

Risk of harm is always an issue with individuals who are depressed. Using objective scales such as the Columbia Suicide Severity Rating Scale\(^3\) can be helpful, but clinical judgment always is the final judge of risk. Utilization of inpatient or partial hospitalization program resources to help both you and your patient through this crisis should be considered.

Thank you for collaborating with us to care for our members. BCN Behavioral health stands by you to assist with authorizing your interventions and providing contracted referral resources that can help you develop a treatment plan that will have a good likelihood of success.

3. www.cssrs.columbia.edu/
Quality corner: Supplemental self-help therapy

What are self-help or nonprofessional therapy resources?
Self-help can come in the form of books or materials, online forums and, very commonly, support groups. The ideas behind self-help practices are very broad, and the concepts themselves sometimes include community awareness campaigns on a population health level. For the purposes of this Quality Corner, we are primarily focusing on nonprofessional or self-help support groups (both in-person or virtual) which can be used in conjunction with therapy.

What are the benefits of self-help groups?
Numerous research articles in various segments of behavioral health, including psychiatric issues, substance abuse, weight problems, and bereavement, have found that those who participated in self-help groups received many benefits.

- In one study, those who had chronic psychiatric problems and were in a self-help group spent fewer days in a psychiatric hospital when compared to a cohort with similar demographics.
- In a study regarding bereavement, those who participated in self-help groups experienced less depression and grief than those who did not participate.
- Another experiment looked at alcoholic patients admitted to hospital treatment programs. The researchers found that the more sessions of Alcoholics Anonymous that were completed, the longer the patient remained abstinent.

These benefits on their own are compelling reasons why self-help groups are important. In addition, an increasing number of people are seeking treatment and a large proportion of individuals may go untreated, which puts pressure on behavioral health providers and strains available behavioral health resources. This further underscores the significance of self-help groups.

We realize that not all self-help programs may be effective or have the same efficacy for various patients. It depends on individual patient engagement, diagnosis severity and other factors that determine which program structure is most suitable. Generally, participating in self-help groups is beneficial when used in conjunction with professional therapy. However, the therapist and the patient should determine whether pursuing self-help resources is valuable for their overall well being.

What can behavioral health providers do?
Patients may not be aware of what resources to seek outside of professional therapy. Knowing local groups who are reputable and supportive for specific conditions to readily advise the patient would be a great advantage for them. Having brochures or the group’s information on hand takes the burden off the patient to look up the information themselves and makes it easier for them to follow up. It’s important that the patient understand that this does not substitute their therapy sessions, but rather works in sync with therapy to maximize positive outcomes.

Resources
Please see the materials and articles cited for more in depth information on the benefits of self-help groups.

References
Coming October 1 for behavioral health higher levels of care: Changes in submitting initial authorization requests, concurrent reviews and discharge summaries

Starting Oct. 1, 2016, the requirements for how Blue Care Network’s behavioral health facilities submit initial authorization requests, concurrent reviews and discharge summaries will change, for inpatient, partial hospital and intensive outpatient services. The changes will affect both substance use and mental health cases.

Here’s a summary of the changes:

<table>
<thead>
<tr>
<th>Type of request</th>
<th>Current practice</th>
<th>Changes effective Oct. 1, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial authorization</td>
<td>Currently, all initial authorization requests are submitted by phone.</td>
<td>When the member is in the emergency department and not yet admitted to a bed, and you need an immediate response to your request, continue to call in your request to BCN at 1-800-482-5982.</td>
</tr>
<tr>
<td></td>
<td>When the member has already been admitted to a bed, you must submit the initial authorization request through the e-referral system.</td>
<td></td>
</tr>
<tr>
<td>Concurrent review</td>
<td>Currently, concurrent reviews are submitted using the Behavioral Health IP/PHP/IOP Concurrent Review Form.</td>
<td>You must submit requests for concurrent reviews through the e-referral system. You’ll need to complete a questionnaire within the e-referral system. BCN will no longer accept concurrent review requests submitted by fax. The Behavioral Health IP/PHP/IOP Concurrent Review Form will no longer be available. The questionnaire in the e-referral system will take the place of the form.</td>
</tr>
<tr>
<td>Discharge summary</td>
<td>Currently, discharge summaries are submitted via fax, using a Microsoft® Word® version of the BCN Behavioral Health Discharge Summary form.</td>
<td>You must complete an Adobe® PDF version of the BCN Behavioral Health Discharge Summary form and attach it to the case in the e-referral system. The PDF form is now available on BCN’s Behavioral Health web page at ereferrals.bcbsm.com.</td>
</tr>
</tbody>
</table>

**e-referral User Guide will be updated**

BCN’s Behavioral Health e-referral User Guide will be updated before Oct. 1 to include instructions for the higher levels of care. Watch for the announcement!

You can refer to the updated User Guide for instructions on how to attach the BCN Behavioral Health Discharge Summary form to the case in the e-referral system. The User Guide will also show you how to complete the questionnaire for a concurrent review.

You can access the user guide at ereferrals.bcbsm.com. Click Training Tools.

**Sign up to use the e-referral system**

BCN-contracted facilities that have not already signed up for access to the e-referral system should apply immediately. Each utilization review user at each facility will need his or her own individual access.

To get access to e-referral, you must register to use the Blue Cross / BCN Provider Secured Services portal. Go to ereferrals.bcbsm.com and click Sign Up or Change a User. Follow the instructions under the heading “To sign up as a new e-referral user.”

This applies whether your facility is new to Provider Secured Services or you’re already signed up for Provider Secured Services and just need access to the e-referral system.

It is critical that you sign up as soon as possible since granting access takes some time and you’ll need access before Oct. 1.
Blue Care Network helps members manage depression

BCN’s Chronic Condition Depression Management program provides education and self-management strategies to members diagnosed with depression. The program was developed in conjunction with the Michigan Quality Improvement Consortium guideline *Primary Care Diagnosis and Management of Adults with Depression*.

The goals of the program include:

- Provides member education about basic pathophysiology of depression and current treatment modalities with emphasis on acute and continuation phases of treatment, self management techniques and the importance of medication compliance
- Decreases absenteeism in the workplace
- Decreases inappropriate inpatient admissions and emergency room visits
- Addresses comorbid medical conditions
- Helps providers track and monitor services for members with depression

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

Enrolled members receive a program booklet and introductory letter, a depression self-management booklet, medication refill reminder letters if necessary, ongoing telephone support from a complex case manager, and web-based depression management information and tools.

If a member is admitted to the hospital with a primary diagnosis of major depression, he or she will receive all information previously mentioned, as well as the opportunity to enroll in a behavioral health case management program provided by BCN’s Behavioral Health department. The behavioral health case manager makes sure that a follow-up visit is scheduled within seven days of discharge and monitors appointment compliance. Phone contact is made with noncompliant members to provide support and education. Additional support is provided to members with readmissions including a member-specific plan of care.

To learn more about BCN’s Chronic Condition Depression Management program or to refer a member, contact a behavioral health complex case management specialist at 1-800-482-5982 or 1-800-257-9980 for TTY users, Monday through Friday, 8:00 am to 5:00 pm.
Blue Care Network Behavioral Health Incentive Program 2016

To accommodate the continuous growth in self-reported form submissions for the Behavioral Health Incentive Program, we created the electronic submission method, which is faster and easier for providers. It also reduces administrative work for Blue Care Network and expedites the process of reviewing self-reported submissions. We are happy to report that a greater percentage of forms are being sent electronically. Providers who submit forms electronically are eligible for $10 more per form for either measure.

If you are faxing, please ensure that patients are commercial members, double check to be sure you are not sending a duplicate form, and review the form to make certain it is complete and legible. In order to give proper credit, we must have accurate information.

For more details regarding faxing tips, please refer to the Frequently Asked Questions 2016 document, which has a full section addressing faxing suggestions.

To view the 2016 program documents on web-DENIS, please follow these steps:
- Go to BCN Provider Publications and Resources
- Click on Behavioral Health under Resources
- Scroll down to Behavioral Health Incentive Program

Let us know what you think

BCN has created a survey regarding the Behavioral Health Incentive Program. Our survey addresses familiarity with the program, understanding of program policies, feedback for program improvement and any barriers to participation. Regardless of whether or not you are participating in the incentive program, we would like your feedback. The survey will be closed on Sept. 1, so please respond as soon as possible. Your responses are used when making decisions regarding design, strategy, and evaluation for the 2017 program.
The national Blue Cross Blue Shield Association invited BCN Medical Director Dr. William Beecroft, along with Julie Hambright, manager of Provider Affairs and Elana Mosesova, senior analyst to present result of BCN’s Behavioral Health Incentive Program for behavioral health providers at the association’s national summit in Orlando in May. BCN is a national leader in using this innovative program to improve member outcomes.

“BCN is one of the first, if not the first, in the country to offer an incentive program such as we’ve designed,” said Dr. Beecroft.

“Our team did a lot of research,” said Mosesova. “We looked at how to get people to adhere to medications, do better in terms of therapies and to improve not just their mental health but their physical health. After a number of focus groups and surveys, we came to a consensus, a dashboard of measures and details surrounding the measures

“The next question was how to get providers to do what we’re asking them to do.”

There are a number of incentive targets – two that stand out are quality of psychotherapy and pharmacy. In terms of therapy, “Our goal is to enhance the quality in our network, to have the best psychotherapists treating our patients,” said Dr. Beecroft. “Psychotherapy is a powerful tool in treating mental illness, and we’re providing incentives for therapists to recognize their communication effectiveness, which has been proven to produce better results.”

Pharmacy measures include antidepressant medication management, pharmacy adherences for bipolar disorder and appropriate glucose monitoring, since the majority of the antipsychotic and antidepressant medications cause weight gain, the underlying cause for diabetes and a reason people may choose not to take the drugs.

Following the protocol of this program helps our members while boosting our HEDIS® scores. Antidepressant medication adherence is a current HEDIS measure and next year, improving on the medication result will become a HEDIS measure. According to Dr. Beecroft, in 2015, our HEDIS score was in the 50th percentile. “We are currently in the 75th percentile, a significant improvement, due to this team’s efforts to raise awareness with this program. At one point we touched on the 90th percentile, and our goal is to get there again and sustain that level.”

“Compliance with hemoglobin A1c in members taking antipsychotic medications, follow-up from psychiatric hospitalization with seven days and improvement in therapeutic alliance monitoring have been tangible outcomes that have improved within the year,” said Mosesova. “We’ve also noticed a large improvement in hospitalizations.”

There are greater implications that concern Dr. Beecroft. “People with chronic mental illness, recurrent depression, schizophrenia or bipolar disorder die 20 years earlier as a group than the general population. In order for us to give them a better quality of life and health care, it’s imperative that we monitor developing illnesses like diabetes, heart disease, or COPD if they’re a smoker, liver disease if they drink alcohol, to be able to increase their lifespan equal to that of the general population.”

“I count five wins,” Dr. Beecroft said. “The patient gets better. The doctor wins because he got his patient better. Families win by getting their family member back. BCN wins by decreasing our costs. And people who buy our insurance win because it’s more affordable.”
HEDIS tips: Acute upper respiratory tract infections

Members with acute upper respiratory tract infections account for many visits to the primary care office. Although the majority of these infections are viral, many are treated with antibiotics.

Blue Care Network has two clinical practice guidelines for antibiotic utilization for upper respiratory infections that can be downloaded from the Michigan Quality Improvement Consortium website. These guidelines are based on several sources with levels of evidence provided for the most significant recommendations. The **Acute Pharyngitis in Children 2-18 years old** guideline was updated in 2015. The **Management of Uncomplicated Acute Bronchitis in Adults** guideline was updated May 2016.

Viruses account for 70 to 80 percent of pharyngitis in children and GABH Strep accounts for 15 to 30 percent of infections.

The **Acute Pharyngitis in Children 2-18 Years Old** MQIC guideline includes:
- Possible etiologies for pharyngitis and/or tonsillitis
- Recommended assessments and treatments
- Recommendations if there is clinical failure
- Rheumatic fever considerations

The **Management of Uncomplicated Acute Bronchitis in Adults** MQIC guideline includes:
- Recommended assessments and treatments
- Clinical information and testing for diagnosis
- Treatment section recommends avoiding antibiotics
- Education and counseling recommendations

It’s challenging to work with a patient or family who requests an antibiotic when it’s not appropriate. Below are some websites to help you educate your patients about the proper use of antibiotics:

- **CDC website**: Interventions that Work. Enter “Get Smart Home” in the search box. Click on the category titled *Interventions that Work* for recommended interventions that reduce inappropriate outpatient prescribing of antibiotics.

- **MARR website** has a program called PEARLS where you will find recommended actions to use for patients who request antibiotic therapy that isn’t needed.

- **Choosing Wisely** has materials available explaining when it is appropriate to use antibiotics. Consumer Health Choices has *The 5 Questions to ask your doctor before you take antibiotics* flier that you can give to your patients and posters you can use in your office.

These guidelines were developed as a resource to assist practitioners and aren’t intended to be a substitute for medical judgment. Individual patient considerations and advances in medical science may supersede or modify these recommendations.
Colorectal cancer screening: Options could be the key to higher compliance rates

The third leading cause of cancer death in the United States is colorectal cancer. Colorectal screening tests can help detect the presence of cancerous and precancerous abnormalities. Early detection is the key to combating the high mortality rate from colorectal cancer.

Healthcare Effectiveness Data and Information Set, or HEDIS®, specifications recommend that adults 50 to 75 years old are screened for colorectal cancer. There are currently three types of recommended screening methods. Each method has its own set of advantages and disadvantages. The key to compliance could be as simple as offering members the option to choose with method works best for them.

Colonoscopy
• This test is needed once every 10 years, unless an abnormality is detected.
• Colonoscopy allows the clinician to visualize the entire colon, and perform polypectomies as needed.
• This test requires bowel preparation and sedation.
• It has a higher chance of complications compared to the other screening methods.

Sigmoidoscopy
• This test is needed once every five years, unless an abnormality is detected.
• The clinician can visualize the lower portion of the colon.
• This test requires a degree of bowel preparation, but not as extensive as a colonoscopy.
• If abnormalities are detected, the provider will recommend a colonoscopy for further evaluation.

Fecal occult blood test, or FOBT
• There is no bowel preparation or sedation required.
• This test can be completed at home by the member.
• This test needs to be completed every year.
• If abnormalities are detected, the provider will recommend a colonoscopy for further evaluation.

The following provider in-office billing codes meet HEDIS® specifications regarding FOBT, and will be reimbursed by Blue Care Network: *82270 and *82274.

Please note: The Cologuard® test does not meet screening guidelines for the colorectal screening measure as part of the Blue Cross Blue Shield of Michigan and Blue Care Network 2016 Performance Recognition Program.

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HEDIS tips: Physical activity counseling for children

The Childhood Weight and Assessment Counseling measure is one of many HEDIS® accreditation measures for health plans. It looks at members 3–17 years of age, who had an outpatient visit with a primary care physician or obstetrician/gynecologist and had evidence of all of the following: BMI percentile, counseling for nutrition and counseling for physical activity.

- The following are ICD-10 codes that can be used for this measure:

<table>
<thead>
<tr>
<th>ICD-10 CM diagnosis codes for BMI percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z68.51 BMI pediatric &lt;5%</td>
</tr>
<tr>
<td>Z68.52 BMI pediatric 5% – &lt;85%</td>
</tr>
<tr>
<td>Z68.53 BMI pediatric 85% – &lt;95%</td>
</tr>
<tr>
<td>Z68.54 BMI pediatric &gt;=95%</td>
</tr>
</tbody>
</table>

Codes to identify nutrition counseling

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>HCPCS</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z71.3</td>
<td>G0270, G0271, G0447, S9449, S9452, S9470</td>
<td>*97802-97804</td>
</tr>
</tbody>
</table>

Code to identify physical activity counseling

- Currently, there is an ICD-10 code that is in the 2017 HEDIS Value Set for physical activity counseling; it is Z02.5. This code is specific to an encounter for an examination for participation in sports.
- If the above code is not applicable, HEDIS requires that the medical record include any of the following: notation of specific sports participation/exercise or anticipatory guidance for activity. Activities directly related to developmental milestones do not count toward this measure.

**Note:** This measure looks at children as early as 3 years of age; please ensure that young children are being counseled as well.

If you would like more information about HEDIS®, contact Blue Care Network, Population Health and Analytics HEDIS message line at 1-855-228-8543.

References:


HEDIS® 2016 Technical Specifications for Health Plans

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Starting DMARDs early improves quality of life, long-term management for rheumatoid arthritis patients

Rheumatoid arthritis is the most common form of autoimmune arthritis and it affects more than 1.3 million Americans. According to the Centers for Disease Control and Prevention, RA is the leading cause of disability among U.S. adults. Thirty percent of RA patients will experience work limitations and in patients with inadequate treatment, 60 percent will be unable to work 10 years after disease onset. The American College of Rheumatology recommends that physicians prescribe a disease-modifying antirheumatic drug, or DMARD, for all RA patients, regardless of severity or how active the patient’s RA is.

For your patients with RA, consider prescribing a DMARD. DMARDs not only relieve symptoms but can change the natural history of a patient’s rheumatoid arthritis. Only DMARDs have been shown to reduce or even halt the progression of RA. While nonsteroidal anti-inflammatory drugs and corticosteroids may be useful for symptom control, use should be short-term until DMARD response is achieved. Treatment target should ideally be low disease activity or remission.

In the first few months following onset of rheumatoid arthritis, it’s crucial that patients get appropriate treatment to avoid long-term complications. Current guidelines recommend beginning DMARD therapy within three months of initial diagnosis of RA in order to achieve and maintain the greatest response rates.

Early DMARD therapy directly correlates to increased patient response rates, decreased radiographic progression rates and decreased patient reported pain. This means patients are more likely to lead an active lifestyle and less likely to need joint replacements later in life. Delaying DMARD therapy increases the risk of serious joint injuries because the longer the active disease persists, the less likely patients will respond to therapy.

References:
Changes coming Oct. 7 for medications covered under the medical benefit

Effective Oct. 7, 2016, Blue Care Network will manage authorization requests and claim edits for medications covered under the medical benefit through our Pharmacy Services department rather than through our Care Management department.

What’s changing?
Starting Oct. 7, you’ll submit authorization requests for these medications through the NovoLogix system rather than through the e-referral system. Submitting these requests electronically is the preferred method, since it saves time and allows you to view the status of the request at any time.

Sign up for training on the NovoLogix system
To find out how to use the NovoLogix system, you should plan to attend the training webinar we’re offering. The webinar will include an opportunity to get your questions answered. See the additional information on this page about how to register for one of the webinar sessions. Blue Cross has been using Novologix for the past two years so some providers may be familiar with the tool.

Other things you should know
You can also submit requests to authorize medications covered under the medical benefit by fax at 1-877-402-7695 or by phone at 1-800-437-3803. These fax and phone numbers are effective Oct. 7 and are different from the ones you use now.

BCN will move the current active authorizations from the e-referral system to the NovoLogix system before Oct. 7 so that these authorizations will not be interrupted when the change in systems occurs.

Logging in to the NovoLogix system
The NovoLogix system won’t be available for BCN providers until Oct. 7, but once it’s available, here’s how you’ll log in:

1. Visit bcbsm.com/providers and log in to Provider Secured Services (Click Login. On the log-in menu, click Provider, enter your user ID and password and click Login.)
2. On the Provider Secured Services welcome page, click BCN Medical Benefit — Medication Prior Authorization.
3. Enter your NPI.

This will bring you to the NovoLogix welcome page.

Available resources
Training materials and videos are available on the NovoLogix website, on the Help menu.

Additional resources related to submitting authorizations and billing for medications covered under the medical benefit are available at these locations:

- At ereferrals.bcbsm.com. Click BCN and then click Medical Benefit Drugs – Pharmacy. This web page is available now and will have more information added to it as time goes on.

- In the Pharmacy chapter of the BCN Provider Manual. To access the chapter, log in to Provider Secured Services and click BCN Provider Publications and Resources. Click Provider Manual and click Pharmacy. Look in the section titled “Drugs covered under the medical benefit.”

Sign up for the Novologix webinar

Choose from one of four sessions:

<table>
<thead>
<tr>
<th>SESSION NO.</th>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Thursday, Sept. 29, 2016</td>
<td>10 a.m.</td>
</tr>
<tr>
<td>2</td>
<td>Thursday, Sept. 29, 2016</td>
<td>1 p.m.</td>
</tr>
<tr>
<td>3</td>
<td>Tuesday, Oct. 11, 2016</td>
<td>10 a.m.</td>
</tr>
<tr>
<td>4</td>
<td>Tuesday, Oct. 11, 2016</td>
<td>1 p.m.</td>
</tr>
</tbody>
</table>

Registration is required. Here’s how to register:

1. Complete the registration form.
2. Submit the completed form to BCN in one of the following ways:
   - Email it to ProviderInvitations@bcbsm.com
   - Fax it to 1-866-652-8983

Each training session will last about one hour.
Remicade and Inflectra added to site of care optimization program on October 1

There are many injectable or infusible drugs covered under Blue Care Network members’ medical benefit that can be safely and effectively administered at various sites of care. The most common sites include an outpatient hospital facility, a physician’s office, or a member’s home. However, the cost of these drugs varies widely between treatment sites.

In an effort to help manage these costs, starting on Oct. 1, 2016, BCN will add Remicade® and Inflectra® to its site of care optimization program. This program redirects patients receiving select injectable or infusible drugs in the outpatient hospital setting to a lower cost, alternate site of care, such as the physician’s office or member’s home.

The site of care requirements will initially apply only to BCN commercial members who start Remicade or Inflectra on or after Oct. 1, 2016. Members who have a paid claim for one of these medications in the outpatient hospital setting before Oct. 1, 2016 will be allowed to continue receiving their therapy in the outpatient facility for one year. Starting Oct. 1, 2017, all users will be required to transition to a lower cost, alternate site of care.

As with other drugs in BCN’s site of care program, if the provider believes a member is not a candidate to receive the drug at a site other than the outpatient hospital setting, the provider must present documentation supporting medical necessity to the plan for review. Requests will be evaluated on a case-by-case basis.

For a full list of drugs in the program and information about how to request authorization, go to ereferrals.bcbsm.com, click BCN, then click Clinical Review & Criteria Charts. Finally, click to open the BCN Referral and Clinical Review Program document.

BCN limiting opioids to a 30-day supply; first fills of opioids to 15 days on Dec. 1

Blue Care Network is working to make sure that our members have access to the medications they need while ensuring the appropriate use of opioid drugs. To help meet these goals, starting Dec. 1, BCN will limit all fills of opioid to a 30-day supply.

In addition, members who haven’t recently filled a prescription for opioid therapy will be limited to a 15-day supply for first fills of short-acting opioids.

We’ll be reaching out to affected members and physicians soon. We’ll publish details about these new requirements in the next issue of BCN Provider News.

BCBSM and BCN drug lists updated, available online

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.

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.
Billing Q&A

Question:
We are an anesthesia provider requesting clarification on filing a labor epidural (01967). The ABU’s are capped at 17 units. Is there an additional time unit used for calculation, making the total number of units submitted 18?

Answer:
BCN’s claim’s system is configured to process claims for that anesthesia code 01967* as a flat 18-unit rate for commercial claims regardless of the units reported. This change has been in production since June 2012.

Question:
We are having trouble with getting payments on institutional claims for outpatient surgical procedures performed at our ambulatory surgery center. We are an ophthalmologist office so our procedures are done on one eye at a time a few weeks apart to make sure no complications arise before proceeding to the next eye. We will always bill in a professional charge and an institutional charge for each eye. When we bill the second eye, we are receiving denials on the facility charge as an inclusion in the global period of the first eye. We have tried variations on modifiers including SG, 79, SG, 79, SG, EYE and each time the claim is denied as being within the global period. Any advice?

Answer:
Appropriate modifiers must be used to indicate the service is not part of the initial surgical procedure with the global period. Typically these modifiers are 58, 78 or 79. These modifiers would indicate a staged procedure, an unplanned return to surgery related to the initial procedure, or an unrelated procedure or service. We would expect you to use these modifiers when the same physician — or a physician in the same provider group and of the same specialty — performs the subsequent procedure or service.

If an office visit occurs in the global period, a different modifier, 24, is used when the evaluation and management service is not related to the initial procedure.

It is important to use the appropriate modifier when submitting claims. Incorrect reporting of modifiers can adversely affect how your claim processes. When claims with these types of edits are received, it is important to note what modifier you would report and include a corrected claim with the appeal. Modifiers used in the global period, such as return to surgery when it is related to the initial procedure, may affect reimbursement.
**Billing Q&A, continued from Page 38**

**Question:**
Our office has not received full payment on some office visit codes. From what I can see they are the higher level codes. I was told it was a new edit, but I am not sure what it is editing against. Can you explain?

**Answer:**
In December 2015 Blue Care Network implemented a new program looking at providers who routinely report the higher level evaluation and management codes; *99204, 99205, 99214 and 99215. We review all diagnoses. If none support the higher level code, the claim is repriced to the level supported, but no lower than a level 3 code. Claim lines that we reprice receive a designated explanation (EX) code of QM4.

If the provider disagrees with the repricing of the claim line, a clinical editing appeal should be submitted with the appropriate documentation supporting the services provided.

Note: Please refer to the Clinical editing billing tips in this issue, or the BCN Provider Manual, for information on submitting a clinical editing appeal.

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**Reminder: Status Claim Review Form no longer accepted**

Please note that Blue Care Network announced last year that 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** have been removed from BCN’s published documents.
Coding Corner

Medical record documentation for COPD and associated respiratory conditions

With the increased specificity required by ICD-10-CM, accurate and detailed medical record documentation is more important than ever. Chronic obstructive pulmonary disease and associated respiratory conditions need to be properly documented in the medical record to support the correct ICD-10-CM diagnosis code.

What is COPD?
Chronic obstructive pulmonary disease is a common and progressive disease that causes airflow from the lungs to be obstructed. Common symptoms include a productive cough, wheezing, shortness of breath and chest tightness. The two main forms of COPD are emphysema and chronic bronchitis. However, many patients with COPD have both emphysema and chronic bronchitis.

What causes COPD?
Smoking tobacco and exposure to tobacco smoke are the leading causes of COPD. According to the Centers for Disease Control and Prevention, smoking also accounts for as many as eight out of 10 COPD-related deaths. However, as many as one out of four people in the U.S. who have COPD never smoked cigarettes. Other causes include long-term exposure to lung irritants such as air pollution, chemical fumes and dust.

Tips to remember
• When coding for COPD, bronchitis (acute, chronic), asthmatic bronchitis (acute, chronic), emphysema and other associated respiratory conditions, indicate through coding whether or not the condition is acute, chronic or in acute exacerbation.
• Since COPD-related conditions can be coded in a variety of ways, the final code selection must take into account all the specific details of a patient’s condition, as documented by the health care provider.
• ICD-10-CM code J44.9 (chronic obstructive pulmonary disease, unspecified) should only be used if the type of COPD being treated is not specified in the medical record.
• Always document and code to the highest specificity. For example, if the provider documents “acute bronchitis” or “chronic bronchitis” (both unspecified), then report ICD-10-CM codes J20.9 and J42.0, respectively. However if the provider does not indicate whether the bronchitis is acute or chronic, then the appropriate ICD-10-CM code would be J40 (Bronchitis not specified as acute or chronic).
• When COPD with an acute exacerbation is documented without acute bronchitis, then report ICD-10-CM code J44.1 (chronic obstructive pulmonary disease with acute exacerbation).

Please see Coding Corner, continued on Page 41
Coding Corner, continued from Page 40

- Code J44.0 (chronic obstructive pulmonary disease with acute lower respiratory infection) when the medical record supports acute bronchitis and COPD. Use an additional code to identify the infection.

<table>
<thead>
<tr>
<th>ICD-10-CM code</th>
<th>Description of respiratory condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>J41.0</td>
<td>Simple chronic bronchitis</td>
</tr>
<tr>
<td>J41.1</td>
<td>Mucopurulent chronic bronchitis</td>
</tr>
<tr>
<td>J44.–</td>
<td>Other obstructive pulmonary disease</td>
</tr>
<tr>
<td>J44.0</td>
<td>J44.0 COPD with acute lower</td>
</tr>
<tr>
<td>J44.1</td>
<td>respiratory infection</td>
</tr>
<tr>
<td>J44.2</td>
<td>J44.1 COPD with (acute) exacerbation</td>
</tr>
<tr>
<td>J44.3</td>
<td>J44.9 COPD, unspecified</td>
</tr>
<tr>
<td>J41.8</td>
<td>Mixed simple and mucopurulent</td>
</tr>
<tr>
<td>J42</td>
<td>chronic bronchitis</td>
</tr>
<tr>
<td>J43.9</td>
<td>Emphysema, unspecified</td>
</tr>
<tr>
<td>J45.–</td>
<td>Asthma (additional 5th and/or 6th</td>
</tr>
<tr>
<td>J45.2</td>
<td>characters required</td>
</tr>
<tr>
<td>J45.3</td>
<td>J45.2 – Mild Intermittent asthma</td>
</tr>
<tr>
<td>J45.4</td>
<td>J45.3 – Mild persistent asthma</td>
</tr>
<tr>
<td>J45.5</td>
<td>J45.4 – Moderate persistent asthma</td>
</tr>
<tr>
<td>J45.6</td>
<td>J45.5 – Severe persistent asthma</td>
</tr>
<tr>
<td>J45.9</td>
<td>J45.9 – Other and unspecified asthma</td>
</tr>
<tr>
<td>R09.02</td>
<td>Hypoxemia</td>
</tr>
<tr>
<td>Z93.0</td>
<td>Tracheostomy status</td>
</tr>
<tr>
<td>Z99.81</td>
<td>Dependence on supplemental oxygen</td>
</tr>
<tr>
<td>Z43.0</td>
<td>(code the underlying condition first)</td>
</tr>
</tbody>
</table>

It is important to review the ICD-10-CM Coding Guidelines (Chapter 10: Diseases of Respiratory System J00-J99), as well as any instructional notes under the various COPD subcategories and codes in the tabular list of the ICD-10-CM manual to select the correct code. In addition to the codes listed above, you may need to use additional codes to identify current or previous tobacco usage and dependence or other environmental exposure.

**Note:** ICD-10-CM coding for all conditions should follow coding conventions, chapter specific guidelines and general coding guidelines.

Clinical editing billing tips

In most issues we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that the performed procedure is correctly reported to us. To view the full content of the tips, click on the Clinical editing billing tips below.

This issue’s billing tips include the following:

- Reminders when submitting a clinical editing appeal
eviCore healthcare makes additional tools available for providers

eviCore healthcare has made additional tools available to smooth the process of requesting authorization for radiation therapy services.

The addition of pathways inside eviCore’s electronic system and physician worksheets on the website should streamline the process of submitting an authorization request and decrease the percentage of cases requiring physician review.

Pathways inside eviCore’s electronic system

eviCore added pathways for the cancer types listed below for providers using eviCore’s electronic system. Beginning July 15, 2016, the new pathways began to function as part of the process providers use to build a case. In each case, the pathway is available in the CPT Code drop-down menu:

- Vulva cancer pathway, represented as RCVULV
- Testicular cancer pathway, represented as RCTESC
- Multiple myeloma pathway, represented as RCMUMY

Physician worksheets on eviCore’s website

In addition, eviCore has updated the physician worksheet for liver cancer, to allow for the request of selective internal radiation therapy.

To access eviCore’s radiation therapy physician worksheets, take the following steps:

2. On the Solutions tab, click Radiation therapy.
3. Scroll down and click Radiation Therapy Physician Worksheets, under the Educational Links heading.

eviCore’s worksheets are tools you can use to assemble pertinent information before submitting an authorization request through eviCore’s secure provider portal. If you answer the questions on the worksheet beforehand, your submission should go more smoothly. In addition, the percentage of requests requiring physician review should decrease.

What eviCore does

As a reminder, Blue Care Network partners with eviCore healthcare (formerly known as CareCore National, LLC, and Landmark Healthcare, Inc.) to oversee the following:

- Select cardiology, pain management, radiation therapy and radiology services for BCN HMO℠ (commercial) and BCN Advantage℠ members provided in BCN-participating freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices
- Outpatient physical, occupational and speech therapy services for BCN HMO℠ (commercial) and BCN Advantage℠ members delivered by independent physical therapists, outpatient therapy providers, physician practices and hospital-based outpatient therapy services
- Physical medicine services provided for BCN HMO members by chiropractors
Effective Oct. 1, BCN reviewing inpatient readmissions that occur within 30 days of discharge

BCN reviews inpatient readmissions from facilities reimbursed by diagnosis-related groups when the member is readmitted with the same or a similar diagnosis.

What's changing?
Effective Oct. 1, 2016, BCN is reviewing inpatient readmissions that occur within 30 days of discharge. Prior to that date, readmissions that occur within 14 days of discharge were reviewed.

We make a determination as to whether the readmission should be billed separately or bundled with the previous admission. In some instances, the two admissions are combined into one for purposes of DRG reimbursement.

Documents were updated
The documents listed below were updated to reflect the change to 30 from 14 days:

- Guidelines for bundling admissions
- The Care Management and Claims chapters of the BCN Provider Manual
- The readmission checklist, which facilities should use to ensure that all necessary documentation is available for the review of a readmission that has occurred within 30 days

Additional information
For additional information, you can access all these documents by completing the following steps:

1. Visit bcbsm.com/providers and click Login.
2. Log in to Provider Secured Services using your user ID and password.
3. Click BCN Provider Publications and Resources.
4. Click either Billing/Claims, Provider Manual or Forms, to open the appropriate web page and locate the documents.

The Care Management chapter is also available on the public web, at ereferrals.bcbsm.com. Click BCN, click Provider Manual Chapters and then click Care Management chapter. Look in the section titled “Guidelines for observations and inpatient hospital admissions,” in the subsection titled “Review of readmissions that occur within 30 days of discharge.”
Update and reminder about clinical review requirements for certain surgeries

Effective for dates of service on or after Dec. 5, 2016, clinical review is required for laparoscopic cholecystectomies. Previously, we communicated that the effective date for this change was Oct. 3, 2016, but the date has been changed. This applies to BCN HMO℠ (commercial) and BCN Advantage℠ members and to services related to procedure codes *47562-*47564.

**Reminder**

Effective for dates of service on or after Oct. 3, 2016, clinical review is required for the following surgeries:

- Cervical spine surgeries
- Total joint replacements (hip, knee and shoulder)

This applies to BCN HMO (commercial) and BCN Advantage members and to services related to the following procedure codes:

- *22551*  
- *22554*  
- *22586*  
- *22600*  
- *27130*

- *27132*  
- *23470*  
- *23472*  
- *27446-*27447*  
- *63001*

- *63015*  
- *63020*  
- *63045*  
- *63050-*63051*

- *63075*

**Questionnaire**

When you submit a request to authorize these surgeries in the e-referral system, you’ll be presented with a questionnaire that you’ll need to complete about the member’s condition.

**Other information**

The revised effective date for laparoscopic cholecystectomies is reflected in the updated BCN Referral/Clinical Review Program document, which was made available online at the end of July.

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Effective Oct. 3, 2016, all requests to authorize outpatient facility and clinic-based sleep management studies for adult members 18 years of age and older will require submission of evidence from the member’s medical record. This evidence must confirm the specific condition the member has that would exclude or contraindicate a home sleep study. This applies to BCN HMO℠ (commercial) and BCN Advantage℠ members.

This new requirement is in addition to the completion of a questionnaire in the e-referral system, which is already required. Reimbursement for sleep studies is available only to providers who have specifically contracted with BCN to perform these services.

**Additional information**

For information on which patients qualify for various types of sleep studies, refer to the Sleep Management Program page at ereferrals.bcbsm.com.

More information is also available in the article titled Guidelines for billing sleep studies, with updates on authorization requirements, on Page 42 of the July-Aug 2016 issue of BCN Provider News. In this article, you’ll find information about the change in requirements for home sleep studies and guidelines for billing sleep management studies.
eviCore healthcare to review epidural and facet joint procedures for BCN effective Sept. 1

Effective with dates of service on or after Sept. 1, 2016, eviCore healthcare will complete clinical reviews for non-emergent pain management services for epidural and facet joint injections. Blue Care Network Care Management has reviewed these procedures since April 2011 but with this change, eviCore will manage those services for us.

For epidural and facet joint procedures, clinical review will be required for all diagnoses, for BCN HMO SM (commercial) and BCN Advantage SM adult and pediatric members, in all BCN-participating freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices that provide these services.


**Submitting requests**

Starting Sept. 1, you’ll be able to submit requests for clinical review for these procedures in one of two ways:

- Preferred method: online at evicore.com
- By phone at 1-855-774-1317

Starting Aug. 25, you can call eviCore at 1-855-774-1317 to review requests for services that will begin on or after September 1.

All requests must be reviewed prior to the services being provided. If a treating physician does not receive a medical necessity determination and authorization number from eviCore prior to performing procedures for which eviCore’s review is required, claims may not be reimbursed.

eviCore encourages ordering physicians to secure the authorizations and pass them on to the facility at the time the services are scheduled. Each authorization is made up of numerals followed by one or more procedure codes; the procedure codes are those that pertain to the services authorized.

Please see Epidural and facet joint procedures, continued on Page 46
Epidural and facet joint procedures, continued from Page 45

Some important information
Here’s more information you need to know:

• For multiple pain management injections:
  - eviCore will authorize only a single injection on a single date of service. The single injection could be the same injection at various levels.
  - An additional authorization request is needed for each subsequent injection. This is because eviCore does not authorize “a series of injections.” Instead, eviCore will evaluate the medical necessity of each subsequent injection after considering the member’s response to the previous injection.

• Pain management services performed in conjunction with an inpatient or observation stay or during an emergency visit do not require authorization.

• Urgent requests — those in which services are required within 48 hours due to the member’s medical condition — should be called in to eviCore at 1-855-774-1317. Be sure to ask the eviCore representative to expedite your authorization request because the member needs medically urgent care.

Clinical guidelines
eviCore’s interventional pain clinical guidelines are available at evicore.com. On the Solutions tab, click Musculoskeletal. Click Clinical Guidelines. Then click to open the specific guideline you’re looking for.

Other information
The document Procedures that require clinical review by eviCore healthcare was updated to include the pain management procedure codes. This document is available on the eviCore-Managed Procedures page at ereferrals.bcbsm.com, which was also updated. Other documents, including the Care Management chapter of the BCN Provider Manual, are also being revised to incorporate this change.

eviCore will manage additional pain management services for BCN starting Dec. 1, 2016. We’ll give you the details about those services in a later issue of BCN Provider News and in a news item posted at ereferrals.bcbsm.com at the beginning of October.

This review of pain management procedures is in addition to the reviews eviCore already completes on behalf of BCN for certain outpatient radiology, cardiology and radiation therapy services. Separately, eviCore also reviews physical, occupational, and speech therapy, and physical medicine services provided by chiropractors.

Questions?
Attend eviCore’s online orientation to find out more about requesting authorizations. Click here to see the orientation schedule and to access other training resources.

*CPT codes, descriptions and two-digit modifiers only are copyright 2015 American Medical Association. All rights reserved.
e-referral User Guide updated; e-Learning modules coming soon

The e-referral User Guide has been updated on the Training Tools page of ereferrals.bcbsm.com. The updated guide now includes:

- How to check BCBSM member eligibility and benefits in web-DENIS
- How to submit authorization requests and referrals to the University of Michigan Health System and Henry Ford Health System
- An example of the Potential Duplicate Referral or Authorization screen
- A section outlining how to submit an emergency/urgent Inpatient Authorization
- A section discussing how to submit for a sick/ill newborn
- An expansion of how the Outpatient Authorization questionnaire works

The User Guide also has an expanded explanation of how providers can attach clinical documentation (both initial clinical and continued stay or discharge information) to their request in the e-referral system. The Case Communication pages of the User Guide outline the accepted file formats as well as a note that file names should not contain any special characters or symbols to prevent an error message.

New self-paced, e-Learning modules are also being added to the Training Tools page of ereferrals.bcbsm.com to help you learn the main functions of the updated e-referral tool in an interactive way.
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