Changes to individual plans announced for 2017

Blue Cross Blue Shield of Michigan and Blue Care Network will offer 38 different options for individual coverage on the Health Insurance Marketplace for 2017. Open enrollment for individual health plan purchasers opens Nov. 1, 2016 and runs through Jan. 31, 2017.

To help individuals with their plan selections, all of the 26 different BCN individual plans will have HMO added to their plan name. The Bronze high deductible health plans will have HSA (for health savings account) added to their plan names. Here are highlights of changes to our individual products for 2017.

- **Three PCP visits before deductible** – Members with the Blue Cross® HMO Bronze Extra plan will pay only their copay for the first three visits with their primary care physician each year. Starting with the fourth visit, the deductible will be applicable. Visits that will count toward the three PCP visits include:
  - A visit with a physician that is on call for the member’s PCP
  - A visit with an obstetrician-gynecologist
  - An online visit with American Well®

Blue Cross and BCN to cover medical and pharmaceutical services for gender transition

Effective on or after Jan. 1, Blue Cross Blue Shield of Michigan and Blue Care Network are making changes to benefits for gender transition services. Benefits may include gender reassignment surgery, hormone therapy, psychotherapy and counseling and mastectomy for female to male transitions.

Blue Cross and BCN groups that don’t offer any or offer just some gender transition benefits today will add benefits as appropriate. These benefits are also being added for individual customers. Always remember to check a member’s eligibility and benefits.
Plan changes, continued from Page 1

- **Pharmacy copay or coinsurance before deductible** – Members with the Blue Cross® HMO Bronze Extra and Blue Cross® HMO Silver Extra plans will have prescription coverage with a copay or coinsurance before their deductible is met. This is a change from 2016 when prescription drug coverage was available only after the deductible.

- **Lab services coinsurance after deductible** – Members with the Blue Cross® HMO Bronze Extra and Blue Cross® HMO Silver Extra plans will have coinsurance applied to laboratory services after they have reached their deductible.


As always, check member eligibility and benefits at every visit before providing services. You can do this through web-DENIS or by calling our [Provider Automated Response System](#).

Gender transition, continued from Page 1

**Impact on BCN’s Woman’s Choice program**

Members identified as males will be required to obtain a referral from their primary care physician for gynecological services.

**Why are benefits for gender transition changing?**

Benefit changes are due to a final rule under Section 1557 of the Affordable Care Act issued by the Department of Health and Human Services this year. The rule prohibits discrimination on the basis of race, color, national origin, sex, age or disability in health programs or activities that receive federal financial assistance.

The rule defines discrimination on the basis of sex to include discrimination based on gender identity and outlines protections for those seeking gender transition services.

This is the first time gender transition benefits have been mandated for health care coverage. The rule states gender transition benefits must be available on plan years starting on and after Jan. 1, 2017.

**How will Blue Cross and BCN meet the requirements of the federal rule?**

Blue Cross and BCN have been working to adjust internal systems to ensure members will have access to these services no later than their plan years on and after Jan. 1.

*The information in this document is based on preliminary review of the national health care reform legislation and is not intended to impart legal advice. The federal government continues to issue guidance on how the provisions of national health reform should be interpreted and applied. The impact of these reforms on individual situations may vary. This overview is intended as an educational tool only and does not replace a more rigorous review of the law’s applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice.*

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Spouses with Healthy Blue Living coverage will no longer have to complete a health assessment or a qualification form in 2017 plan year

Effective for plan years beginning on or after Jan. 1, 2017, Blue Care Network is removing the wellness requirements for covered spouses in the Healthy Blue LivingSM product. This move will keep our standard wellness products aligned with federal regulations.

Spouses or domestic partners won’t be required to complete a health assessment or a qualification form beginning with the 2017 plan year. In addition, covered spouses in Healthy Blue Living who are currently in a weight management or tobacco cessation program will no longer have to meet those requirements. We’ll no longer cover the cost for weight management, but members can still participate at a discount through Blue 365®.

Spouses or domestic partners are still covered for annual physical exams and may choose to take a health assessment and participate in tobacco cessation coaching, both of which are available to these members at no cost through their HMO base benefit. BCN will only reimburse providers for filing qualification forms for patients who are required to do so.

Providers can check to see if a member is required to submit a qualification form by checking Health e-Blue. If the member is displayed in the Health e-Blue Health Qualification Form section, then he or she is required to submit the qualification form.

Please see the attached table for plan variations.

Some customized Healthy Blue Living plans maintain spouse wellness requirements

Blue Care Network has a number of group customers with customized Healthy Blue Living plans and some of these maintain the wellness requirements for spouses, including the qualification form and tobacco and weight management requirements.

Please remember to ask the member or check Health e-Blue’s Health Qualification Form section to see if the member is required to submit the qualification form and meet wellness requirements.
Out-of-pocket maximum added to commercial pharmacy products for certain members when paired with BCN 65 product

Commercial pharmacy product when paired with BCN 65 will have a $7,150 out-of-pocket maximum applied to the pharmacy coverage only for group members effective Jan. 1, 2017. Members who reach their prescription-only out-of-pocket maximum will have their prescription drugs covered in full for the rest of their plan year.

The new out-of-pocket maximum applies only to prescription coverage. It does not apply to medical services. The change does not apply to grandfathered or retiree-only groups.

BCN 65 is a commercial HMO product that is secondary to Medicare. BCN 65 covers Medicare copayments, coinsurance and deductibles and provides some additional benefits such as preventive care.

Blue Care Network is closed Nov. 8, 24 and 25

Blue Care Network offices will be closed Nov. 8 for Election Day and Nov. 24 and 25 for Thanksgiving. 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 AdvantageSM 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.
**MSU clarifications**

Reminder: MSU student and graduate assistant members don’t need referrals to see any provider who isn’t in the MSU Student Health Services Network.

We want to remind Southeast and East region providers that referrals for the MSU Student Health Plan and the MSU Graduate Assistant Health Plan have different referral requirements than other Blue Care Network products.

Please note that there is **no** referral required for MSU Student Health Plan and MSU Graduate Assistant Health Plan patients to see any provider who is not in the MSU Student Health Services Network. However, BCN clinical review requirements apply.

Only providers who are in the MSU Student Health Services Network need to have a referral to treat a patient. However, even when services are provided by an MSU Student Health Services Network provider there are some exceptions to the need for referrals. The following members can self-refer and referrals do not need to be submitted to BCN:

- Dependent children (of any age)
- A member whose contract is part of one of the excluded subgroups determined by MSU

When you check eligibility and benefits for a member who is in one of the excluded subgroups, web-DENIS and PARS will indicate that referrals don’t need to be submitted to BCN.

A flier is available to explain the important details for the MSU plans. Find it by clicking the link or by following these instructions:

- Log in at **bcbsm.com**
- Click on **BCN Provider Publications and Resources**
- Under Products, click on **BCN Products**
Providers should check participation in the MSU Student Health Services Network to determine whether referrals are needed

Providers who see MSU Student Health Plan and MSU Graduate Assistant Health Plan patients should check to see if they participate in the MSU Student Health Services Network to determine whether referrals are required.

The network includes BCN providers primarily in Michigan’s Mid-region within 45 miles of MSU’s Olin Health Center in East Lansing. The decision to include or exclude providers from this network was based on the primary address associated with the provider group. Thus, it is possible that a physician could still be in the network even though the physician’s practice address is outside the general area.

Here are the steps to check your participation status:

• Go to bcbsm.com/find-a-doctor and click GET STARTED.

• Under Choose a health plan, type the provider’s last name, followed by first name in the field marked Search for a doctor, hospital name or specialty. Click on the provider’s name when it appears in the dropdown and then click Search.

• Click on the correct provider’s name, find the correct location and then click on Plans Accepted.

• Look under Employer Group Plans, HMO Plans, Michigan State University Graduate Assistant and Student Health Plans.

• If Student Health Services Network (within 45 miles of Olin) is listed, the provider is in the MSU Student Health Services Network.

• If Blue Care Network – MSU (outside 45 miles of Olin) is listed, the provider is not in the network.

Make sure your CAQH applications are accurate

Blue Cross Blue Shield of Michigan and Blue Care Network use CAQH applications to facilitate our credentialing and recredentialing processes. Our Provider Data Analytical team continuously refers to CAQH in order to display your practice information correctly in directories for our members.

Please remember to routinely attest to the accuracy of your information on CAQH ProView™, and ensure that your demographics, hospital affiliations and group affiliations are updated appropriately.

See the attached PDF on Provider Data Integrity for more information.
BCN Advantage makes product changes for 2017

We’ve made changes to some of our existing BCN Advantage products for the 2017 plan year and have added two new ones: BCN Advantage℠ HMO HealthySaver and BCN Advantage℠ HMO-POS Core. (See article on Page 9 for more information on the new plans.)

We’ve also expanded our current BCN Advantage HMO products into additional counties.

Here’s a summary of the changes:

• BCN Advantage℠ HMO MyChoice Wellness will begin serving Ottawa County in addition to Kent, Muskegon and Oceana Counties.
• BCN Advantage℠ HMO ConnectedCare will add Arenac, Iosco and Saginaw Counties, expanding its service area from eight counties to 11.
• The new BCN Advantage HMO℠ HealthySaver product will be available in all counties served by BCN Advantage℠ MyChoice Wellness and BCN Advantage℠ ConnectedCare (15 counties in total).
• The new BCN Advantage℠ HMO-POS Core product will be available in all 69 counties serviced by our existing BCN Advantage HMO-POS product.

Products and plans available in 2017

The BCN Advantage products and plans available in 2017 are:

• BCN Advantage℠ HMO-POS Elements
• BCN Advantage℠ HMO-POS Basic
• BCN Advantage℠ HMO-POS Classic
• BCN Advantage℠ HMO-POS Prestige
• BCN Advantage℠ HMO-POS Core – New
• BCN Advantage℠ HMO MyChoice Wellness
• BCN Advantage℠ HMO ConnectedCare
• BCN Advantage℠ HMO HealthySaver – New

Please see BCNA product changes, continued on Page 8

New alternative drug plan structure for BCN Advantage Basic members

There are significant changes in the BCN Advantage Basic plan’s Part D pharmacy segment for 2017. It has changed from a coinsurance-based program to a copayment/coinsurance standard. That means that members will pay fixed copays for drugs in the most commonly used Tiers (Tiers 1, 2 and 3) instead of paying a percentage of the drug’s cost. For example, a $100 Tier 1 drug charged to members at 25 percent cost $25 in 2016. In 2017, the member cost will be $5. Not only will drugs cost less. In many cases, members can have peace of mind knowing they won’t be affected by drug price fluctuations throughout the plan year.

This new drug plan strategy only applies while a member is in the initial coverage stage. The next stage is the coverage gap or donut hole. Most members likely will not enter this stage, in which case 2017 BCN Advantage Basic plan members can count on paying fixed copays of $5 for Tier 1 preferred generics, $18 for Tier 2 generics and $47 for Tier 3 preferred brand-name drugs throughout the plan year. They can save even more by requesting a 90-day supply. For Basic members, the Tier 4 nonpreferred drug copay is $45 and Tier 5 special drugs have a 33 percent coinsurance.

There will be an increased pharmacy deductible for Basic members in 2017, from $360 to $400. However, in 2017 the deductible is waived for Tier 1 generic drugs.
BCN product changes, continued from Page 7

Specific 2017 BCN Advantage benefit changes
• All HMO-POS plans will carry a $200 BlueCard® deductible.
• Out-of-pocket maximums will increase; the amount varies by plan.
• Classic and Prestige plans will have a small increase in the hospital per diem.
• In-hospital surgery copayment will go from $150 to $175 across plans, except for the BCN Advantage HealthySaver plan, which is $200, and Core, which carries a 20 percent coinsurance.
• The outpatient ambulatory surgery copay will increase incrementally across plans as will the copay for renal dialysis.
• The copay for ambulance services goes from $150 to $200 across all plans.
• There will be slight increases in drug-related costs for all plans that include Part D.
• The Basic plan goes from a 25 percent pharmacy coinsurance to the tiered cost system inherent in all other BCN plans with Part D. (See article on the alternative drug plan structure on page 7)
• The Part D deductible for the Basic plan will increase from $360 to $400. However, for the 2017, the deductible does not apply to Tier 1 generics.
• The CMS annual mandated changes for Part D will increase the initial coverage limit (ICL), true out-of-pocket (TrOOP) and catastrophic costs across the board.
• The Elements plan will include a fitness benefit for 2017.

New online program helps BCN Advantage members make treatment decisions
Available at no additional charge to all BCN Advantage plan members, Welvie\textsuperscript{SM} \* is an online program that helps members decide on, prepare for and recover from surgery. Here are some important things to know about Welvie:

• The program takes people considering surgery through the entire process, including talking with their doctor about treatment options so they can make the best and most informed decisions.
• Once patients are prepared for surgery, Welvie helps with recovery so members can achieve the best results.

\*Welvie is an independent company retained by Blue Care Network to provide a surgery decision-support program to BCN Advantage members.
BCN Advantage™ offers two new products effective January 2017

Starting Jan. 1, 2017, you may see patients in your office covered by one of the two new BCN Advantage™ products: BCN Advantage HMO HealthySaver or BCN Advantage HMO-POS Core. Keep in mind, the member’s ID card will show the BCN Advantage HMO HealthySaver or BCN Advantage HMO-POS Core product name on the front of the card at the top.

BCN Advantage HMO HealthySaver
The BCN Advantage HMO HealthySaver product is available to Medicare-eligible residents of the following counties: Arenac, Genesee, Iosco, Kalamazoo, Kent, Livingston, Macomb, Muskegon, Oakland, Oceana, Ottawa, Saginaw, St. Clair, Washtenaw and Wayne. HealthySaver members are served by the doctors and hospitals of Mercy Health in West Michigan and in Southeast Michigan, the Bay area and Kalamazoo, the doctors and hospitals of Together Health Network, formed by Ascension Health Michigan and Trinity Health.

• The medical deductible is $0.
• The out-of-pocket maximum is $4,500.
• Out-of-pocket costs are the same or slightly higher than for BCN Advantage HMO ConnectedCare and MyChoice Wellness, two other provider-specific HMO plans each serving a segment of this 15-county area.
• The hospital stay copayment is $280 for days 1 through 7 and is $0 for days 8 through 90.
• There is a Part D prescription benefit with a $100 deductible; however, the deductible does not apply to Tier 1 or Tier 2 drugs.
• Prescription copays are as little as $5 for preferred generics.
• The monthly premium ranges from only $15 to $25.
• A fitness benefit is included.
• There is no transportation benefit.

BCN Advantage HMO-POS Core
Available in all 69 counties served by the BCN Advantage HMO-POS network, the BCN Advantage HMO-POS Core product is similar to a PPO in that the coinsurance for most services is 20 percent. This is instead of the copayment in specified dollar amounts that exists for other BCN Advantage plans. In addition:

• The medical deductible is $166.
• The out-of-pocket maximum is $6,700.
• The member’s cost for a hospital stay is $1,590 after the deductible.
• This product has medical coverage but no Part D prescription drug coverage.
• The monthly premium is $20.
• All providers contracted to serve BCN Advantage HMO-POS members can serve BCN Advantage HMO-POS Core members.
• Although we expect only a limited number of members to enroll in this product, it’s important for you to know the specific coverage that each BCN Advantage HMO-POS Core member has.

Remember: Regardless of the plan, you should always look up the member’s name or enrollee ID in web-DENIS so you can verify the member’s eligibility and review the coverage details. Do this at each visit; that way, if the member’s coverage has changed since the last visit, you’ll be aware of the details of the member’s new coverage.
BCN Advantage announces formulary changes for 2017

The BCN Advantage HMO-POS™ plan formulary for individual and group members will change for 2017. We’ll notify affected BCN Advantage members by mail. The member letter recommends that members discuss medication alternatives with their primary care physician before refilling a prescription in 2017.

The table below summarizes the types of formulary changes for 2017. Please refer to the 2017 Formulary for more details. The 2017 Formulary will be posted at bcbsm.com before Jan. 1, 2017. Refer to the PDF below for a complete list of changes.

<table>
<thead>
<tr>
<th>Year</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
<th>Tier 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>Preferred generics $3 to $5</td>
<td>Generics $10 to $20</td>
<td>Preferred brands $35-$47</td>
<td>Nonpreferred drugs 45% coinsurance</td>
<td>Specialty 25% to 33% coinsurance</td>
</tr>
<tr>
<td>2016</td>
<td>Preferred generics $3 to $5</td>
<td>Generics $10 to $15</td>
<td>Preferred brands $35 to $47</td>
<td>Nonpreferred drugs $75 to $100</td>
<td>Specialty 25% to 33% coinsurance</td>
</tr>
</tbody>
</table>

**High cost generics are moving to higher cost share tier**
- Many high cost generics are moving from Tier 2 to Tier 4, nonpreferred drugs status. For most members in BCN Advantage individual plans, the out-of-pocket cost share will move from a $10 copayment to a 45 percent coinsurance based on the ingredient cost of the medication.
- Members who are in employer group sponsored Medicare Advantage plans may also experience an out-of-pocket cost increase, depending on their group’s formulary benefit design.
- Most generic maintenance medications, including cholesterol-lowering therapy, oral diabetes medications, angiotensin converting enzyme inhibitors and angiotensin receptor blockers, will remain at Tier 1. This is the lowest copayment, which is $3 for most members.

**Medication deletions**
- Several multisource brands will be removed from the formulary but the generic equivalent will still be covered. Examples include Crestor, Exelon and Namenda. Some high-cost generic products will be removed when there is a lower cost generic alternative, for example, Glumetza 500mg and 1000mg tablets.

**Addition of cumulative opioid point of service edit**
- See New CMS changes related to prescribing opioids, on page 32, for details.
What providers should know about billing qualified Medicare beneficiaries

It’s important to be aware that federal law prohibits all Medicare providers from billing qualified Medicare beneficiaries for Medicare deductibles, coinsurance or copayments. This means that all Medicare and Medicaid payments you receive for providing services to a qualified Medicare beneficiary are considered payment in full.

The wording related to the law is included in your BCN provider contract under the “Member Hold Harmless” provision, as required by the Centers for Medicare & Medicaid Services. It says, “Provider is also prohibited from holding Members liable for Medicare Parts A and B cost sharing that are the legal obligation of Health Plan or the State.”

Rule applies to dual-eligible members who are qualified Medicare beneficiaries

This rule applies to dual-eligible members who are qualified Medicare beneficiaries, or QMBs — those members who have BCN AdvantageSM as their primary coverage and a Medicaid product as their secondary coverage.

This means that you must accept payment in full or bill the state for applicable BCN Advantage cost sharing for enrollees who are eligible for both Medicare and Medicaid. You must also abide by these provisions even if you don’t accept Medicaid and regardless of whether the state Medicaid agency is liable to pay the full BCN Advantage cost sharing amounts.

You are subject to sanctions if you bill a QMB individual for amounts above the sum total of all BCN Advantage and Medicaid payments — even when Medicaid pays nothing.

Use payment explanations to guide you

BCN Advantage uses the payment explanations on the claim to indicate when you shouldn’t bill a member for the balance. Specifically, the Remittance Advice statement will show:

- Explanation Code: Q76 – “When your patient has Medicare and MDCH coverage, the patient isn’t responsible for Medicare cost sharing amounts.”
- Reason Code: 22 – “This care may be covered by another payer per coordination of benefits.”
- Remark Code: N192 – “Patient is a Medicaid/Qualified Medicare Beneficiary.”

On the 835 electronic standard transaction for these claims, the HIPAA Remark Code N192 will be displayed with every Claim Adjustment Segment.

Additional information

You can find additional information about dual-eligible categories and benefits in the Medicare Learning Network document ICN 006977, titled Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs.
Medicare Part D prescribers are required to enroll in Medicare or opt out

The Centers for Medicare and Medicaid Services requires physicians and other eligible professionals who write prescriptions for Part D drugs to be enrolled in Medicare or have a valid opt-out affidavit on file in order for their prescriptions to be covered under Part D. Recently CMS has announced that it will delay enforcement of the requirements in 42 CFR § 423.120(c)(6) until Feb. 1, 2017.

Beginning Feb. 1, 2017, Medicare Part D prescription drug benefit plans may not cover drugs prescribed by providers who are not enrolled in (or validly opted out of) Medicare, except in very limited circumstances. Unless you enroll (or validly opt out), Medicare Part D plans will be required to notify your Medicare patients that you aren’t able to prescribe covered Part D drugs. Part D plans will only cover up to one three-month provisional supply of a drug, if prescribed by a provider who hasn’t enrolled in or validly opted out of Medicare.

If you opt out, you can’t receive reimbursement from traditional Medicare or a Medicare Advantage plan, either directly or indirectly (except for emergency and urgent care services).

We strongly encourage you to enroll as soon as possible to allow CMS time to process your application before the implementation date.

In addition, in order for Part D claims to adjudicate appropriately, eligible prescribers must ensure their taxonomy information is accurate in the CMS National Plan and Provider Enumeration System National Provider Identifier registry. You can search the registry to verify the taxonomy code associated with your NPI. The taxonomy code is an element that Express Scripts® uses to determine whether or not a claim may be paid based on eligibility to prescribe.

For the latest information about these requirements, please visit Part D Enrollment Information at CMS.
Proper coding and diagnosis can lead to more effective treatment of substance use disorders

By William Beecroft, M.D.

Frequently in our practices we see patients who we identify as having a substance use disorder. We may also see patients who have issues with alcohol or narcotics, but who haven’t crossed the line into disordered use. Eventually, we see that they do. A patient might show up in the emergency department with a fractured limb because he or she fell while intoxicated. Or a spouse accompanies a patient to your office and states that he or she “passed out” after taking too much narcotic medication that had been prescribed for a pain issue. Whatever the presentation or trigger that finally leads you to believe there is a problem, it’s important to accurately diagnose it in order to provide the most effective treatment.

The most recent Diagnostic and Statistical Manual of Mental Disorders characterizes substance “use” disorders, formerly known as substance abuse disorders. The most recent version, DSM-5, is much more specific in defining the use disorders and is now based on ICD-10, which offers a broader depth as to the detail of the diagnosis that can be made.

DSM-5 uses a symptom format to make diagnosis. The number of symptoms met for the diagnosis determines the severity. For example, alcohol use disorder has 11 symptoms for diagnosis. The patient is rated as having mild (two to three symptoms), moderate (four to five symptoms) or severe (six or more symptoms). The characterization can be further outlined if the patient is in early or sustained remission and if this is in a controlled setting.

For example, a patient could be diagnosed with alcohol use disorder, mild, in early remission, in a controlled setting (F10.10). When there is intoxication, the code becomes F10.129, indicating that the substance use disorder is mild but the patient is intoxicated. Using this detailed diagnostic coding is very helpful to track improvement or worsening of the patient’s course of treatment.

It’s helpful to code all the diagnoses you are treating to capture the multiple problems and accurately reflect the complexity of the patient’s issues. For example, filling in the ICD-10 codes for diabetes, hypertension, chronic pain, depression and a substance use disorder gives a better clarification of the work you are doing with that member.

Please see From the medical director, continued on Page 14
From the medical director, continued from Page 13

Treating substance abuse disorders

Diagnosing the patient is one thing, but actually initiating treatment is the next big hurdle. There is a Healthcare Effectiveness Data and Information Set® measure that has been developed for efficacy of treatment. It tracks patients who are evaluated and start treatment within 14 days of initial diagnosis of a substance use disorder and are seen at least two more times within 30 days of the initial visit.

Often, it’s difficult to get a patient to acknowledge he or she has a substance use disorder. Generally, the provider who makes the initial diagnosis has the best likelihood of getting appropriate treatment by capturing a thorough substance use history and utilizing helpful tools such as the Michigan Alcohol Screening Test or Drug Abuse Screening Test.

Suggesting medications that can help with the withdrawal process either as an inpatient or even as an outpatient can be a step to initiate treatment. Motivational Interviewing is a helpful technique to learn as a method to help the patient see the benefit of treatment and to believe that he or she is actually making this decision. A simple intervention might be to have the patient imagine what his or her life might be like without the substance and what might be possible. Another example would be to have the patient identify something they really want to occur and address the steps it takes to get there – minus the substance.

Helping the patient get additional community help can bolster the energy to start and maintain treatment. Telling the patient where to attend Alcoholics Anonymous and getting specific outpatient treatment by a specialist is the next step. Medications to prevent relapse such as Campral®, Revia® or injectable naltrexone can be useful. These tools can assist in preventing relapse. Antabuse® (disulfiram) isn’t commonly used but may have a role with specific individuals.

Psychotherapy, especially cognitive behavioral therapy and motivational interviewing, are helpful tools to improve long term abstinence and remission, which is the goal of treatment. Following up with the patient to see if he or she followed your recommendations can help change the patient’s course and consequences of medical comorbidities. Similarly, narcotics, cannabis, caffeine, phencyclidine, hallucinogen, anxiolytics/sedative, inhalant and psychostimulant use disorders all can be treated if identified and given the correct incentive along with resources provided to the patient. Once again, because of the negative effects of the substances, complete abstinence is the goal of remission. Treating to remission is the standard of care. Typically, attempting to cut back on use only prolongs or worsens the issue.

Any provider who comes into contact with patients is really the first line of treatment. Getting them to a specialist is a good goal. However, starting treatment and remaining involved in your patient’s recovery is the more likely winning strategy. Transitions with this population are fraught with difficulty and we know that patients frequently don’t complete the transition.

This may not be your chosen specialty, but getting patients started on the road to recovery enhances the trust they have in you and increases the likelihood they will follow-up on the specialty referral you give them. There are plenty of online screening tools that are free and don’t take much time to use.

With the advent of pay for performance, reimbursement for member’s health care means screening and treating these disorders provides better outcomes and better quality of life for your patients. Attending continuing education in this area might be something you can do to refresh your skills. Identifying and treating substance use disorders have significantly improved in the past several years and there are new technologies and strategies in the works to help you and your patients.

BCN Behavioral Health is always available to assist you with meeting you and your patient’s needs. Contact us at 1-800-482-5982 for triage and referral assistance.

References:
Diagnostic and Statistical manual of mental Disorders, 5th Edition; American Psychiatric Association, American Psychiatric Publishing
When are vitamin D tests recommended?

In previous issues of BCN Provider News we discussed Choosing Wisely®, an initiative that promotes conversations between physicians and patients about medical tests and procedures that may be unnecessary or potentially harmful. In this issue, we discuss the Choosing Wisely campaign on vitamin D testing.

Low vitamin D increases the risk of broken bones. It may also contribute to other health problems. That’s why doctors often order a blood test to measure vitamin D. However, many people don’t need the test. Even though many people have low levels of vitamin D, few have seriously low levels. If your patient is at risk for other diseases, like diabetes and heart disease, a vitamin D test isn’t usually helpful. It’s important to advise your patients to make lifestyle changes —stop smoking, aim for a healthy weight and be physically active.

Encourage your patients to get enough vitamin D from sun and their diet. A quick 10-minute walk during the middle of the day in the summer can give a body all of the vitamin D it needs for the day. The body even stores some of the extra vitamin D to help during the darker winter months. Darker skinned people might need to spend up to an hour in the sun to get the same amount of vitamin D.

Also, encourage your patients to eat foods rich in vitamin D. Some foods rich in vitamin D include:
- Meat, poultry and fatty fish
- A small serving (3 ounces) of salmon (530 IU)
- Shrimp, mackerel, sardines and fresh herring
- Tofu, orange juice and dairy products with added vitamin D
- Two eggs, a glass of orange juice and a bowl of cereal and milk can add up to about 300 IU of vitamin D—half of the daily requirement.

Be sure to discuss supplements with your patients when appropriate. The daily recommended dose of vitamin D for adults under the age of 70 is 600 international units. For adults over the age of 70, the daily dose is 800 IU.

Here are some conditions where you might order a vitamin D test:
- Your patient has osteoporosis
- Your patient has a disease that damages the body’s ability to use vitamin D. These are usually serious and ongoing diseases of the digestive system, such as inflammatory bowel disease, celiac disease, kidney disease, liver disease, pancreatitis and others.

For more information on vitamin D testing, please visit Choosing Wisely.
Type 2 diabetes in children can be prevented

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

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

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

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

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

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

- Performing a history (including focused family history) and physical exam
- Measuring and recording weight and height on CDC BMI-for-age growth chart
- Assessing risk factors, including pattern of weight change. Watch for increases of three to four BMI units/year.
- Dietary patterns (for example, frequency of eating away from home, consumption of breakfast, frequency of fruit and vegetable intake, portion sizes)
- Physical activity level

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

Overweight or obese children may benefit from weight loss supervision from their health care practitioners. Studies in adults have indicated that if an individual can reduce his or her body weight by 5 to 7 percent and maintain at least moderate activity for 30 minutes most days of the week, the risk of diabetes is reduced.

Young people and their families should receive counseling about nutrition, weight control and physical activity, as well as an individualized plan of care. The child may also need treatment for hypertension and hyperlipidemia, including follow-up every three months. Pharmacologic therapy for weight loss isn’t recommended for children until more safety and efficacy data is obtained.
Blue Care Network follows guidelines from the American Academy of Pediatrics for the use of Synagis® (palivizumab). Palivizumab was approved in 1998 and has reduced respiratory syncytial virus hospitalizations. The guidance was developed to implement palivizumab in the most cost effective way.

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

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

Due to the immense advancement in neonatal care since 1998, there has been a steady decline in RSV hospitalization both with and without prophylaxis. This has changed the need for palivizumab. Because high-risk infants are no longer at such a risk, AAP has developed new criteria to identify those high-risk infants. Therefore, palivizumab is recommended for infants born before 29 weeks, 0 days gestation, who are younger than 12 months at the start of RSV season.

Palivizumab is no longer recommended for infants born at 29 weeks, 0 days gestation or later, but may be indicated for:

- Infants younger than 12 months with hemodynamically significant congenital heart disease
- Infants younger than 12 months with chronic lung disease — defined as birth at before 32 weeks, 0 days, and less than 21 percent oxygen for at least 28 days after birth
- Infants less than 24 months who are profoundly immunocompromised during the RSV season, children who required at least 28 days of oxygen supplementation after birth and those who require medical intervention (oxygen, chronic corticosteroids, diuretic therapy)
- Children younger than 12 months with pulmonary abnormalities or neuromuscular disease that impairs the ability to clear secretions from upper airways

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

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

A recent publication and commentary published in August 2016 issue of Pediatrics demonstrated additional support for the current recommendations. As of July 31, 2016, no additional changes have been noted to the AAP guidance.

RSV surveillance data is available at the Centers for Disease Control and Prevention at the following links:

http://www.cdc.gov/features/dsRSV/index.html
http://www.cdc.gov/surveillance/nrevss/rsv/index.html

References:
BCN Policy, Palivizumab.
Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection. Pediatrics 2014; 134;415; originally published online July 28, 2014.
Screen kids early to avoid cardiovascular disease

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

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

**Michigan Quality Improvement Consortium guidelines** recommend screening for children older than 2 who are at increased risk for genetic forms of hypercholesterolemia. The best method for testing is a fasting lipid profile. If the child has values within the normal range, testing should be repeated in three to five years. Children 8 years and older with abnormal cholesterol readings may be considered for cholesterol-reducing medications. Younger children with abnormal readings should focus on weight reduction, healthy eating habits and food selection, and an active exercise program.

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

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

- Family history of heart disease
- Family history of obesity
- Family history of high blood pressure
- Family history of diabetes
- Height and weight and body mass index
- Blood pressure measurement at age 3 and then yearly if normal
- Lipid screening if indicated
- A review of child’s diet and daily physical activity
- Tobacco use by parents and by the child (beginning at age 12) including second-hand smoke exposure; counseling for smoking cessation

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

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

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**

- Noninvasive measurement of central blood pressure (for example, SphygmoCor® System)
- Fecal incontinence—investigational treatments

**Covered services**

- Proteomic testing for non-small cell lung cancer (for example, VeriStrat®)
- Myoelectric prosthetic components for the upper limb
Use The Great American Smokeout to educate patients about smoking cessation

The American Cancer Society marks the Great American Smokeout on the third Thursday of November each year by encouraging smokers to use the date to make a plan to quit or to plan in advance and quit smoking that day.

By quitting even for one day smokers will be taking an important step toward a healthier life, one that can lead to reducing cancer risk. This is also a time for users of smokeless tobacco to quit as well, since there is no safe alternative to smoking. Oral or smokeless tobacco products also cause cancer and can lead to nicotine addiction. The use of any smokeless tobacco product isn’t considered a safe substitute for quitting.

Tobacco use is the most preventable cause of death in the United States, yet approximately 42 million Americans or one in every five adults still smokes cigarettes, according to the American Cancer Society. As of 2013, there were also 12.4 million cigar smokers in the U.S., and 2.3 million who smoke tobacco in pipes.

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

- Side stream smoke: Smoke from the lighted end of a cigarette, pipe, cigar or tobacco burning in a hookah.
- Mainstream smoke: The smoke exhaled by a smoker

While it is known that mainstream smoke can be detrimental, side stream smoke is also very toxic. Side stream smoke has higher concentrations of cancer-causing agents (carcinogens) and is more toxic than mainstream smoke. It has smaller particles than mainstream smoke. These smaller particles make their way into the lungs and the body's cells more easily. When nonsmokers are exposed to secondhand smoke, it’s called involuntary smoking or passive smoking. Nonsmokers who breathe in secondhand smoke take in nicotine and toxic chemicals by the same route smokers do. Quitting smoking alleviates exposure to secondhand smoke that is harmful to others.

Blue Care Network partners with WebMD to provide a telephone-based tobacco cessation and lifestyle coaching program.

We encourage physicians to counsel all patients who smoke or use smokeless tobacco to quit at each visit until they are successful.

Sources: US Surgeon General Report 2014 and American Cancer Society
Diabetes patients require certain tests

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

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

The following tests are recommended:
- Hemoglobin A1C (two to four times annually based on individual therapeutic goal)
- Urine microalbumin measurement (annually)
- Serum creatinine and calculated glomerular filtration rate (annually)
- Fasting lipid profile (annually)
- Dilated eye exam by ophthalmologist or optometrist or digiscope evaluation (annually, or every two years in absence of retinopathy)
- Consider thyroid-stimulating hormone levels test and liver function test

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

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

Blue Care Network’s Chronic Condition Management program provides members with tools to make informed health choices and manage their conditions. To refer members to the diabetes chronic condition management program, call Chronic Condition Management at 1-800-392-4247, TTY 1-800-257-9980. Our specialists are available Monday through Friday, 8:30 a.m. to 5 p.m.
Question:
Under Adult Acute Coronary Syndrome in the Intermediate and Critical subsets, can heparin be administered subcutaneous to meet the anticoagulant requirement under Interventions?

Answer:
Under the subset Adult Acute Coronary Syndrome for Intermediate and Critical, anticoagulant is listed as a required intervention. This particular criteria point refers to administration of therapeutic anticoagulant therapy. It doesn’t refer to prophylactic dosing.

Therapeutic anticoagulation, such as a heparin drip protocol, or Fondaparinux, is used to treat an underlying thromboembolic event or may be required for certain vascular and cardiovascular problems.

An example of prophylactic anticoagulation therapy is heparin subcutaneously administered every eight hours to prevent thrombosis. The administration of prophylactic anticoagulant therapy doesn’t support or meet the intent of the criteria.

Question:
Can the gastrotomy procedure under the Guidelines for Surgery and Procedures in the Inpatient Setting under the General surgery section be used to approve a gastrostomy tube placement as an inpatient? Is it allowable if it’s an open g-tube placement (mini laparotomy) and not percutaneous?

Answer:
Up until 2008, McKesson had criteria for gastrostomy procedures and the recommendation was to treat it as an outpatient procedure. The criteria subsets that have been removed include:
• Gastrostomy (G-tube Insertion),
• Laparoscopic gastrostomy (G-tube Insertion)
• Open gastrostomy (G-tube Insertion)
• Percutaneous, endoscopic (PEG)

The gastrostomy procedure on the Adult Inpatient list (page INPT-8) should not be used to justify an inpatient setting for a feeding tube placement as that is not the intent of the listing.
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 available online October 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 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. They will each 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 want to participate in the survey but wish to be included in the drawing, you may enter by emailing BCNPhysicianSurvey@bcbsm.com. Please include your name, phone number, office name and address. All requests must be emailed no later than Dec. 31, 2016.
Behavioral health telemedicine visits, also called telepsychiatry visits, delivered to BCN HMOSM (commercial) and BCN AdvantageSM members must follow the guidelines for telemedicine visits that are explained in the BCN Provider Manual. These guidelines are located in the Claims chapter, in the section titled “E-visits and telemedicine visits.”

In addition, telepsychiatry visits are eligible for reimbursement only if the following conditions are met:

- Services must be delivered only by MD/DO psychiatrists or psychiatric nurse practitioners credentialed and contracted with Blue Care Network. (Any medical services delivered at the originating site can also be billed, as appropriate.)
- Services can be billed with any evaluation and management code or with procedure code *90792, with or without a crisis code or interactional complexity code, based on clinical appropriateness, but without add-on psychotherapy codes. In addition, the GT modifier needs to accompany the codes billed. No psychotherapy services can be billed as telemedicine visits.

Also, a hosted visit, with a medical practitioner in the room with the patient, is preferred for most psychiatric patients due to the additional clinical information that can be gathered and the potential clinical complexity of the patient’s condition, which may require timely medical intervention.

To access more information about BCN’s telemedicine guidelines, do the following:

1. Visit bcbsm.com/providers.
2. Click Login and log in to Provider Secured Services using your user name and password.
3. Click Provider Manuals, at the right on the Provider Secured Services Welcome page.
5. Click Claims (Billing) in the list of chapters. In the Claims chapter’s Table of Contents, click E-visits and telemedicine visits.
   OR
5. Click Medical Policy Manual in the left navigation. Click Policies by Name. Click T and click Telemedicine. This opens BCN’s medical policy on telemedicine.

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

Proper coding and diagnosis can lead to more effective treatment of substance use disorders

Please see the Medical director column on Page 13 for the full article on substance abuse treatment.
Quality corner: The Importance of the initial therapy sessions

Many factors influence the first couple of sessions of therapy. The start of treatment proves to be a very important and valuable time, particularly since more patients drop out of therapy after the initial session than at any other point of treatment.¹ Here are just a few suggestions providers can use during their initial sessions that can help patients get the most out of therapy.

Introduction to therapy

Some patients may be coming to therapy with prior experience while others are trying therapy for the very first time. Not all patients may understand the expectations of therapy (the time commitment, possible “homework”, or their role, for example) or their expectations may vary.² Therefore, an introduction to therapy during the first session may enhance outcomes. It serves to establish the relationship and roles between the patient and the therapist, sets the expectations for progress and encourages adherence to therapy sessions.³,⁴ This introduction is likely to provide the most benefit for those patients who are new to therapy, but can also prove useful to patients who have experienced therapy in the past.⁵

Setting goals and consensus

Goal setting for therapy is different for each patient. First steps, progress and presumed end results will vary. However, determining goals together with each individual patient and agreeing on goals may provide better psychotherapy outcomes.⁶

Goal consensus includes the following:⁷

- Patient-therapist agreement on goals,
- The extent to which a therapist explains the nature and expectations of therapy and the patient’s understanding of this information
- The extent to which goals are discussed and the patient’s belief that goals are clearly specified
- Patient commitment to goals
- Patient-therapist agreement on the origin of the patient’s problem and on who or what is responsible for the problem and solution

Therapeutic alliance

We have discussed the importance of therapeutic alliance in general, (May-June BCN Provider News), but research suggests that it is a significant factor right from the beginning of therapy. In fact, treatment for the diagnosed condition, and this connection between the therapist and patient, begins at the very first session. Establishing therapeutic alliance early is significant because it is a good predictor of outcome “when established and measured early in treatment.” Furthermore, “poor early alliance has been empirically connected with clients’ premature termination of treatment”.⁸

An initial connection may be influenced by everything from preconceptions of what therapy is to prior experience the patient has already had. Nevertheless, some fundamental level of trust is established at the first session and the relationship continues to strengthen.⁹

Resources for you

The materials and articles cited offer more in-depth information on the benefits of self-help groups.

Footnotes
1 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4592639/
2 https://www.gc.cuny.edu/CUNY_GC/media/CUNY-Graduate-Center/PDF/Programs/Ed%20Psych/Tryon---Winograd-(2001).pdf
5 https://www.researchgate.net/publication/232431230_Effectiveness_of_a_Client_Pretherapy_Orientation_Videotape
6 https://www.gc.cuny.edu/CUNY_GC/media/CUNY-Graduate-Center/PDF/Programs/Ed%20Psych/Tryon---Winograd-(2001).pdf
7 https://www.gc.cuny.edu/CUNY_GC/media/CUNY-Graduate-Center/PDF/Programs/Ed%20Psych/Tryon---Winograd-(2001).pdf
8 https://www.gc.cuny.edu/CUNY_GC/media/CUNY-Graduate-Center/PDF/Programs/Ed%20Psych/Tryon---Winograd-(2001).pdf
9 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4592639/
Reminder: Starting Nov. 1, authorization requests for outpatient ECT and TMS must be submitted through e-referral

Effective Nov. 1, 2016, BCN behavioral providers must submit authorization requests for outpatient electroconvulsive therapy and transcranial magnetic stimulation services via the e-referral system.

If you’re a BCN behavioral health provider requesting authorization for these services through e-referral, you’ll be presented with a questionnaire pertinent to the service you’re requesting. You’ll need to complete the questionnaire.

You’ll also need to complete a form and attach it to the authorization request in the e-referral system. You’ll complete a form for one of the following:

- ECT – initial outpatient treatment
- ECT – continuation of outpatient care
- TMS – outpatient

All of these forms are available on the Behavioral Health page on ereferrals.bcbsm.com.

Instructions for attaching information to an authorization request in the e-referral system are found in the BCN Behavioral Health e-referral User Guide.

You can access the User Guide at ereferrals.bcbsm.com. Click Training Tools.

Sign up to use the e-referral system. BCN-contracted providers who have not already signed up for access to the e-referral system should apply immediately.

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.”
Blue Care Network Behavioral Health Incentive Program 2016 and 2017

Thanks to all the providers who responded to our Behavioral Health Incentive Program survey and for helping us improve the program so we can continue to advance behavioral health care quality for our members.

Stay tuned for more information about the 2017 program in the next issue. Information about the 2016 program is available on web-DENIS.

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

**Self-reported measures**

Remember that submitting self-reported forms electronically is faster and easier for providers. You are eligible for $10 more per form for either measure when you submit electronically. To learn more about sending forms electronically, go to the Behavioral Health section on the BCN Provider Publications and Resources page.

If you are faxing, make sure that patients are commercial members, double check that you aren’t 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, refer to the Frequently Asked Questions 2016 document, which has a full section addressing faxing suggestions.
**Best Practices**

**Making colorectal cancer screening a priority**

Constant vigilance is the way Dr. Mark Oberdoerster’s office makes sure all eligible patients get a colorectal cancer screening done. Using electronic medical records and staff dedicated to checking alerts in those records, the Ann Arbor office has achieved a high compliance rate.

“We work off the Health e-Blue lists and we task certain employees to update those and flag alerts on the electronic health records,” says the doctor. “Every time we see a patient, we check the alert on the electronic medical record and see what we need to do. If it’s close to the end of the year and some patients are behind on their preventive tests, we start contacting them by email or mailing letters. In some cases, we’ll devote an afternoon to calling patients.”

Dr. Oberdoerster regularly recommends a colonoscopy to patients 50 and over. “I have a conversation with the patient. I let them know there are other ways of screening, but a colonoscopy has the highest level of specificity, especially if the patient has a history of adenomas or a family history of colon cancer,” he says.

Some patients worry about the procedure and may delay screening. “If a patient is reluctant, I explain that the procedure is better than early detection; it’s prevention. The vast majority of cancers arise out of polyps. But, we’ll also review options if they don’t want to do the colonoscopy,” says Dr. Oberdoerster.

There can be minor challenges to getting full compliance. “Most patients are concerned about the preparation for the procedure,” says Dr. Oberdoerster. “I let them know there are several options for preps and explain that they are sedated so they won’t feel discomfort during the procedure.

“Everyone is aware that they need to get screened for colorectal cancer,” he says. “It just takes a little convincing sometimes.”

The office has always focused on cancer screening and other preventive tests. But Dr. Oberdoerster says, “We’ve gotten much better at tracking with the electronic medical record. And we participate in pay for performance programs. That’s just given us incentives to do a better job.”

**HEDIS measure definition for colorectal cancer screening**

The percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test; flexible sigmoidoscopy every five years; or colonoscopy every 10 years.
BCN members receive reminders about preventive care

Blue Care Network mailed gaps in care letters to members in October to ensure that members and their children are up-to-date on their immunizations and screenings. Letters for children's immunizations were addressed to the parent or guardian.

The letters outline the suggested screenings for the member based on gender, age and our Guidelines to Good Health. We're asking members to review the information with their doctors at their next visit.

Letters also identified the member’s primary care physician and phone number. Members who haven’t selected a primary care physician are instructed to call customer service to select one.

We want to thank providers for working with members to ensure they have all their preventive screenings.
**HEDIS 2016 Results**

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

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

In this issue, we report the results of our Commercial HMO and Marketplace/Quality Health Plan business. We'll report the results for BCN Advantage in the January-February issue.

Areas of improvement were noted in the following measures:

**Commercial HMO**
- Immunizations for adolescents — combo 1
- Childhood immunizations — combo 2
- HPV vaccine for female adolescents
- Well-child visits 3 to 6 years of age
- Weight assessment and counseling for nutrition and physical activity — nutrition and physical activity
- Appropriate testing for children with pharyngitis
- Diabetes A1c testing
- Comprehensive diabetic care — eye exam
- Comprehensive diabetic care — nephropathy screening
- Diabetes blood pressure <140/90
- Adult BMI
- Controlling high blood pressure
- Postpartum care
- Prenatal care
- Cervical cancer screening
- Persistence of beta-blocker treatment after a heart attack
- Use of spirometry testing in the assessment and diagnosis of COPD
- Asthma medication ratio — total ratio >50%
- Follow-up after hospitalization for mental illness — seven days
- Antidepressant medication management — acute and continuation phase

**Marketplace/Qualified Health Plan**
- Cervical cancer screening
- Comprehensive diabetic care — nephropathy attention
- Controlling high blood pressure
- Postpartum care
- Prenatal care
- Weight assessment — BMI, physical and nutrition

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

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

BCN is involved in activities throughout the year that positively impact our HEDIS® rates, including:
- Performance Recognition Program which is tied to some of the HEDIS® measures
- Health e-BlueSM Web
- Member interactive reminder telephone calls and cards
- Member and physician education
- Member health fairs
- Disease management programs
- Care management follow-up telephone calls and letters
- Member incentive programs
- HEDIS/CAPHS Summit Meeting
- MedXM at-home services (bone mineral density)

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

For more information about HEDIS®, contact Blue Care Network, Population Health and Analytics Department at 1-855-228-8543.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
2017 HEDIS measure for cervical cancer screen has changed

There is an important change to the cytology and HPV co-testing criteria for the cervical cancer screening for Healthcare Effectiveness Data and Information Set® 2017 specifications. Testing performed subsequent to an initially ordered and resulted test (reflex testing) no longer meets criteria for this measure. With co-testing, both the cytology and HPV test should “be performed (the samples are collected and both test are ordered, regardless of cytology results) on the same date of service”.

The HEDIS measure counts women age 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

Ordering: Doe MD, John Performing #: 000_Sunquest Location: 000 Internal Medicine
Test Ordered: Pap, Thin Prep Diagnostic w/HPV Regardless (TPDHPR)

This is now the only criteria that is acceptable for co-testing when evaluating this HEDIS® measure. So, when considering cervical cancer screening for your patients keep in mind that the 2017 HEDIS® specification for CCS states “Do not include reflex testing. In addition, if the medical record indicates the HPV test was performed only after determining the cytology result, this is considered reflex testing and does not meet criteria.”

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

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
BCN limits opioid pain relievers to a 30-day supply; first fills of short-acting opioids will be limited to 15 days

Changes effective Dec. 1, 2016

The use of narcotic painkillers has quadrupled in the past 10 years\(^1,2\), yet the amount of pain reported among Americans hasn’t changed. The United States represents only 5 percent of the global population, yet consumes 80 percent of the world’s opioid supply.\(^3\)

This overuse of prescription painkillers has resulted in an epidemic of opioid overdoses.

Opioid quantities for acute pain often exceed the duration necessary for treatment leaving unused pills in households. More than three out of four people who misuse prescriptions use drugs that are prescribed to someone else.

Health plans can help reduce opioid abuse and misuse and potentially limit opioid diversion. That’s why Blue Care Network is taking action.

Effective Dec. 1, 2016 BCN will change how we manage opioids for our commercial members.

All fills of opioid pain relievers will be limited 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.

These changes will not apply to members with an oncology diagnosis or terminal illness.

Other health plans have already lowered limits for opioid quantities. Blue Cross Blue Shield of Massachusetts implemented similar quantity limits and applied prior authorization to opioids in 2012. They saw prescriptions of narcotic painkillers drop by an estimated 6.6 million pills in 18 months.

Working together, health care providers and health plans can ensure appropriate access to pain management while decreasing the risk that these powerful drugs may be abused.

BCN recommends providers continue to use the Michigan Automated Prescription System when prescribing opioid prescriptions. Registration for MAPS online takes only a few minutes and reports can be requested at any time.

These changes do not apply to BCN Advantage\(^\text{SM}\) members.

References:


Other sources:


It’s easy to register for MAPS. See MAPS reports can prevent diversion and abuse of controlled substances, on page 36 of the July-August 2014 BCN Provider News.
CMS changes limit cumulative daily dose of opioids

New regulations from Centers for Medicare & Medicaid Services require health plans to make a change for members who have pharmacy coverage through their Medicare plans.

Effective Jan. 1, 2017 for Blue Cross and BCN Medicare members, any opioid or combination of opioids prescribed that results in a cumulative daily dose of at least 250 morphine equivalent doses, also known as MED, will be stopped at the point of sale for a clinical review and prior authorization. This is a hard edit, meaning that the prescription can’t be filled until it is reviewed and approved by a BCN clinical pharmacist.

Since this edit is based on cumulative dosing, it is important to note that while a particular physician’s prescribing may not exceed the daily 250 mg MED limit, a combined dosing through multiple prescribers will trigger the edit and point-of-sale hard edit. This could affect prescriptions written by any physicians within the member’s care model since it will be the prescription that exceeds the 250 mg threshold that will require clinical review.

BCN recommends that health care providers use of the State of Michigan Automated Prescription System to track patient controlled substance prescription use.

Maintaining continuity of care for our members is important. The Blue Cross and BCN Medicare Pharmacy Services team may contact prescribers to complete a form documenting medical necessity of certain opioid prescriptions that have total cumulative daily MED greater than 250 mg. With each opioid prescription, we are asking physicians to provide a phone number in the event a Pharmacy team member needs to contact you for review, which will help avoid delaying care for members and allow for a timely review of these medication requests.

The opioid drug class consists of numerous painkillers in varying strengths. The standard baseline reference for dosing is morphine.

For example, oxycodone 1 mg is the same potency as 1.5 mg of morphine; therefore 20 mg oxycodone is considered 30 morphine equivalent doses, or 30 MED.

Opioids include*:

<table>
<thead>
<tr>
<th>Buprenorphine</th>
<th>Hydromorphone</th>
<th>Opium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butorphanol</td>
<td>Levorphanol</td>
<td>Oxycodeine</td>
</tr>
<tr>
<td>Codeine</td>
<td>Meperidine</td>
<td>Oxymorphone</td>
</tr>
<tr>
<td>Dihydrocodeine</td>
<td>Methadone</td>
<td>Pentazocine</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Morphine</td>
<td>Tapentadol</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Nalbuphine</td>
<td>Tramadol</td>
</tr>
</tbody>
</table>

*Includes brand and generic as well as combination products

Online tools for providers

There are several online tools available to help providers manage their patients’ opioid medication use.

- **Morphine equivalency factors** are available from CMS.
- The Centers for Disease Control and Prevention also provides instructions for calculating morphine equivalent doses.
- CMS has a Drug Diversion Toolkit available for providers.
- CDC has additional resources for prescribing opioids.
- Fact sheet of CDC guidelines for opioid use in chronic pain.
Five things you should know about epinephrine auto-injectors

In light of the recent news concerning EpiPen® pricing, here are some facts about currently marketed epinephrine auto-injector products:

1. There’s no FDA-approved generic EpiPen (yet)
   There is no true generic epinephrine auto-injector on the market. Currently, only the original brand EpiPen and an authorized generic, Adrenaclick®, are being distributed. Adrenaclick is no longer available as a branded drug. Mylan has announced that it will soon release an “authorized generic” of the EpiPen brand that will be available at a discounted price from the brand EpiPen. True generics are in the drug pipeline and awaiting Food and Drug Administration approval, but the release date of these products is unknown.

2. Adrenaclick is an authorized generic
   An “authorized generic” is a brand-name prescription drug already approved by the FDA under the brand drug’s New Drug Application and marketed as a generic under a private label. The AG is sold and distributed as a generic product by the private label company. It is identical to the brand-name drug in both active and inactive ingredients. It may or may not process with a generic (lowest) copayment for insured patients because claims processing systems may still classify it as a brand.

3. Generics and authorized generics are similar, but not the same
   The FDA approves generic drugs under an abbreviated new drug application that proves bioequivalence to the brand-name drug. Generics have the same active ingredients but unlike an AG, aren’t required to have identical inactive ingredients. Typically, generic drugs will process with a generic (lowest) copay for insured patients. In general, generic drugs cost less than brand name and AG products.

4. Coupons tend to increase overall cost
   Coupons for these products may be available. While coupons may initially save the patient money, the overall affect is that they tend to increase the overall cost of health insurance. For more information on drug costs, see any of the following Value Partnerships Update articles:
   - July 2016 – Blue Cross is excluding certain drugs to help control healthcare costs
   - Apr 2016 – It pays to keep drug costs down
   - Jan 2016 – Some drug makers engage in controversial business practices

5. Current pricing of epinephrine auto-injector products

<table>
<thead>
<tr>
<th>Auto-injector product</th>
<th>Manufacturer</th>
<th>Strength</th>
<th>Administration</th>
<th>Average wholesale price</th>
</tr>
</thead>
<tbody>
<tr>
<td>EpiPen 2 pack</td>
<td>Mylan</td>
<td>0.3 MG/0.3ML</td>
<td>Hold auto-injector in place for 3 seconds</td>
<td>$553.20/pack</td>
</tr>
<tr>
<td>EpiPen JR 2 pack</td>
<td>Mylan</td>
<td>0.15 MG/0.3ML</td>
<td>Hold auto-injector in place for 3 seconds</td>
<td>$553.20/pack</td>
</tr>
<tr>
<td>Adrenaclick AG 2 pack</td>
<td>Impax</td>
<td>0.3 MG/0.3ML</td>
<td>Hold auto-injector in place for 10 seconds</td>
<td>$372.88/pack</td>
</tr>
<tr>
<td>Adrenaclick AG 2 pack</td>
<td>Impax</td>
<td>0.15MG/0.15ML</td>
<td>Hold auto-injector in place for 10 seconds</td>
<td>$372.88/pack</td>
</tr>
<tr>
<td>EpiPen AG</td>
<td>Mylan</td>
<td>TBD</td>
<td>TBD</td>
<td>N/A</td>
</tr>
</tbody>
</table>

AG = authorized generic
Select high-cost medications will be removed from BCN drug lists and won’t be covered starting Jan. 1, 2017

Prescription drug prices have been on the rise. Over the past year prices have doubled or tripled, and in some cases increased by over 1,000 percent overnight. As a result, BCN’s drug lists were reviewed to ensure the best value for our members. Drug lists are first reviewed for clinical appropriateness and secondly for cost-effectiveness. Typically, there are several treatment options to choose from within a drug class or for a certain condition, but these may vary greatly in price. Some prescription drugs are much more expensive than others but provide no added health benefit.

To provide appropriate therapy while helping manage drug costs, BCN is removing several of these drugs from our drug lists starting Jan. 1, 2017. For each excluded drug, BCN will provide coverage for clinically equivalent lower-cost alternatives. These changes apply to the Custom Drug List, Custom Select Drug List and Comprehensive Drug List.

Drugs that aren’t on our drug lists aren’t covered, even if the member is currently taking that drug.

We’ve written to affected members and encouraged them to discuss alternatives with their doctors.

Below, we’ve listed the drugs that we’re removing from our drug lists, along with therapeutic alternatives that are on our drug lists. You can view our drug lists at bcbsm.com/pharmacy.

**Alternatives for drugs excluded from drug lists effective Jan. 1, 2017**

<table>
<thead>
<tr>
<th>Drug class</th>
<th>Drug name</th>
<th>Average cost*</th>
<th>Average cost for alternatives*</th>
<th>Therapeutic alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSAID combination</td>
<td>Duexis</td>
<td>$1,600</td>
<td>$100</td>
<td>Over-the-counter NSAID such as generic Motrin plus OTC H1 antagonist such as generic Pepcid</td>
</tr>
<tr>
<td></td>
<td>Vimovo</td>
<td>$2,250</td>
<td>$125</td>
<td>OTC NSAID such as generic Motrin plus OTC proton pump inhibitor such as generic Prilosec</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Carac</td>
<td>$3,000</td>
<td>$950</td>
<td>Generic Aldara or Efudex, Tolak</td>
</tr>
<tr>
<td></td>
<td>Vanos</td>
<td>$2,000</td>
<td>$125</td>
<td>Generic Clobevate, Diprolene, Olux or Ultravate</td>
</tr>
<tr>
<td>Acne</td>
<td>Clindagel, Evoclin, Onexton, Retin-A Micro 0.08%, Veltin, Ziana</td>
<td>$900</td>
<td>$200</td>
<td>Generic Dau, Differin or Retin-A</td>
</tr>
<tr>
<td></td>
<td>Acticlate, Solodyn (brand)</td>
<td>$1,600</td>
<td>$60</td>
<td>Generic minocycline or doxycycline</td>
</tr>
<tr>
<td>Antifungal**</td>
<td>Jubia, Kerydin, Onmel</td>
<td>$4,500</td>
<td>$400</td>
<td>Generic Sporanox, Lamisil tablets or Penlac</td>
</tr>
</tbody>
</table>

*Average cost based on a 30-day supply prescription

**Average cost per treatment course
Certain drug classes with over-the-counter alternatives aren’t covered starting Jan. 1.

Change affects members who use the Custom Drug List

Effective Jan. 1, 2017, BCN will remove all proton pump inhibitors, non-sedating antihistamines and nasal steroids from the Custom Drug List. These medications have alternatives in the same drug class that are available over-the-counter.

Each year more prescription-only drugs are approved by the Food and Drug Administration for use as over-the-counter medications. OTC medications are safe and effective for use by the general public and are available without a prescription, which provides members with direct access to effective medications. Some drug classes have a variety of products with OTC availability.

Drugs that aren’t on our drug lists aren’t covered, even for members who are currently taking that drug.

We’re writing to affected members and asking them to talk to their doctors about their medication options.

We’ve listed some common prescription drugs in these classes and over-the-counter alternatives below.

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Examples of prescription drugs that won’t be covered in 2017</th>
<th>Over-the-counter options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proton pump inhibitors</td>
<td>Aciphex, Dexilant, Nexium, Prevacid, Prilosec, Protonix, Zegerid</td>
<td>Nexium 24HR, Prevacid 24HR, Heartburn Relief 24 Hour Prilosec OTC, Zegerid OTC</td>
</tr>
<tr>
<td>Non-sedating antihistamines</td>
<td>Clarinex, Xyzal, Zyrtec</td>
<td>Allegra, Allegra-D Claritin, Claritin-D Zyrtec, Zyrtec-D</td>
</tr>
<tr>
<td>Nasal steroids</td>
<td>Beconase AQ, Dymista, Flonase, Nasacort AQ, Nasalide, Omnaris, Qnasl, Rhinocort Aqua, Veramyst, Zetonna</td>
<td>Flonase Allergy Relief Nasacort Allergy 24HR Rhinocort Allergy</td>
</tr>
</tbody>
</table>
BCBSM and BCN drug lists updated, available online

Blue Cross Blue Shield of Michigan and Blue Care Network regularly update our drug lists. For the most recent updates, go to bcbsm.com.rxinfo.

Please help 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.

Flumist nasal flu spray vaccine won’t be covered for 2016-2017 season

Blue Cross and BCN follow guidelines from the Centers for Disease Control and Prevention’s Advisory Committee on Immunization practices. ACIP recently announced that the nasal flu spray vaccine should not be used during the 2016-2017 influenza season. Data show that the nasal spray has been less effective than flu shots in protecting against flu.

We encourage members to get an annual flu vaccination. For the 2016-2017 flu season, Blue Cross and BCN will cover flu shots, but the nasal flu spray vaccine is not covered.

Two vaccines are available for those who have allergies to eggs or egg proteins.

Questions? Contact the Pharmacy Clinical Help Desk at 1-800-437-3803.

Remicade requires BCN approval

In the Sept.-Oct. issue of BCN Provider News (Page 37) we told you about new site of care requirements for Remicade and Inflectra that started Oct. 1, 2016. Blue Care Network reminds providers that Remicade requires plan approval before we’ll cover this drug. Please see the BCN Referral and Clinical Review Program for details.
Morbid obesity

With increasing numbers of our population suffering from obesity, it’s crucial for doctors to recognize the degree to which obesity and its accompanying complications can negatively affect a patient’s health.

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

The Centers for Medicare & Medicaid Services includes morbid obesity (ICD-10-CM code E66.01) and its associated body mass index values (40 and above: ICD-10-CM code range Z68.41-Z68.45) in its ICD-10 Hierarchical Condition Categories for calendar year 2016. This categorization makes a big difference in how providers should document the condition.

From a coding perspective, documentation indicating morbid obesity in the medical record makes it easy to assign code E66.01 with an associated Z-code.

A potential coding issue occurs when only “obesity” is noted in the medical record, but there’s sufficient evidence to indicate that the patient is actually morbidly obese. For example, if the patient has a BMI over 40 and has a comorbid condition, such as osteoarthritis, sleep apnea, diabetes, coronary artery disease, hypertension, hyperlipidemia or gastroesophageal reflux disease, you should code for morbid obesity.

Can a BMI value of 40 with comorbid conditions and no mention of morbid obesity in the medical record still be used to code for morbid obesity? Yes.

According to Dr. Raymond Hobbs, Blue Cross Blue Shield of Michigan medical consultant, capturing all the medical complications associated with an obesity diagnosis helps define and document the specific clinical condition (morbid obesity).

“Because obesity is a serious health condition that often includes comorbidities, the BMI value is an important factor in identifying and treating this condition,” said Dr. Hobbs. “The impact of weight on other medical conditions can be significant, so it’s important that all clinical complications be evaluated as part of the patient’s diagnosis and treatment.”

The health care provider might not document morbid obesity in its early stages as he or she may decide to evaluate the patient over time and recommend several interventions that could help reverse the trend. These may include referral to a dietitian, helping the patient incorporate an exercise regimen into his or her daily routine or education about how the condition can affect overall health.

To sum up, documentation is key to coding morbid obesity. A coder must review the medical record thoroughly when only obesity is documented but the patient has a BMI of 40 or above, along with comorbid conditions affecting the patient’s overall health. In these circumstances, code for morbid obesity.

To access a flier on this topic, click here.

None of the information included in this article is intended to be legal advice and, as such, it remains the provider’s responsibility to ensure that all coding and documentation are done in accordance with applicable state and federal laws and regulations.
Billing Q&A

**Question:**
We have a physician that transferred to our group practice from another one. He is now under a different tax ID. Some of his patients have followed him. When he sees them for the first time at our practice, can we bill a new patient visit?

**Answer:**
While this physician is under a new tax ID, his provider identification number is the same. Additionally, the patients that he will be seeing in his new setting are familiar to him, so regardless of whether the records transfer with the patient, he may only be able to report an established patient visit.

If the patient comes in to see his or her physician and there was a face-to-face visit or service in the prior three years at either practice location, it is only appropriate to report an established patient visit. If there has not been such an encounter, or the patient is seen by a different physician at the new practice, then a new patient visit may be reported. Once the patient is seen at that practice, whether by his or her current physician or another physician, the patient would be considered established at that practice when seen by physicians of the same group and specialty.

**Question:**
When we see Medicare Advantage or BCN Advantage patients and perform an evaluation and management service with an annual wellness visit, we’ve been told that we must submit an appeal to get the E&M paid. When we do this, though, it is not always paid, and occasionally the E&M has been paid and the payment for the wellness visit is questioned or taken back. This is confusing to us as Medicare pays for both, so why is BCN making us submit documentation?

**Answer:**
Blue Care Network reviews documentation when both an evaluation and management and an annual wellness visit are reported on the same date of service. Even though only one service may receive an edit, documentation for both services should be submitted on an appeal.

BCN will review the documentation to ensure that:
- There is no overlapping of services. Services provided in the annual visit can’t be counted towards the level of evaluation and management reported.
- The documentation submitted supports the services in the evaluation and management and are separate and distinct from the annual wellness visit.
- The components required by Medicare for the initial or subsequent annual wellness visit are met.

BCN will make a determination on the documentation that is submitted but may contact you for the additional information. It is important to submit all pertinent information for services performed on a given date of service, even if those services were reimbursed as they may have an effect on a denied service.

Have a billing question?
If you have a general billing question, we want to hear from you. Click on the envelope icon to open an email, then type your question. It will be submitted to BCN Provider News and we will answer your question in an upcoming column, or have the appropriate person contact you directly. Direct urgent questions to your provider consultant. Do not include any personal health information, such as patient names or contract numbers, in your question to us.
BCN’s updated web-DENIS Billing/Claims web page offers help in billing

Looking for information about billing correctly? On locating a remittance advice or negative balance report online?

We suggest you visit BCN’s recently updated web-DENIS Billing/Claims web page. There you will find a variety of resource materials that can help make billing easier for you.

Take a look:

We moved the link to the Billing/Claims web page to the top of the list. We know how important it is to bill correctly.

Please see Web-DENIS, continued on Page 40
Here’s what opens when you click the links under the General Information heading. We’re listing the links in the order in which they appear on the web page.

<table>
<thead>
<tr>
<th>Link name</th>
<th>What you can learn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link to authorization / referral information</td>
<td>Jump to the Authorizations / Referrals web page and review the resource materials there. Following authorization and referral guidelines is important in ensuring you’re paid for your services.</td>
</tr>
<tr>
<td>Guidelines for bundling admissions</td>
<td>Learn which admissions are likely to be combined with readmissions within 30 days for billing purposes.</td>
</tr>
<tr>
<td>In-office laboratory procedures billable to BCN</td>
<td>See which procedure codes CLIA-certified physicians can bill BCN directly for labs done in the office rather than through BCN’s laboratory vendor, JVHL.</td>
</tr>
<tr>
<td>Locating a Remittance Advice online</td>
<td>Review the steps for finding a remittance advice statement (voucher) online. You can look using an EFT trace number or span of time or you can look for a specific member.</td>
</tr>
<tr>
<td>Specific revenue codes to be billed with five-digit procedure codes</td>
<td>Learn which revenue codes must be billed with a specific procedure code in order to be payable.</td>
</tr>
<tr>
<td>Locating a negative balance report online</td>
<td>Review the six steps that show how to locate a negative balance report online for both facility and professional claims.</td>
</tr>
<tr>
<td>Understanding negative balances</td>
<td>Learn how negative balances work and how to read the reports.</td>
</tr>
<tr>
<td>Claims troubleshooting</td>
<td>Read our tips on what to do when you run into claims problems.</td>
</tr>
<tr>
<td>Where to send paper claims for BCN HMO℠ and BCN Advantage℠ members</td>
<td>Review which types of services you can bill on paper and find the mailing addresses for sending the claims.</td>
</tr>
<tr>
<td>Provider consultant</td>
<td>Find who to contact if you need to see a BCN fee schedule.</td>
</tr>
</tbody>
</table>

We’ll include more information about the resources on BCN’s web-DENIS Billing /Claims web page in future newsletter issues.

To access this page, do the following:

2. Click Login and log in to Provider Secured Services using your user name and password.
3. Click [BCN Provider Publications and Resources](http://bcbsm.com/providers), at the right on the Provider Secured Services Welcome page.
4. Click Billing/Claims.
What providers should know about billing qualified Medicare beneficiaries

Federal law prohibits all Medicare providers from billing qualified Medicare beneficiaries for Medicare deductibles, coinsurance, or copayments. This means that all Medicare and Medicaid payments you receive for providing services to a qualified Medicare beneficiary are considered payment in full.

For details, please see full article on Page 11.

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:

- Appropriate use of modifiers in a global period
- Appropriate use of modifiers 24, 25, and 57
- Evaluation and management coding
Authorization criteria now available for certain surgeries

Authorization criteria, also called medical necessity criteria, are now available for the following surgeries:
- Cervical spine surgeries
- Total joint replacements (hip, knee and shoulder)
- Laparoscopic cholecystectomy

You can access these criteria by completing the following steps:
2. Click BCN.
3. Click Clinical Review & Criteria Charts.

Reminder: These surgeries require clinical review for both BCN HMOSM (commercial) and BCN AdvantageSM members, as shown in this table:

<table>
<thead>
<tr>
<th>Surgery type</th>
<th>Effective date for clinical review requirement</th>
<th>Codes affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical spine</td>
<td>Dates of service on or after Oct. 3, 2016</td>
<td>*22551 *22554 *22586 *22600</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*23470 *23472 *27130 *27132</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*27446 *27447 *63001 *63015</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*63020 *63045 *63050 *63051</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*63075</td>
</tr>
<tr>
<td>Total joint replacements (hip, knee and shoulder)</td>
<td>Dates of service on or after Oct. 3, 2016</td>
<td>*47562 *47563 *47564</td>
</tr>
<tr>
<td>Laparoscopic cholecystectomy</td>
<td>Dates of service on or after Dec. 5, 2016</td>
<td></td>
</tr>
</tbody>
</table>

Please see Authorization criteria, continued on Page 43

Reminder: Authorization requirements were changed for certain sleep studies effective Oct. 3, 2016

For dates of services on or after Oct. 3, 2016, all requests to authorize outpatient facility and clinic-based sleep management studies for adult members 18 years of age and older require submission of evidence from the member’s medical record. This evidence must confirm the specific condition 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 questionnaire in the e-referral system, which is already required.

To attach the required clinical information to your authorization request in the e-referral system, follow the instructions in the e-referral User Guide. The user guide is available on the ereferrals.bcbsm.com website by clicking Training Tools in the left navigation and then clicking e-referral User Guide. In the subsection titled “Submit a Global Referral or Authorization,” look under “Create new (communication).”

For more information, see the article titled “How to attach clinical information to your authorization request in the e-referral system” on Page 44 of this newsletter.

Additional information

Reimbursement for sleep studies is available only to providers who have specifically contracted with BCN to perform these services.

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 pages 42 and 43 of the July-August 2016 issue of BCN Provider News. In this article, you’ll find information about the change in requirements for home sleep studies. You’ll also find guidelines for billing sleep management studies.

*CPT codes, descriptions and two-digit modifiers only are copyright 2015 American Medical Association. All rights reserved.
Authorization criteria, continued from Page 42

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. You can review the criteria to prepare for answering the questionnaire. We suggest that you identify the clinical information outlined in the criteria for a particular surgery and have that information at hand when completing the questionnaire.

To facilitate the review process, attach the clinical information to your authorization request in the e-referral system by following the instructions in the e-referral User Guide. The user guide is available on theereferrals.bcbsm.com website by clicking Training Tools in the left navigation and then clicking e-referral User Guide. In the subsection titled “Submit a Global Referral or Authorization,” look under “Create new (communication).”

For more information, see the article titled “How to attach clinical information to your authorization request in the e-referral system” on Page 44 of this newsletter.

If the clinical information you enter into the e-referral system matches the authorization criteria for that procedure, your authorization request will be approved.

Preview questionnaires for these procedures are available on the Clinical Review & Criteria Charts page at eereferrals.bcbsm.com. They reflect the questions you’ll see in the e-referral system questionnaire.

Other information

The requirement for clinical review for these procedures is reflected in the updated the BCN Referral/Clinical Review Program document, which was posted in July.

New e-referral online training available

If you’re new to using the e-referral tool, or want to learn more about it, check out our online training. Go to the Training Tools page on our e-referral website where you can find a link to 10 new online self-paced learning modules. Click on the module you need and learn at your own pace. Our Training Tools page also has user guides and other documentation to help you use e-referral.
How to attach clinical information to your authorization request in the e-referral system

Attaching clinical information to your authorization request in the e-referral system facilitates the process of clinical review for those procedures that require it. When the member’s clinical information is entered into the e-referral system, your request is reviewed and a decision can be made more quickly.

To learn how to attach clinical information to your authorization request, follow the steps in the e-referral User Guide.

We’ve reprinted the steps from the user guide right here, for your easy reference:

Create New (communication)

To attach clinical information (both initial clinical and continued-stay or discharge information) to the request in the e-referral system, click the Create New button in the Case Communication field.

In the dialog box that opens, enter a subject and your message. Fields marked with an asterisk are required. Click Attach File. Locate the document in your files and double-click so they upload. File formats accepted include: .bmp, .doc, .docx, .gif, .jpg, .pdf, .png, .ppt, .txt, .xls and .xlsx. Maximum file size is 10 MB. Please be sure your file name does not contain any special characters or symbols as you will receive an error message. In the dialog box, check off the items to be reviewed. Click Send.

Please see Authorization request, continued on Page 45
Authorization request, continued from Page 44

The dialog box closes. You’ll be able to see your attached documents after clicking the Subject link.

![Image of authorization request form]

The e-referral User Guide is available on the ereferrals.bcbsm.com website. Click Training Tools in the left navigation and then click e-referral User Guide. In the subsection titled “Submit a Global Referral or Authorization,” look under “Create new (communication).”
eviCore healthcare to review additional outpatient pain management services effective Dec. 1

For dates of service on or after Dec. 1, 2016, authorization is required through eviCore healthcare for additional outpatient pain management services for adult and pediatric Blue Care Network HMO™ (commercial) and BCN AdvantageSM members, for all diagnoses.


These codes represent sacroiliac joint injections, epidural adhesiolysis and regional sympathetic blocks.

The list of procedures that require review by eviCore healthcare is being updated to reflect these additional codes.

Authorization from eviCore is required for these outpatient pain management services. Services performed without authorization may be denied for payment, and you may not seek reimbursement from members.

Pain management services don’t require authorization when they are performed in conjunction with an inpatient stay, an observation stay or an emergency room visit.

You can submit authorization requests for these additional procedures at evicore.com as early as Nov. 21. Click Providers and log in to eviCore’s provider portal.

This management of additional procedures by eviCore is in addition to the authorizations eviCore currently manages on behalf of Blue Care Network for interventional pain management (facet joint and epidural injections); for select cardiology, radiation therapy and radiology services and for physical, occupational and speech therapy services and physical medicine services by chiropractors.

Additional information about procedures managed by eviCore healthcare for BCN is available on the eviCore-Managed Procedures page at ereferrals.bcbsm.com. Click BCN. Then click eviCore-Managed Procedures to open the web page.

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Updated authorization criteria now available for lumbar spine surgery, knee arthroscopy for adult members

Updated authorization, or medical necessity, criteria are now available for lumbar spine surgeries and knee arthroscopy procedures for adult members 18 years of age or older.

The updated lumbar spine surgery criteria are reflected in the revised questionnaires that appear in the e-referral system when authorization requests are submitted for dates of service on or after Oct. 3, 2016. Knee arthroscopy questionnaires are displaying for authorization requests submitted for all dates of service.

You can access the updated criteria by completing the following steps:
2. Click BCN.
3. Click Clinical Review & Criteria Charts.

Criteria are specific to conditions or procedures
The criteria are written for the conditions or procedures listed here.

<table>
<thead>
<tr>
<th>Lumbar spine surgeries (based on the member’s condition)</th>
<th>Knee arthroscopy (based on the procedure the member is having)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acute traumatic spine injury</td>
<td>• Diagnostic arthroscopy with or without synovial biopsy</td>
</tr>
<tr>
<td>• Cauda equina syndrome</td>
<td>• Chondroplasty</td>
</tr>
<tr>
<td>• Primary bone or metastatic tumor of the lumbar spine</td>
<td>• Lateral release</td>
</tr>
<tr>
<td>• Vertebreal body destruction secondary to osteomyelitis</td>
<td>• Removal or stabilization of intra-articular osteochondral lesion or loose body</td>
</tr>
<tr>
<td>• Nontraumatic instability</td>
<td>• Resection or repair of stable meniscal tear</td>
</tr>
<tr>
<td>• Lumbar disc herniation or foraminal stenosis</td>
<td>• Resection or repair of unstable meniscal tear</td>
</tr>
<tr>
<td>• Degenerative disc disease</td>
<td>• Synovecotomy, limited</td>
</tr>
<tr>
<td></td>
<td>• Synovecotomy, major</td>
</tr>
</tbody>
</table>

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

We suggest that you review the updated criteria, identify the clinical information you’ll need for a particular procedure and have that information at hand when completing the questionnaire.

Preview questionnaires also available online
Updated preview questionnaires for lumbar spine surgeries and knee arthroscopy procedures are also available on the Clinical Review & Criteria Charts page atereferrals.bcbsm.com. You can review these preview questionnaires to see the questions you’ll need to answer in the e-referral system.

Attach the clinical information to your authorization request
To facilitate the review process, attach any required clinical information to your authorization request in the e-referral system by following the instructions in the e-referral User Guide. The user guide is available on theereferrals.bcbsm.com website by clicking Training Tools in the left navigation and then clicking e-referral User Guide. In the subsection titled “Submit a Global Referral or Authorization,” look under “Create new (communication).”

For more information, see the article titled "How to attach clinical information to your authorization request in the e-referral system," on Page 44 of this newsletter.

If the clinical information you enter into the e-referral system matches the authorization criteria for that procedure, your authorization request will be approved.
Reminder: eviCore to review additional radiation therapy codes for BCN effective Nov. 1, 2016

Effective for dates of service on or after Nov. 1, 2016, eviCore healthcare will review authorization requests for additional radiation therapy services for BCN HMO℠ (commercial) and BCN Advantage℠ members. This is a reminder about information we communicated earlier as a news item atereferrals.bcbsm.com and as a web-DENIS message.

The additional services eviCore will review are associated with the following procedure codes: *79101, *79403, A9543, C2616 and Q3001.

Here’s what you need to know:

- Authorization is required before providing services.
- You’ll need to submit pertinent clinical information with the authorization request.

An updated list of codes reviewed by eviCore, including these additional codes, is available on the eviCore-Managed Procedures page atereferrals.bcbsm.com.

BCN contracts with eviCore healthcare to review select non-emergent cardiology, interventional pain management, radiation therapy and radiology procedures when performed in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices for BCN HMO and BCN Advantage members.

Reminder: Starting Nov. 1, authorization requests for outpatient ECT and TMS must be submitted through e-referral

Effective Nov. 1, 2016, BCN behavioral providers must submit authorization requests for outpatient electroconvulsive therapy and transcranial magnetic stimulation services through the e-referral system.

See full article on Page 25.
Use these tips to transition PT, OT, ST cases continuing into 2017

Blue Care Network has implemented a year-end transition plan for the physical, speech and occupational therapy authorization process. This process worked well for therapy providers and members in the past. Therefore, the same strategy applies for 2017.

Care that starts in November or December
All 2016 treatment authorizations for physical therapy, occupational therapy and speech therapy will end Dec. 31, 2016 for members whose coverage follows a calendar-year plan. If an episode of care begins in 2016 and is expected to continue into 2017, the following apply:

- An initial evaluation or reevaluation for therapy isn’t necessary to continue an active episode of care into 2017.
- You must enter a new referral through e-referral. If you are unable to use e-referral, you may contact Care Management.
- A member does not need a new referral from the member’s primary care physician to complete the active episode of care.

Care that continues into 2017
Physical, occupational and speech therapy providers should enter their own referrals for therapy services for all patients receiving therapy services in December that will carry over into January 2017. The referral begin date should be the date of the first appointment in 2017. You may enter the 2017 referral into e-referral in December 2016. If you are unable to use e-referral, contact Care Management at 1-800-392-2512. For more information or instructions on using e-referral, download the e-referral User Guide on ereferrals.bcbsm.com.

Approvals for 2017 must meet these requirements:
- The member is an eligible BCN member on the date services are provided.
- Services received must be a benefit covered under the member’s contract.
- Benefits must be available or remaining as defined by the member’s contract.

Please see Transition, continued on Page 50
Therapists should enter the 2017 referral in e-referral with the following information:

**Physical Therapy**

<table>
<thead>
<tr>
<th>Procedure code</th>
<th>Submit applicable procedure code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start date</td>
<td>Enter date of the first visit for 2017</td>
</tr>
<tr>
<td>Count</td>
<td>1</td>
</tr>
<tr>
<td>Date span</td>
<td>60 days</td>
</tr>
</tbody>
</table>

- Category A and B therapy referrals are processed according to their tier level and therapists receive a determination letter.
- Category C providers who have patients currently under care or new patients who begin treatment in January will receive a letter approving three therapy visits. The three visit approval will be granted through Jan. 31, 2017. Be sure to submit a treatment plan prior to the third visit to avoid the risk of lapse in treatment due to lack of authorization. Beginning Feb. 1, 2017, new referrals revert to the established policy of one evaluation and one visit for all new patients seen by Category C providers.

**Speech Therapy**

<table>
<thead>
<tr>
<th>Procedure code</th>
<th>*92521, *92522, *92523, *92524</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start date</td>
<td>Enter date of the first visit for 2017</td>
</tr>
<tr>
<td>Count</td>
<td>1</td>
</tr>
<tr>
<td>Date span</td>
<td>60 days</td>
</tr>
</tbody>
</table>

- Requests automatically pend for speech therapy. eviCore healthcare processes speech provider referrals according to the established process and therapy providers receive a determination letter.

Speech therapy providers should submit a treatment plan as soon as they determine that care is required for 2017. eviCore healthcare will review for medical necessity and send a determination letter. BCN Care Management accepts requests for transition cases by phone or by e-referral. Please call Care Management at 1-800-392-2512.

**Occupational Therapy**

<table>
<thead>
<tr>
<th>Procedure code</th>
<th>Submit applicable procedure code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start date</td>
<td>Enter date of the first visit for 2017</td>
</tr>
<tr>
<td>Count</td>
<td>1</td>
</tr>
<tr>
<td>Date span</td>
<td>60 days</td>
</tr>
</tbody>
</table>

- eviCore healthcare (formerly known as Landmark) processes occupational therapy referrals according to the established process and therapy providers receive a determination letter.

For members with plan year benefits

Most BCN plans apply benefits on a calendar year basis, but some groups administer benefits on a plan year with renewal dates other than January 1. Health care providers can verify this information when checking eligibility on web-DENIS or PARS. If you identify a member with a plan year other than Jan. 1, adjustments to the start and end date of an authorization is subject to the benefit year renewal date. BCN and eviCore healthcare work together to administer benefits accordingly.
Chiropractors: For physical medicine services that continue into 2017

Chiropractic providers should enter their own referrals for physical medicine services for all patients receiving physical medicine services in December that will carry over into January 2017. The referral begin date should be the date of the first appointment in 2017. You may enter the 2017 referral into e-referral in December 2016. If you are unable to use e-referral, you may contact Care Management at 1-800-392-2512. For more information or instructions on using e-referral, please contact your provider representative.

Approvals for 2017 must meet these requirements:

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

<table>
<thead>
<tr>
<th>Physical Medicine Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure code</td>
</tr>
<tr>
<td>Start date</td>
</tr>
<tr>
<td>Count</td>
</tr>
<tr>
<td>Date span</td>
</tr>
</tbody>
</table>

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