Watch Blue Care Network’s video series to help improve communication with your patients

Blue Care Network has asked members throughout the state about their interactions with physicians. Then we interviewed doctors with high patient satisfaction scores. Each group shared thoughts in four areas: Listening to patients, respecting patients, explaining effectively and spending enough time with patients.

Physicians agreed that better communication can lead to better patient compliance and more satisfied patients.

Here’s a sampling of what they said.

**Listening**

“These days, like it or not, we’re all doing computer work while we’re listening to patients. Sometimes you get a patient with a lot of problems. You just have to put the computer away. And sit and talk and listen.”

—Dr. James LaFleur, Saginaw

Obstetrician-gynecologists can refer patients to specialists

Obstetrician-gynecologists and gynecologists can refer their patients for OB-GYN-related specialty services. While we believe the patient’s total care, including the coordination of care by specialists, is best managed by the primary care physician, OB-GYN providers can issue referrals to specialists for obstetrical or gynecological related items and services without patients needing to obtain referrals from their primary care physicians.

OB-GYN providers should use e-referral to refer their patients.

We encourage OB-GYN providers to talk to their patients regarding their relationship with their primary care physicians and, whenever possible, to refer patients to specialists who work with the member’s primary care physician.
BCN video series, continued from Page 1

Respect
“I show respect to my patients by understanding their personal beliefs including involving them in decision-making.”
—Dr. Naheed Rizvi, Midland

Explaining effectively
“I do believe, 100 percent, that better communication, reassuring the patient and being sure they understand what the problem is, leads to less office calls and fewer emergency room visits.”
—Dr. Miguel Perez, Flint

Spending time
“The key is to sit. Once you sit, you are giving attention and are willing to give enough time for the patient to talk and explain why they are here.”
—Dr. May Antone, Southfield

Learn more about what physicians and patients said. To watch the four videos, go to the following brainshark.com/bcbsm/patientcommunication.

You can watch each video by topic or all at one time. We encourage practices to watch them with staff so you can discuss individual techniques with other doctors in your practice.

Tools
As a thank you to those who watch the video, we’re offering some tools to enhance patient communication in your office. You can order the tools at the end of the video.

Please provide your feedback at the end of the video or email your comments to bcnprovidernews@bcbsm.com.

When you log into the guestbook in the Brainshark URL, check the “Remember Me” box so you can watch videos separately. It will remember where you stopped viewing.

Blue Care Network only collects email and address information through the guestbook to send provider tools if you order any. We won’t send solicitation emails or provide your information to anyone for other purposes.
Please remember to check the member’s coverage in web-DENIS to ensure you refer your patient to a specialist within their specific network for the services to be covered.

Providers in the Mid and West regions are not required to go through the e-referral system; however, the referral should be documented in the patient’s medical record.

There are no changes to the pre-authorization process. Current pre-authorization rules still apply.

Lastly, OB-GYN providers have the ability to send patients to another maternal fetal medicine provider with just a prescription, similar to the Woman’s Choice program.

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**Sign up for e-referral**

If you don’t have an e-referral user ID [sign up](#) today.

If you don’t know how to use e-referral, please go to [training tools](#) on the e-referral website.

Remember, you must login at least once every 180 days to keep you user ID active. If your user ID is not working, fax a request on company letterhead to 1-800-495-0812 asking for the ID to be reconnected. Include the user ID, your name and email address, and have it signed by the authorized individual in the office. For additional help, call the Web Support Help Desk at 1-877-258-3932.

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**Reminder: 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 and domestic partners in the Healthy Blue Living℠ product.

Spouses or domestic partners won’t be required to complete a health assessment or a qualification form beginning with the 2017 plan year.

See the full article in the **November-December 2016** issue for details.
Blue Care Network offices will be closed Dec. 23, 26 and 30 for the Christmas holiday and on Jan. 2, 2017 for New Year’s Day. When BCN offices are closed, call the BCN After hours Care Manager Hot Line at 1-800-851-3904 and listen to the prompts for help with:

- Determining alternatives to inpatient admissions and triage to alternative care settings
- Arranging for emergency home health care, home infusion services and in-home pain control
- Arranging for durable medical equipment
- Emergency discharge planning coordination and authorization
- Expedited appeals of utilization management decisions

**Note:** Clinical review for admissions to skilled nursing facilities and other types of transitional care services should be called in during normal business hours unless there are extenuating circumstances that require emergency placement.

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

Do not use this number to notify BCN of an admission for commercial or BCN 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.
Adobe Flash player is required to search the BCN Provider Manual and BCN Provider News annual archives

You now need Adobe® Flash® player to use the BCN Provider Manual portfolio or search BCN Provider News using the complete yearly archives.

If you don’t have Flash player, a dialog box will prompt you to download and install the latest Flash player when the PDF is opened. If you aren’t able to do this, contact your information technology support services. The portfolio may not work on mobile devices.

The BCN Provider Manual opens in portfolio mode when you use Adobe® Reader® version 9.0 or later. You may download the latest version of Adobe Reader at get.adobe.com/reader.

To search the manual when it is in portfolio mode, follow the instructions in the Searching the BCN Provider Manual document, available on bcbsm.com/providers. To find it:

• Log in to Provider Secured Services.
• Click on BCN Provider Publications and Resources.
• Click on Provider Manual.
• Click on How to search the manual.

You will also need Adobe Flash to open the yearly archives for BCN Provider News. You can always open the archived copy of each issue separately. The yearly archive file contains all the issues published to date during the year.

Members have power to compare provider treatment costs with redesigned feature

The newly redesigned Find a Doctor feature at bcbsm.com allows our HMO members to find treatment cost estimates by provider. Treatment costs are available for nearly 1,600 different health services.

Blue Care Network and Blue Cross Blue Shield of Michigan have improved the Find a Doctor feature over the past two years. Members can get provider quality data, discover which doctors offer extended office hours and read and write patient reviews about a particular doctor’s services.

Soon members will be able to get out-of-pocket-expense estimates for specific health services.
New member app helps your productivity, patient experience

Our new mobile app connects members securely to their health care plan information conveniently from their smartphones. Since we’re putting information and tools into the hands of our members, it can help your office run smoother and help your patient satisfaction ratings, too.

Ask them to tap the app

When a Blue Cross Blue Shield of Michigan or Blue Care Network member is at your reception desk and doesn’t have his or her plastic member ID card or doesn’t know his or her copayment, deductible or prescription information, you can:

• Ask the patient to download the Blue Cross app from the Apple® App Store or Google® Play using key word “BCBSM” to get the information they need*
• Let them know if they haven’t created a member account already, they can do it through the app

The ID card feature on the app allows your patient to look up and confirm details like:

• Contract and group number
• Customer service numbers
• Copayments for office, urgent care and emergency room

It also helps you:

• Save time by preventing staff from having to look up phone numbers or calling Provider Inquiry.
• Refer patients to providers without having to search for contact information. The app’s Find a Doctor button allows them to search by name.
• Enhance your patient’s experience. Your patients will appreciate your knowledge about the Blue Cross app and the information at their fingertips.
• Improve your Blue Cross quality ratings. Remind patients to use the app to rate your excellent service.

See for yourself what our mobile app can do. Learn more today at bcbsm.com/app.

*The app isn’t available for tablets yet and is only available on certain operating systems.

Providers: Remind patients to add newborns to BCN coverage

Coverage available to newborns varies based on the member’s benefit design and applicable regulations.

To ensure reimbursement, providers should remind new parents to add their newborn to their Blue Care Network policy within the applicable timeframe. Babies will then be added based on applicable eligibility rules.

Providers should also check web-DENIS for eligibility and benefits when providing services to newborns.
Make sure your CAQH application is accurate

Blue Cross Blue Shield of Michigan and Blue Care Network use CAQH applications to aid credentialing and recredentialing. We continuously refer to CAQH to display your practice information correctly in directories for our members.

Please remember to routinely check your information on CAQH ProView™ and ensure that your credentialing contact name, information, demographics, hospital affiliations, professional liability insurance and group affiliations are updated. When updating your professional liability insurance information, provide CAQH with a copy of your current insurance face sheet.

Smoking cessation contest winners

Congratulations to winners of Blue Care Network’s smoking cessation contest.

The following offices won our office contest for handing out our tobacco use surveys and Quit Guides to Blue Care Network commercial members aged 18 to 65 for the last few months of 2016.

The office staff at each provider’s office split $1,000 in Visa gift cards.

- Zuhair Abualrihy, M.D., Portland
- Bruce Cassidy, D.O, Novi
- Praveen Modi, M.D., Plymouth
- Jorge Plasencia, M.D., Saginaw
- Mark Rosenberg, D.O., Macomb Medical Clinic PC, Sterling Heights

Smoking cessation continues to be a top priority for Blue Care Network in 2017. When smokers receive advice from their health care providers, their chances of quitting smoking successfully are doubled.

We need you to help us reach out to our members who smoke so they get this important advice from you — their trusted provider.

If you don’t have surveys and quit guides and would like copies for patients, please call 248-799-6959.
Blue Care Advantage earns 4.5 star rating from CMS

Blue Care Network has earned an overall 4.5-star rating from the Centers for Medicare & Medicaid Services for its BCN Advantage plans for the fifth year in a row. Blue Cross earned an overall 4 out of 5 star rating for the fourth year in a row.

CMS releases new star ratings for Medicare Advantage plans every year, with each plan rated on a scale of 1 to 5 stars. In addition, Blue Care Network was named one of the two top-ranked Medicare Advantage plans in Michigan for 2017, according to *U.S. News & World Report*.

To stay competitive, we must improve our already successful programs and add new ones. Consider a few examples of the work that contributed to our recent success:

• At Blue Care Network, our pharmacy area focused on improving the number of Part D Comprehensive Medication Reviews as part of the CMS-required Medication Therapy Management Program. To reduce the number of member complaints to CMS, BCN formed a cross-functional work group aimed at addressing root-cause resolution. BCN also focused on innovative reward and incentive programs which helped close gaps in care and improve Healthcare Effectiveness Data and Information Set® results.

• At Blue Cross, we continue to focus on initiatives to improve member experience, such as Understand Your Plan and Clear and Simple messaging. We’ve increased administrative clinical data collection through robust provider education on billing and chart collection. Collectively, more than 20 initiatives focused on improving star ratings for the 2017 rating. We have more than 30 initiatives targeting the next rating period.

HEDIS® results for 2016
BCN Advantage

In the last issue, we reported HEDIS® results for BCN HMO commercial and our qualified health plans. Our results for our Medicare business — BCN Advantage℠ — are reported on the PDF below.

BCN Advantage saw improvement in the following areas for 2016:

• Comprehensive diabetic care — eye exam
• Comprehensive diabetic care — HbA1c testing
• Comprehensive diabetic care — nephropathy
• Controlling high blood pressure
• Adult BMI
• Colorectal cancer screening
• Use of spirometry testing in the assessment and diagnosis of COPD
• Annual monitoring for patients on persistent medications
• Antidepressant medication management — Effective acute and continuation phases
• Follow-up after hospitalization for mental illness — Seven days and 30 days
• Osteoporosis management in women who had a fracture
• Use of high-risk medications in the elderly — One prescription
• Use of high-risk medications in the elderly — Two prescriptions
• Initiation of alcohol and drug dependence treatment — Engagement
• Pharmacotherapy management of COPD — Bronchodilators
• Advising smokers to quit

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Patient Assessment Form saves time and enhances communication

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

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

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

BCN Advantage doesn’t record the answers; the form is merely a tool you can use in your office.

This form is also not a replacement for the more comprehensive Medicare Advantage member health assessment form that we mail to every new BCN Advantage member and annually to all BCN Advantage members.

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

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

Additional information
CMS surveys BCN Advantage and other Medicare Advantage members to assess the adequacy and quality of the health care they receive. The surveys focus on the topics that are included in the Patient Assessment Form. When you use this form with your patients, those patients will be in a position to respond in surveys that you’ve discussed these key topics with them during their visits.
Treatment dilemma: Use of opiates in chronic pain management

By William Beecroft, M.D.

New preparations of opiates and expansion of their use in treating chronic pain have been both a boon and a curse for the treating providers. While some patients are getting much needed relief, easy access to illicit drugs are causing problems for many.

The use of narcotic pain medications has quadrupled in the past 10 years, 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.

Blue Care Network of Michigan wants to help you provide the most effective treatment options for your patients. Please review the Sept.-Oct. and Nov.-Dec. 2016 issues of the BCN Provider News, under Pharmacy News for more details about coming opioid limitations.

The November-December issue of BCN Provider News featured an article about the identification and management of substance use disorders, a new HEDIS measure. We are developing procedures to get evaluations done in a timely manner when you refer someone for treatment. The clinical benefit is enhanced when you initiate treatment within 14 days of the initial diagnosis. A good first step in recognizing misuse of medications is to check the Michigan Automated Prescription System for every patient who comes in for opiates. The recent recommendations by Centers for Disease Control and Prevention may help you avoid prescribing opiates in the first place. Review these recommendations with your patients to help them see that the quick answer may not be the best answer for them. Use of non-opiate pain medications and interventions takes a lot more time and effort from both you and the patient but often leads to a better outcome.

The following are CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative and end-of-life care:

Determining when to initiate or continue opioids for chronic pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

Please see From the medical director, continued on Page 11
From the medical director, continued from Page 10

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid selection, dosage, duration, follow-up, and discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release or long-acting opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days is rarely needed.

7. Clinicians should evaluate benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing risk and addressing harms of opioid use

8. Before starting, and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day) or concurrent benzodiazepine use are present.

9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

* All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care and end-of-life care) except recommendation 10 (designated category B, with individual decision-making required); see full guideline for evidence ratings.4
The use of psychotherapy, especially cognitive behavioral treatments, has very good outcomes to assist in managing chronic pain and the subsequent stress due to family, work and other life areas that are affected.

The 5 “As” of chronic pain management can help you remember all the options you have.

- **Analgesics**, aggressive acetaminophen use, NSAIDS, use of topical NSAIDS (some compounding pharmacies will make stronger versions of this with topical analgesics such that the member gets the local anti-inflammatory effect without the systemic consequences that are problematic with long term NSAID use) and aspirin would be examples.

- **Antidepressants** (especially SSNRIs such as Cymbalta). Some of the newer medications for irritable bowel syndrome fit in this pharmacologic category.

- **Anxiolytics** — examples would be mindfulness, yoga, meditation, and benzodiazepines, as well as antidepressants that have strong anxiolytic action (Remeron or Trazodone). In effect, these give two pharmacologic actions in one medication — antidepressant and anxiolytic action.

- **Antipsychotics** — Abilify and Seroquel are FDA approved “add-ons” for antidepressants and provide lots of antianxiety effect in addition to augmenting the analgesic effect of NSAIDS and even TYLENOL.

- **Anticonvulsants** — Tegretol, Trileptal are old standbys, but Lyrica for fibromyalgia and its cousin Neurontin can help with neuritic pain as well as nerve blocks; TENS units.

General measures such as addressing sleeping habits will help determine pain tolerance during the day. Rosarem or melatonin are non-habit-forming preparations. Traditional sleeping aids can be habit forming and have side effects but can also be a great compromise if they allow function during the day and prevent escalation to opioids. Physical therapy, therapeutic massage and surgical interventions round out a variety of non-opioid interventions. This list isn’t complete and this article isn’t intended to be an all-encompassing statement on chronic pain management. Its focus is on considerations for nonopioid interventions.

Even when opioids are necessary, providers should incorporate one or more of these interventions to limit opioid use.

Additional tools such as saliva or urine tests for opioids may also help manage your patients’ medications. A quick stop at the lab before coming to your office or doing these tests in-house could become part of routine visits.

Other ideas to help you communicate your partnership with your patient:

- Develop a narcotic contract with built-in monitoring so you can manage a member’s escalation of the prescribed medications.

- Set strict rules about refills.

- See patient regularly.

- Don’t supply refills early.

We recognize your difficult environment and the pressures of patient expectations. Let us know how we can enhance your options in managing your patients who get opiate treatment.

Contact BCN Behavioral Health at 1-800-482-5982 for opiate information, triage assistance and referrals for mental health and substance use concerns.

References


4. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016
Help patients start the new year by doing a health check

As the new year approaches, people make resolutions to improve their health. Below is a checklist to help your patients reach their goals.

• Get an early start with patients in 2017. Record a BMI on every patient. All patients under 20 years old need a BMI percentage, height and weight. Children 3 to 17 years old must have:
  - Counseling for nutrition (for example, eats three meals per day). Complete checklist verifying nutrition discussion.
  - Counseling for physical activity (for example, exercises one hour each day). Providers should complete checklist verifying discussion of physical activity.

• Monitor diabetics. Do HbA1c, nephropathy monitoring (urine for protein or on ACE/ARB meds or renal diagnosis) and blood pressure check. Encourage patients to schedule a diabetic eye exam. Schedule follow-up visits as results indicate.

• Follow up with patients who have hypertension. Follow up on medication regime and document lifestyle changes and blood pressure checks to ensure appropriate management.
  - Age 18-59 years old BP 139/89 or less
  - Age 60-85 years old with a diagnosis of diabetes BP 139/89 or less
  - Age 60-85 years old without a diagnosis of diabetes BP was 149/89 or less

• Review history and order colon cancer screening test, if needed (Age 50-75, colonoscopy every 10 years). For patients that refuse a colonoscopy, suggest they complete an FOBT.

• Order a mammogram for all females between age 50-74. Order a mammogram (if patient hasn’t had one for 27 months) and cervical cancer screening age 21-64 (if patient hasn’t had one in three years or five years). If the last Pap and HPV tests were done on same date of service, patients have to be 30 years old on the date of service of the PAP/HPV in order to meet the five-year interval requirement.

• Talk to every patient about physical exercise. Recommend at least 30 minutes a day.

• Discuss falling risks with seniors. Help them to create a safe home environment.

• Conduct a depression assessment on patients.

• Keep records on childhood immunizations. Check immunization records on the Michigan Care Improvement Registry and schedule visits to ensure complete and timely immunizations.

Blue Care Network appreciates your efforts to help keep our members healthy.

For information on preventive services, please call Population Health and Analytics at our HEDIS® message line at 1-855-228-8543.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Patient Safety Week is in March

The National Patient Safety Foundation has designated March 12-18, 2017 as National Patient Safety Week. This marks a dedicated time to increase awareness about patient safety among health professionals and their patients.

Blue Care Network supports the efforts of the Patient Safety Foundation and encourages providers to help patients become active participants in their own care.

Studies show that patients who are more involved in their health care have better outcomes.

Here are some things you can do:

• Provide an environment where patients feel comfortable talking openly.
• Provide information about your patient’s care in a manner that is understandable to them.
• To learn more, visit the National Patient Safety Foundation website.

How to serve as a primary care physician for pediatric patients

As a reminder, Blue Care Network members can select a pediatrician as their child’s primary care physician. This includes all pediatric specialists. Physicians in a pediatric specialty who want to be primary care physicians can contact their provider consultant for more information.
January is cervical cancer awareness month

Please remind your female patients age 21 and older about the benefits of routine cervical cancer screening. Blue Care Network supports the Michigan Quality Improvement Consortium’s recommended preventive health clinical guidelines. The recommendations are outlined in the chart below:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>When</th>
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<tbody>
<tr>
<td>Cervical cancer screening – Pap smear</td>
<td>• Ages 21 to 65 Every three years with cytology or, for women age 30 to 65 years who want to lengthen the screening interval, screen with a combination of cytology and human papillomavirus testing every five years. Testing for HPV before age 30 not recommended. • If not high risk, have had adequate screening with normal Pap smears, recommend against screening women older than age 65. • Routine Pap smear screening not recommended in women who have had a total hysterectomy for benign disease or age less than 21.</td>
</tr>
</tbody>
</table>

Blue Care Network also recommends chlamydia and gonorrhea screening
• Screen for chlamydia and gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.

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

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
• Composite tissue allotransplantation of the hand and face
• Vertebral body tethering and stapling for scoliosis

Covered services
• Genetic testing for cytochrome p450 polymorphisms
February focus is on heart health

February is American Heart Month and Blue Care Network is reminding providers that it's important for members to be appropriately screened for conditions that can affect heart health.

BCN supports Michigan Quality Improvement Consortium guidelines, including those for screening and management of hypercholesterolemia, hypertension, overweight and obesity and tobacco control.

Cardiovascular disease

Hypertension is a serious condition that, if left untreated, can lead to coronary heart disease, kidney disease and possibly stroke. According to the National Health Blood and Lung Institute, about one in three adults in the United States has hypertension and it usually starts between the ages of 35 and 50.

Providers can remind patients of risk factors and what they can do to improve their cholesterol levels.

Risk factors that can’t be controlled
- Age (45 and older in men, 55 and older for women)
- Family history of early heart disease

Risk factors that can be controlled by the member with guidance from the provider
- High cholesterol (high LDL or “bad” cholesterol)
- Low HDL (“good” cholesterol)
- Smoking
- High blood pressure
- Diabetes
- Obesity, overweight
- Physical inactivity

Factors that determine LDL (“bad”) cholesterol level
- Heredity
- Diet
- Weight
- Physical activity and exercise
- Age and gender
- Alcohol
- Stress

Please see Heart health, continued on Page 17
Heart health, continued from Page 16

MQIC screening recommendations
Some highlights from the MQIC guidelines are noted below. For the complete guidelines, visit mqic.org.

Lipid Screening and Management
- Initial screening to include fasting lipid profile (total cholesterol, LDL-C, HDL-C, triglycerides). Repeat every four to six years if normal.
- Screening of LDL-C levels at least annually for member with a cardiac event (AMI, PTCA, CABG) or diagnosis of ischemic vascular disease.
- Treatment based upon presence of clinical atherosclerotic cardiovascular disease (ASCVD); 10-year ASCVD risk calculation for patients 40 to 75 without clinical ASCVD, diabetes mellitus (type 1 or 2) or LDL-C > 190 mg/dl. Refer to MQIC’s ASCVD Risk Estimator Tool.
- Statin dosing intensity based on ASCVD presence and risk.
- Educate about therapeutic lifestyle changes such as losing weight if indicated, increasing exercise to moderate to vigorous activity for 40 minutes per day three to four days of the week and eating more vegetables, fruits, whole grains, low fat dairy, poultry, fish, legumes, nontropical vegetable oils and nuts, and limiting sweets and sugar-sweetened beverages and red meats.

Management of overweight and obesity in adults
- If BMI >30 or >27 with other risk factors or conditions, consider referral to a program that provides guidance on nutrition, physical activity and psychosocial concerns.
- Pharmacotherapy only for patients at increased risk because of their weight and coexisting risk factors or comorbidities.
- BMI >40 or >35 with uncontrolled comorbid conditions, consider weight loss surgery.

Providers can encourage healthy lifestyles by reminding patients to do the following:
- Develop a healthy eating pattern. Eat foods low in saturated fat and cholesterol.
- Reduce salt and sodium. (The Centers for Disease Control and Prevention reports a potential of 11 million fewer cases of hypertension just by reducing sodium intake from the average 3,400 mg daily to 2,300.)
- Maintain a healthy weight.
- Get regular physical activity for at least 30 minutes most days of the week.
- Limit alcohol.
- Quit smoking.
- Take blood pressure medication as prescribed.

Providers can also refer members to the National Heart, Lung, and Blood Institute website for information about heart disease.
Criteria corner

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

**Question:**

In the new 2016 criteria book’s subset “Infection: Skin,” a patient presented with cellulitis of the toe with a history of Type 2 diabetes and no additional comorbidities. Would the history of having Type 2 diabetes qualify using the bullet point for immunocompromised under cellulitis? Can this be a consideration to meet criteria for this criterion set when there are no other contributing factors like steroid use or known cancer history?

**Answer:**

No, a patient with diabetes (or end-stage renal disease, another condition we are frequently asked about) isn’t considered immunocompromised for the purposes of applying this criterion. Although chronic illnesses like diabetes and end-stage renal disease put patients at higher risk for complications of infection, it doesn’t make them immunocompromised as it is described in the note connected to that criteria point. Please see the examples of secondary (acquired) immune deficiency in the note:

"Immunocompromised refers to the patient who has a decreased capacity to recognize and/or defend against invading organisms as a result of an impaired immune system. The principal manifestation of immunodeficiency is increased susceptibility to infection with unusual severity, frequency and duration which differs from that of an immunocompetent individual exposed to the same pathogen. Furthermore, immunocompromised individuals are increasingly prone to opportunistic infections which normally do not afflict healthy individuals. Immunodeficiency is classified as either primary (congenital) caused by inherited disorders of the immune system or secondary (acquired) as a result of a disease process, or as a result of treatment of the disease. Primary causes of immunodeficiency account for more than 100 genetic disorders that impact immune system function.

Examples of primary immunodeficiency include congenital immunodeficiency disease (for example, X-linked a gammaglobulinemia), combined immunodeficiency disease (DiGeorge syndrome, Wiskott-Aldrich syndrome), and chronic granulomatous disease. Examples of secondary immune deficiency include hematopoietic malignancies, patients with allogeneic hematopoietic stem cell transplantation (HSCT), and patients receiving immunosuppressive therapy (for example, chemotherapy, radiation, antirejection medications or prolonged high-dose steroid use). Patients with severe, prolonged neutropenia (for example, absolute neutrophil count < 500/cu.mm (500x10⁶/L)), HSCT, HIV with CD4 count < 200/cu.mm (200x10⁶/L), a history of splenectomy, splenic dysfunction due to sickle cell disease and those who have received intense chemotherapy (for example, childhood acute myelogenous leukemia) are at greatest risk of infection (Kaplan et al. MMWR Recomm Rep 2009; 58(RR-4): 1-207; quiz CE201-204; Bonilla et al., Ann Allergy Asthma Immunol 2005; 94(5 Suppl 1): S1-63)."
Avoid prescribing antibiotics for upper respiratory infections

In this issue, we’d like to discuss the Choosing Wisely campaign on antibiotic use in upper respiratory infections.

The majority of acute upper respiratory infections are viral and antibiotic treatment is ineffective, inappropriate and potentially harmful. Confirmed infection by Group A Streptococcal disease (Strep throat) and pertussis (whooping cough) should be treated with antibiotics. Treatment for URIs consists of treating the symptoms.

It’s important that health care providers talk with their patients about the consequences of misusing antibiotics in viral infections, which may lead to increased costs, antimicrobial resistance and adverse effects.

Choosing Wisely has materials available on when it’s appropriate to use antibiotics and when it’s appropriate to avoid them. Also available: Antibiotics: Do they help or do they harm? at consumerhealthchoices.org.

Consumer Health Choices has the 5 Questions to ask your doctor before you take antibiotics flier that you can give to your patients, and posters that you can use in your office. These materials will help you have conversations with your patients about why antibiotics may not be needed.

For additional information, visit choosingwisely.org.

Blue Care Network continues our partnership with Greater Detroit Area Health Council on Choosing Wisely®. Choosing Wisely is an initiative of the American Board of Internal Medicine Foundation (American Board of Internal Medicine) that aims to promote conversations between physicians and patients to think and talk about medical tests and procedures that may be unnecessary and, in some instances, can cause harm.
Blue Care Network has several smoking cessation initiatives

Blue Care Network has two health improvement plans that focus on smoking cessation.

The Chronic Care Improvement program helps prevent cardiovascular disease in BCN AdvantageSM members. The program uses the clinical interventions championed by Million Hearts™ a public initiative led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services to prevent one million heart attacks and strokes in the U.S. by 2017. Smoking cessation is one of these interventions. Prevention of cardiovascular disease will help us meet our other important goals to decrease heart attacks, strokes and related deaths in BCN Advantage members.

The Quality Improvement Strategy program is a government requirement for the Marketplace population. It will be implemented in 2017. The program focuses on improving health outcomes through effective asthma management which incorporates BCN’s Asthma Management program. One of the interventions is smoking cessation. Reducing triggers, such as smoking and second hand smoke, will improve health outcomes and self-management for members with asthma.

Below are tools you can use to help more members to quit smoking:

- The Blue Cross® Health & Wellness Tobacco Cessation Coaching program, powered by WebMD®, for your Blue Care Network and BCN Advantage patients. It’s a 12-week program for patients who are ready to set a quit date within 30 days. Eligible patients receive five calls from a health coach. If patients need extra support, they can call their health coach at any time. Members can call 1-855-326-5102 to enroll and schedule their first call.

- The BCN Quit Guide offers strategies and medication recommendations to help members quit smoking. Contact your provider consultant to get copies of the Quit Guide for your patients.

- 2017 CMS Million Hearts provider incentive for smoking cessation. The program is explained in detail at BCN’s Health e-BlueSM. It’s located in the Resources section under Incentive Documents. If you have questions, contact your provider consultant.

- MQIC Tobacco Control guideline. This is a one-page guideline to help physicians to get their patients to quit smoking. This guideline is available at mqic.org.

- The CDC website has suggestions on ways to quit smoking at cdc.gov. Enter ‘smoking cessation’ in their search box.

As health care professionals, you play a key role in improving member health outcomes for longer and healthier lives. We appreciate your support.
Blue Care Network supports the Michigan Quality Improvement Consortium’s recommended preventive health clinical guidelines for improving health outcomes for our members. These guidelines are developed using sources from the most current medical and scientific literature. Some of these guidelines cover many of the Healthcare Effectiveness Data and Information Set® measures. HEDIS® is a quality measurement program of the National Committee for Quality Assurance, recognized nationally and by Medicare as a reliable indicator of quality health care.

MQIC provides the following preventive health guidelines which were updated in 2016:

- Adult Preventive Services Ages 18 to 49
- Adult Preventive Services Ages 50 to 65+

The MQIC preventive health guidelines listed below are scheduled to be updated in 2017:

- Routine Preventive Services for Infants and Children Birth to 24 Months
- Routine Preventive Services for Children and Adolescents Ages 2 to 21

Individual patient considerations and advances in medical science may supersede or modify these recommendations. Providers are key in helping BCN members lead healthier lives. We appreciate your support.
Changes coming to Behavioral Health Incentive Program in 2017

Thanks to all the providers who participated in the Behavioral Health Incentive Program in 2016. We appreciate your submissions for the self-reported measures and continued focus on the BCN-assessed measures. Your efforts help us improve behavioral health care quality for our members.

There will be some changes to the 2017 program. The new booklet and other supplementary information will be posted on web-DENIS by the end of December. Please keep an eye out for these documents.

Self-reported measures

We encourage providers to submit their self-reported forms electronically. Providers who do will get a larger incentive amount for both the therapeutic alliance measure and the primary care physician contact measure. To find out more information about sending forms electronically, please go to the Behavioral Health section on the Provider Publications and Resources page in web-DENIS.

Changes in submitting initial authorization requests, concurrent reviews and discharge summaries for behavioral health higher levels of care

The requirements for how Blue Care Network’s behavioral health facilities submit initial authorization requests, concurrent reviews and discharge summaries have changed for inpatient, partial hospital and intensive outpatient services.

The changes affect both substance use and mental health cases.

More information can be found in the Sept-Oct. 2016 issue, Page 28.

Treatment dilemma: Use of opiates in chronic pain management

See Page 10 for a discussion about limiting opiate use when treating patients with chronic pain, including:

- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow-up and discontinuation
- Assessing risk and addressing harms of opiate use
Documenting BMI facilitates conversations about lifestyle changes

Dr. Maria Heck of IHA Milan Family Medicine, believes in giving patients with high BMI achievable steps to be healthier.

Taking a patient’s vitals, including height and weight, are done at every visit. “As long as patients can stand or get out of a wheelchair we have their height and weight recorded,” she said. “Consistency at every visit helps take a lot of the thought process out of it.”

When patients are overweight, Dr. Heck aims for modest changes that patients can adopt.

“Most people know they’re overweight or obese,” said Dr. Heck. “Doing the BMI measure gives us a criterion point and opens up a discussion. I ask my patients what steps they are taking in terms of healthy eating and exercise. They may be just a few adjustments away from getting positive results.”

If patients aren’t taking steps to lose weight, Dr. Heck says she discusses healthy eating and asks the patient to go through an average day with her.

“If they seem motivated, I move on to a dietary discussion and show them how to make their calories count,” she said. “I do that by recommending whole foods and suggesting they avoid foods that are boxed or processed. I suggest they shop the periphery of the grocery store — the aisles where the produce, lean meats and dairy are.”

Small changes help affect risk factors for disease

Dr. Heck stresses that small, consistent incremental lifestyle changes can reduce risk factors for many diseases. “For most people, exercise is the hurdle. It’s the first thing that drops off when we’re busy,” she said. “But I tell patients every step counts and I recommend they get a pedometer or a FitBit or download a free app on their phone. The goal is 10,000 steps a day more days than not. The goal is to get the BMI below 30. A BMI above 30 is when you see an increased diabetes risk, insulin resistance, high cholesterol and effects on blood pressure.”

Weight loss can be successful if you break it down into small components, said Dr. Heck. “Losing weight is a very daunting task. I tell patients that to lose a pound you have to be negative 3500 calories — approximately. You can do two things — count calories and decrease your intake by 250 a day and burn an additional 250 a day with a half hour of walking. Then it becomes more manageable to say you can lose a pound a week.”

Please see Best Practices, continued on Page 24
Best Practices, continued from Page 23

Dr. Heck sees a significant number of patients who are overweight or obese. While she doesn’t recommend follow-up visits for BMI alone, many of her overweight patients also have high triglycerides, high blood pressure or other chronic issues. For those patients, she will schedule follow-up appointments every three to six months.

Let patients see their progress

Dr. Heck likes to show patients the progress they’re making by scheduling lab work with their follow-up visit and letting patients see the trend on their medical records. “I always check vitals when they come in,” she said. “So, the electronic medical records will show a trend. If a patient with diabetes or high blood pressure has been exercising and eliminating fast food, for example, he or she can see a correlation between their vitals and their labs and blood pressure. It’s a good way to reinforce changes.” For patients who get discouraged because the scale isn’t changing, Dr. Heck tells them if they are exercising they are likely gaining muscle. She’ll ask, “Are your pants fitting better? You’re going to lose inches before you lose weight.”

Making lifestyle changes has many benefits. It helps patients feel better, said Dr. Heck. “The body has a huge capacity to heal itself,” she said, remembering a patient who she referred to hematology because of concerns about his bloodwork. The patient had been drinking four, 20-ounce diet pops a day and was encouraged to quit drinking pop, recalled Dr. Heck. “When I saw him three months later, his chronic pain and headaches had gone away and the abnormal labs had returned to normal,” she said.

As a believer in lifestyle changes, Dr. Heck concluded, “Lifestyle changes are harder changes to make but the benefits are enormous. They have the least amount of negative side effects and they’re free.”

Learn more about effective patient communication

You can learn more about physician-patient communication by watching a series of videos we created. The videos feature patients and physicians sharing their views in four areas: Listening to patients, respecting patients, explaining effectively and spending enough time with patients. (See cover story for more details.)

To watch the four videos, go to:

brainshark.com/bcbsm/patientcommunication
Controlling high blood pressure and A1c testing

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

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

<table>
<thead>
<tr>
<th>Reading</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>139/89 mm Hg or less</td>
<td>18-59</td>
</tr>
<tr>
<td>139/89 mm HG or less</td>
<td>60-85 with diabetes</td>
</tr>
<tr>
<td>149/89 mm HG or less</td>
<td>60-85 without diabetes</td>
</tr>
</tbody>
</table>

**Blood pressure**

- A representative blood pressure is the most recent BP reading taken during the measurement year (by Dec 31) and it occurs after the date of service in which the diagnosis of hypertension occurred. If multiple readings occur in a single visit, the lowest systolic and lowest diastolic is the representative blood pressure and determines BP control.
- Reported blood pressure readings taken by your patient are not considered accurate in diagnosing hypertension.
- Record all blood pressure readings taken during a visit and if initial pressure is high (140/90 or 150/90 or higher for age/condition range), we encourage providers to take a second reading and document it.
- Do not round up blood pressure readings.
- Document lifestyle modifications and treatment changes in member’s medical record, for example, changes in medication dosage, diet, exercise and smoking cessation.
- Initiate pharmacologic anti-hypertensive treatment that includes angiotensin-converting enzyme, or ACE, inhibitor or angiotensin receptor blocker (ARB) if lifestyle changes are not effective.
- Make sure the correct cuff size is used.
- Calibrate blood pressure device regularly according to manufacturer’s recommendations.

**Diabetic HbA1c testing**

- For the Comprehensive Diabetes Care measure, members age 18-75 identified as having diabetes should have a HbA1c test every six months with a goal of 7.9 or below.
- Follow-up visits and testing need to be done every three months until the goal is reached.

If you would like more information about HEDIS®, contact Blue Care Network STARS & HEDIS Operations & Data Management department at HEDIS message-line at 1-855-228-8543.

References:


HEDIS® 2017 Technical Specifications for Health Plans

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Quality Improvement program information available upon request

We provide you with ongoing information about our quality improvement programs and clinical practice guidelines through this newsletter. Approved clinical practice guidelines are available to all Blue Care Network primary care physicians, primary care groups and specialists.

Copies of the complete guidelines are available on our secure provider portal. To access the guidelines:

- Log into web-DENIS.
- Click on BCN Provider Publications and Resources.
- Click on Clinical Practice Guidelines.

The Michigan Quality Improvement Consortium guidelines are also available on the organization’s website. BCN promotes the development, approval, distribution, monitoring and revision of uniform evidence-based clinical practice guidelines and preventive care guidelines for practitioners. BCN uses the Michigan Quality Improvement Consortium guidelines to support these efforts. These guidelines facilitate the delivery of quality care and help reduce variability in physician practice and medical care delivery.

Our Quality Improvement Program encourages adherence to MQIC guidelines and offers interventions focusing on improving health outcomes for BCN members. Some examples include member and provider incentives, reminder mailings, telephone reminders, newsletter articles and educational materials. BCN monitors compliance with the preventive health guidelines through medical record reviews and quality studies.

In 2016, BCN (commercial HMO) ranked in the top 10 percent of all health plans nationally on the following HEDIS measures that address important health improvement goals:

- Adult body mass index monitoring
- Adolescent immunizations
- Colorectal cancer screening
- Breast cancer screening
- Follow-up after hospitalization within seven days for mental illness
- Follow-up after hospitalization within 30 days for mental illness
- Weight assessment and counseling for nutrition and physical activity for children/adolescents
- Comprehensive diabetes care – Nephropathy
- Non-recommended cervical cancer screening in adolescent females

Some measures that scored as needing improvement included:

- Appropriate testing for children with pharyngitis
- Medications management for people with asthma – 75 percent
- Use of first line psychosocial care for children on antipsychotics
- Plan all cause readmissions

Please see Quality Improvement, continued on Page 27
In 2016, BCN Advantage received 4 or 5 Stars in the Centers for Medicare & Medicaid Services star rating and the National Committee for Quality Assurance 90th percentile on the following HEDIS measures that address important health improvement goals:

- Adult BMI assessment
- Breast cancer screening
- Colorectal cancer screening
- Use of spirometry testing in the assessment and diagnosis of COPD
- Comprehensive diabetes care – blood sugar controlled
- Comprehensive diabetes care – eye exams
- Antidepressant medication management – acute phase treatment
- Follow-up after hospitalization within seven days for mental illness
- Follow-up after hospitalization within 30 days for mental illness
- Use of high risk medications in the elderly rate one and two

Some measures that scored as needing improvement included:

- Potentially harmful drug-disease interactions in the elderly
- Plan all cause readmissions
- Pharmacotherapy management of COPD exacerbation – bronchodilator
- Comprehensive diabetic care – HbA1c testing

As a part of our focus on achieving positive health outcomes, the quality improvement program addresses potential quality of care concerns such as patient safety, medical errors and serious adverse events for all products to ensure investigation, review and timely resolution of quality issues.

To ensure accessibility of care to our members, BCN has access and availability standards for the following types of appointments: Preventive care, routine primary care, non-life threatening emergency and urgent care and after-hours access. Our quality management staff monitors access to care. We give physicians who don’t comply with access standards an opportunity to correct their noncompliant status. Find more information in the BCN Provider Manual. Log in to web-DENIS, click on Provider Manual and open the Access to Care chapter.

For additional information about our programs or guidelines, contact our Quality Management department via email at BCNQIQuestions@bcbsm.com, or call us at 248-455-2714.
Blue Cross and BCN drug lists updated, available online

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

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

Reminder: Drug list changes may affect your patients

In the November-December 2016 issue, we told you that certain drugs have been removed from our drug lists because more cost-effective treatments are available.

In that same issue, we told you that select drugs with over-the-counter alternatives aren’t covered for members who use the Custom Drug List.

Before prescribing medications for BCN members, please check to make sure the medication is on the member’s drug list.

Tier changes to some hepatitis C drugs are effective Jan. 1, 2017

Blue Cross Blue Shield of Michigan and Blue Care Network are changing how we manage certain hepatitis C drugs. These changes are effective Jan. 1, 2017.

We’re moving Zepatier™ and Epclusa® to the preferred tier on our drug lists. Drugs on the preferred tier have a lower copayment than drugs on the nonpreferred tier. These drugs require approval before we’ll consider coverage. Zepatier™ will be the preferred drug for patients with genotypes 1 and 4 hepatitis C virus infections. Epclusa® will be the preferred drug for patients for whom Zepatier™ is not indicated.

We are moving Sovaldi®, Harvoni® and Viekira Pak™ to a nonpreferred tier on our drug lists. Members must use a preferred drug before we’ll approve a nonpreferred drug.

Patients currently taking these drugs will be allowed to continue treatment and pay their current copay.
Donor services for basic organ transplants covered under the recipient’s policy

Starting Jan. 1, 2017, Blue Care Network will cover living donor-related services under the recipient’s medical policy when the donor is not a listed member. BCN must have approved the transplant for the recipient. The recipient’s medical policy should only be billed for living donors who are donating to a member on the policy. These changes don’t apply to self-donations or cadaveric donations.

**Basic organ transplant living donor billing guidelines**

When a BCN member is the recipient of a basic organ, continue to follow the usual billing guidelines; submit the claim using the recipient’s name and recipient’s member identification number with the applicable recipient procedure and diagnosis codes.

When a BCN member is the donor of a basic organ, submit the claim using the recipient’s name and the recipient’s member identification number with the applicable donor procedure and diagnosis codes. A non-plan member donor claim will be identified by the donor diagnosis codes in the Z52-code section in the ICD-10-CM code set. According to the Official Coding Guidelines, the Z52- diagnosis codes should be listed as a principal diagnosis code. Providers may also submit an attachment that indicates the patient is a donor; however, this is not required.

If the donor and the recipient are family members with coverage under the same policy, submit the claims using the respective donor and recipient names using the applicable procedure and diagnosis codes for recipient and donor.

This requirement doesn’t change any group benefits. It places the medical necessity and financial responsibility with the recipient. The donor will remain financially harmless. Donor coverage for complications is inclusive of the postoperative care period.

Please see Donor services, continued on Page 30
Donor services, continued from Page 29

### Payment of Donor Charges Under Recipient Coverage

** Applies to BCN Approved Transplants  
** Effective January 1, 2017  

Donor services will be charged to BCN recipient’s medical policy up to the contract limits.

<table>
<thead>
<tr>
<th>IF</th>
<th>“Medical necessity rests on the recipient”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient and donor are both BCN eligible members</td>
<td>Submit claims under recipient’s contract with appropriate donor and recipient procedure and diagnosis codes. Coverage will be provided for the recipient and donor. Donor is not charged</td>
</tr>
<tr>
<td>Recipient has BCN coverage and donor has other insurance</td>
<td>Submit claims under recipient’s contract with appropriate donor and recipient procedure and diagnosis codes. Coverage will be provided for the recipient and donor. Donor is not charged.</td>
</tr>
<tr>
<td>Donor has no coverage, the recipient has BCN coverage</td>
<td>Submit claims under recipient’s contract with appropriate donor and recipient procedure and diagnosis codes. Coverage will be provided for the recipient and donor. Donor is not charged.</td>
</tr>
<tr>
<td>Donor has BCN coverage and recipient has other insurance</td>
<td>Submit claims under recipient’s contract with appropriate donor and recipient procedure and diagnosis codes. Recipient’s plan is billed for the donor charges. If the BCN member donor claim is rejected by the other carrier (not a benefit), then the donor services are charged against their BCN policy. Donor is responsible for his or her cost share.</td>
</tr>
</tbody>
</table>

**NOTE:** If the donor and the recipient are family members with coverage under the same policy, submit the claims using the respective donor and recipient name.

Submit BCN claims only from contracted locations

It’s important that you submit claims for Blue Care Network members only from locations for which you are contracted with BCN. We know providers often have multiple contractual relationships. If you submit a claim for a BCN member from a location that doesn’t have a contractual relationship with BCN, the claim will deny and indicate the member is liable unless BCN has authorized the service to be provided at the noncontracted location.

In the past, BCN pended these claims, looked for BCN contractual relationships and processed these claims if a BCN contract was found. We did this in the past because our system sometimes incorrectly identified a wrong location on a claim. Those situations are now rare and we want to use automated system processing in an effort to keep the cost of health care low for our members and group customers.

As a result, we ask that you be vigilant in billing for BCN members only from locations where you have a contracted BCN relationship. If there’s a specific need to serve a BCN member at a noncontracted location, make sure you request and receive BCN authorization before providing the service.
Coding Corner

Best practices for documenting diabetes

With the implementation of ICD-10-CM and coding classification changes, there are now combination codes for diabetes and its associated conditions and manifestations. Specificity of documentation is more important than ever.

Providers either report Type 1 diabetes for patients who don’t produce insulin or Type 2 diabetes for patients who produce insulin but their bodies don’t use it correctly.

To improve documentation and coding practices, it’s essential that medical records provide details on all diabetes-related conditions to the highest level of specificity known.

When documenting diabetes, consider the following:

• Specify whether it’s Type 1 or Type 2 diabetes. When the type isn’t documented in the medical record, the default code would be for Type 2 diabetes mellitus.
• Is the diabetes due to a condition or a drug? If it’s due to a drug, indicate which one.
• Is this a secondary type of diabetes? If so, what’s the cause?
• Specify when diabetes is gestational.
• Was there an incidence of underdosing or overdosing (poisoning)? For example: Did the patient receive too much or not enough insulin?
• Document current status on the diabetes and all associated conditions.

How to improve progress notes

Only providers can diagnose a patient’s medical condition, making documentation even more important. Even if a medical coder can recognize the inference of a condition, only what is documented can be coded.

Example: Type 2 diabetes mellitus with macular edema

1. It is necessary to also document retinopathy; “Diabetes, retinopathy, with macular edema” – E11.311

For instance, if a patient has two medical conditions that are linked, then his or her provider should document that the conditions are related. This allows coders to use a combination code, which is a single code used to describe two diagnoses (a diagnosis with either an associated manifestation or complication).

Example: Type 1 diabetic mellitus with severe nonproliferative diabetic retinopathy with macula edema

Please see Coding Corner, continued on Page 32
Coding Corner, continued from Page 31

Here are three examples of when a report lacks documentation or doesn’t properly link two conditions:

1. A patient visits his podiatrist for an annual diabetic exam. The podiatrist documents a prescription for new shoes. The assessment shows the patient is instructed to return in one year.

   **What’s wrong with this documentation?**
   - The medical coder can’t code the patient’s medical condition as diabetes because the provider didn’t document the patient as being diabetic.
   - The annual diabetic exam may have only been for monitoring purposes; it doesn’t prove the patient has the condition.

2. A patient visits his podiatrist for an annual diabetes exam. The podiatrist documents a prescription for new shoes. The assessment shows the patient understands the importance of checking his feet, because his diabetic condition makes his feet prone to other health issues.

   **What’s wrong with this documentation?**
   - The provider’s note only states the patient is diabetic.
   - The documentation should state any linked or additional diagnoses. Peripheral neuropathy maybe suspected based on the prescription for diabetic shoes, but the provider didn’t document that condition.

3. A patient visits his podiatrist for an annual diabetes exam. The podiatrist documents a prescription for new shoes. The assessment shows peripheral neuropathy and that the patient understands the importance of checking his feet, because his diabetic condition makes his feet prone to other health issues.

   **What’s wrong with this documentation?**
   - The documentation doesn’t support a relationship between the two conditions. Therefore, they would be coded as two separate diagnoses instead of diabetes with a manifestation or complication.
   - To link two medical conditions together, there needs to be verbiage in the record such as “with,” “due to” or “associated with.”

It’s equally important for everyone involved in the patient’s care to understand the relationship of the conditions found in the progress notes. Documenting the cause and effect of a condition in the medical record provides a complete picture of the patient’s office visit.

It’s the health care provider’s responsibility to document when diabetes mellitus is not the underlying cause of other conditions. The fact that a patient has two or more conditions that commonly occur together doesn’t necessarily mean they are related.

The ICD-10 code assignment is crucial in determining the correct reimbursement for these face-to-face encounters and for tracking health care services provided for a diabetic condition.

Requirements for reporting diabetes mellitus and its associated illnesses are located in the ICD-10-CM coding book, “Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00 – E89).”

References: Coding Clinic, First and Second Quarter Issues, 2016

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.
Evaluation and management coding

Blue Care Network continues to identify a high incidence of over-coding for certain evaluation and management services and will be expanding the clinical editing program developed to address this issue. Initially a small number of physicians were identified as outliers and were notified by letter of their inclusion in this program initiated in December 2015.

Effective for claims submitted beginning Feb. 15, 2017, the program is being expanded and will include additional physicians identified as outliers. Letters have been mailed to newly selected physicians explaining the clinical editing process. For physicians currently in the program, no changes are being made; they will remain in the program.

BCN recommends that physicians carefully code each service provided according to national guidelines and that the office documentation supports the code reported. You can learn more about the coding guidelines, including the evaluation and management documentation, by referencing the Center for Medicare & Medicaid Services Evaluation and Management Services Guide.

If you disagree with a clinical edit on an evaluation and management service, you have a right to file an appeal. Follow the clinical editing appeal process as described in the BCN Provider Manual Claims chapter. BCN will review the medical records submitted, assess the intensity of service and complexity of decision-making for the evaluation and management services documented. BCN will make a determination based on the documents and the medical necessity of the evaluation and management service.

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:

- ICD-10-CM sequela coding
- Modifier 25 – should it be reported or not?
- Chest X-rays in asymptomatic patients
- Dual-energy X-ray absorptiometry (DXA) bone density screening
Question:
We have male patients that receive Testopel. Testopel is testosterone hormone pellet that is implanted by our specialist for testicular hypogonadism.

A patient received 16 pellets on one date of service and we received partial payment for 10 pellets, but not for the remaining six. The denial stated, “The service isn’t payable because the units reported exceed the maximum allowed. The patient is responsible.” What is the maximum allowed per day? We have a valid prior authorization for his pellets.

Testopel 75mg
HCPCS: S0189
CPT: 11980
ICD10: E29.1

Answer:
The current limit on this procedure code, S0189 is 10.

When you receive a clinical edit such as the one you did, you have the option to submit a clinical editing appeal. You need to submit the clinical editing form along with relevant clinical documentation. If there is information from the drug company that dosage recommendations have changed or vary based on a patient’s particular diagnosis, you can also submit that information.

Clinical editing appeals must be filed within 180 days of the original clinical editing denial. Information on the process and the clinical editing form are located in the BCN Provider Manual in the Claims chapter.

Question:
When I appealed a clinical edit, it was returned stating that the documentation did not support the service provided. It was for alcohol misuse screening, procedure code G0442. The records noted that we asked the patient about his use of alcohol, so I am not sure why it wasn’t covered.

Answer:
Some of the procedure codes are time-based. This is one of them; the nomenclature states ‘Alcohol abuse misuse screening, 15 minutes.’ Therefore, the documentation in the medical record must support the time spent providing the service. The provider has to note the minutes spent or start and end time. Additionally, the medical records must contain what interventions were conducted during that time and the outcome. In other words, it should say more than ‘alcohol screening and counseling done.’

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. Contact your provider consultant if your question is urgent or time sensitive. Do not include any personal health information, such as patient names or contract numbers.
Blue Care Network’s recently updated web-DENIS Billing/Claims web page offers a variety of resource materials that can help make billing easier for you.

One of the important sections on this page is the link to authorization and referral information. This link opens BCN’s web-DENIS Authorizations/Referrals web page. There you’ll find links to information on the following topics:

- Authorization and referral guidelines
- Medical necessity criteria
- Procedures managed by eviCore healthcare
- Woman’s Choice
- Pediatric Choice
- Bariatric surgery

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:

1. Visit bcbsm.com/providers.
2. Click Login and log in to Provider Secured Services using your user name and password.
3. Click BCN Provider Publications and Resources at the right on the Provider Secured Services Welcome page.
4. Click Billing/Claims.
Reminder: Use NovoLogix web tool for authorizations for drugs covered under the medical benefit

Dec. 1 was the date for the changeover to the NovoLogix web tool for authorizations for drugs covered under the Blue Care Network medical benefit. (This is a change from the earlier date of Oct. 1, which was delayed.)

Several resources are available to help BCN providers familiarize themselves with the NovoLogix web tool. These tools are available on the Medical Benefit Drugs (Pharmacy) page in the BCN section of ereferrals.bcbsm.com.

Many providers are already familiar with the NovoLogix web tool from authorization requests they submit for their Blue Cross members.

Obstetrician-gynecologists can refer to specialists

Obstetrician-gynecologists and gynecologists can refer their patients for OB-GYN related specialty services. While we believe the patient’s total care, including the coordination of care by specialists, is best managed by the primary care physician, OB-GYN providers can issue referrals to specialists for obstetrical or gynecological related items and services without patients needing to obtain referrals from their primary care physicians. OB-GYN providers should use e-referral to refer their patients.

For detailed information, see full article on Page 1.

Reminder: Authorization criteria now available for certain surgeries

Authorization criteria, also called medical necessity criteria, are 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.

Please see the full article on Page 42 of the November-December 2016 issue.
BCN changing inpatient readmission review guidelines starting Jan. 17, 2017

Starting Jan. 17, 2017, BCN is changing the guidelines it uses to review inpatient readmissions of BCN HMO℠ (commercial) and BCN Advantage℠ members for billing purposes. Under the updated guidelines, BCN will combine admissions for members readmitted within 30 days for the same or a related condition whether or not discharge criteria were met.

Currently, the admissions are typically billed separately as long as the member met the discharge criteria and had an appropriate discharge plan, even if the readmission was for a new occurrence of the same condition.

The Guidelines for Bundling Admissions document is being updated to reflect this change. The updated document will be available online before Jan. 17.

You can access that document at bcbsm.com/providers.
1. Click Login and log in as a provider, using your user name and password.
2. Click BCN Provider Publications and Resources.
3. Click Billing/Claims.
4. Click Guidelines for Bundling Admissions.
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