BCN Advantage starts out year as Excellent

The National Committee for Quality Assurance has awarded Blue Care Network an “Excellent” status for our Medicare HMO/POS products. NCQA is the gold standard of care that evaluates plans on their ability to deliver quality, cost-effective care.

Last year, BCN Advantage℠ missed “Excellent” accreditation by less than 0.1 point. For 2017 (based on 2016 data), BCN Advantage’s HEDIS® score increased by more than one point making up the necessary points needed to reach the Excellent threshold of 90.

Much of the work that helped BCN Advantage earn 4.5 stars also helped catapult our HEDIS scores. The increase in HEDIS points was driven by five measures increasing to the 90th percentile, two measures increasing to the 75th percentile and only three measures dropping in percentile.

Please see Excellent, continued on Page 2

Update your information online with Atlas Systems

Blue Cross Blue Shield of Michigan and Blue Care Network have a contract with Atlas Systems to ensure the information we have on file about the providers in our network (address and phone, for example) is accurate and up to date.

Atlas Systems has an online portal called PRIME-Hub, which lets you or your staff confirm your practice’s information and send it directly to Blue Cross and BCN. Every quarter, Atlas Systems will contact your office to remind you to visit PRIME-Hub and verify your data. It only takes a couple of minutes to do, and having accurate information helps our members find you, giving your practice better visibility.

To get started, visit primeatlas.com and click on Provider Login. First-time users can register by creating a user name and password.

Once you or your designated staff person logs in, it takes just four steps to update each provider record specific to that location. Just verify or update your information, hit the

Please see Atlas Systems, continued on Page 2
Excellent, continued from Page 1

The 2016 HEDIS measures with increases to 90th percentile:

- Adult BMI assessment
- Colorectal cancer screening
- Use of spirometry testing in the assessment and diagnosis of COPD
- Antidepressant medication management
- Comprehensive diabetes care — eye exams

Incentive programs for colorectal screening and diabetes care were especially effective in increasing our scores and improving member health.

“Earning NCQA Excellent accreditation is a big accomplishment for us,” said Belinda Bolton, director of Quality Management. “It assures seniors that they are buying a quality plan when they pick BCN Advantage.”

BCN Advantage was also named one of the top rated Medicare Advantage plans in Michigan according to U.S. News & World Report.

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

Atlas Systems, continued from Page 1

Confirm button, and PRIME-Hub takes care of the rest. You’ll receive a confirmation email or fax for your records. It’s fast, it’s easy and it’s free.

You’ll use PRIME-Hub only to confirm the accuracy of your current information. It doesn’t replace the usual enrollment and change procedures you follow with Blue Cross and BCN. Providers who consistently fail to update their information will be excluded from Blue Cross provider directories and may be terminated from Blue Cross and BCN networks.

Atlas Systems has an online chat, or call 1-844-334-9694 from 9 a.m. to 6 p.m. Monday through Friday if you have questions or need to speak with a PRIME-Hub Customer Service representative.

We’re making it easier for you to share your information with us

Later this year, we plan to make it easier for you to share your attestations with Blue Cross and BCN by partnering with DirectAssure™, a CAQH Solution®. DirectAssure eliminates the need for each health plan to contact every provider in their network to obtain timely, correct information. Working in concert with CAQH ProView, DirectAssure will allow health care providers to update and confirm their directory information in one place, where it can be shared with participating health plans.

To increase the accuracy of your information in Blue Cross and BCN directories, we require all providers to attest to their current data that we have on record with Atlas Prime-Hub. In addition, we strongly recommend you continue to update your CAQH ProView information for a smooth transition when Blue Cross and BCN adopt DirectAssure.
Case management services available through BCN

**BCN no longer reimburses physicians for these services**

Blue Care Network will no longer pay for codes to reimburse physicians for care management services. We mentioned in our last issue that we no longer participate in the provider-delivered care management program for primary care physician offices through the Michigan Primary Care Transformation project, known as MiPCT.

Providers may refer BCN members to the BCN case management program. Here are some of the common referral criteria for BCN case management:

- Utilization such as frequent emergency room utilization and multiple readmissions
- Medical diagnosis such as oncology, pediatrics, high risk OB, kidney disease, organ transplants, chronic obstructive pulmonary disease, congestive heart failure, myocardial infarction, spinal injury, stroke, multiple sclerosis, brain injury and chronic conditions such as asthma, hypertension, diabetes and heart disease
- Catastrophic illness
- Complex health care needs such as home care needs for multiple conditions, multiple comorbidities with complications, compliance issues or medication adherence issues
- Behavioral health care needs

To refer a BCN member, call 1-800-943-9744 and leave a message with the following information:

- Member name
- Date of birth
- Reason for referral
- Member phone number
- Physician contact information

A BCN case manager will contact the member to engage in the program.

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Check out our videos on effective patient communication

Can you use some tips to help increase patient compliance with your advice? Do you need new strategies for managing your time with patients? Watch our series of physician-patient communication videos we created.

The videos feature patients and physicians sharing their views in four areas:

- Listening to patients
- Respecting patients
- Explaining effectively
- Spending enough time with patients

To watch the four videos, go to: [brainshark.com/bcbsm/patientcommunication](brainshark.com/bcbsm/patientcommunication).
Provider forums coming to a town near you

Blue Cross Blue Shield of Michigan and Blue Care Network provider forums are coming to you. While we don’t have all of the details yet, we’d like you to be able to hold the date for when we’ll be in a town near you. The list of dates and locations are listed here. Watch the next issue of this newsletter or look to future issues of The Record for details on the topics that will be covered and registration information.

We hope we’ll see you there.

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<tr>
<th>Forum location city</th>
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<th>Time</th>
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<td>Port Huron</td>
<td>DoubleTree by Hilton 800 Harker St, Port Huron, MI 48060</td>
<td>Wednesday, May 10</td>
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<td>Professional providers</td>
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<tr>
<td>Ann Arbor</td>
<td>Courtyard Marriott 3205 Boardwalk Dr, Ann Arbor, MI 48108</td>
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<td>Novi</td>
<td>Crowne Plaza 27000 Karevich Dr, Novi, MI 48377</td>
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<td>Pontiac/Auburn Hills</td>
<td>Hilton Suites 2300 Featherstone Rd, Auburn Hills, MI 48326</td>
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<td>Grand Rapids</td>
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<td>Professional providers</td>
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<td>Kalamazoo</td>
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<tr>
<td>Sterling Heights</td>
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<tr>
<td>Traverse City</td>
<td>West Bay Beach 615 E Front St, Traverse City, MI 49686</td>
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<tr>
<td>Okemos</td>
<td>Holiday Inn Express &amp; Suites 2209 University Park Dr, Okemos, MI 48864</td>
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<td>Professional providers</td>
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<tr>
<td>Marquette</td>
<td>Holiday Inn 1951 US-41, Marquette, MI 49855</td>
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<td>9 a.m. to 5 p.m.</td>
<td>Professional providers</td>
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<tr>
<td>Marquette</td>
<td>Holiday Inn 1951 US-41, Marquette, MI 49855</td>
<td>Wednesday, June 28</td>
<td>9 a.m. to 5 p.m.</td>
<td>Facility providers</td>
</tr>
</tbody>
</table>
Tell us your thoughts about
**BCN Provider News**

**You can win a $25 gift card**

We implemented a redesign of **BCN Provider News** with the May-June 2016 issue and want to know your **thoughts**.

The newsletter now features a streamlined design. Here are some of the things we changed:

- We simplified the color palette and use shades of blue instead of several colors.
- We bumped up the type size a bit to make articles easier to read.
- We redesigned the front page so we can fit more news on the cover.

We kept our traditional sections and navigation so you can still find all the news you need whether you’re a provider, medical assistant, referral coordinator or biller.

Before the redesign, we conducted a short survey to gauge your thoughts about the newsletter and your responses were overwhelmingly **positive**. We used your feedback to make small design changes to improve readability.

Now we’d like your feedback once more to see if the newsletter continues to be a useful source of information for you and others in your office. You can win a gift certificate for $25.

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**About the survey**

Please complete the **online survey** by April 13. You could win a $25 gift certificate.

Participation in the survey is not necessary to win. The drawing is open to all active BCN providers. Enter by completing the survey no later than **April 13, 2017**, or by sending an email with your name, phone number and “Survey drawing” in the subject line to **BCNProviderNews@bcbsm.com** by April 13.

One winner will be selected in a random drawing from among all eligible entries. The winner will receive a $25 gift card. The drawing will take place shortly after April 13. The winner will be notified by telephone or email after the drawing.
Plan medical directors work with affiliated practitioners and providers to ensure appropriate care and service for Blue Care Network members. Plan medical directors are available throughout the state.

Our medical directors:

- Provide clinical support for utilization management activities, including investigation and adjudication of individual cases
- Assist in the design, development, implementation and assessment of clinical protocols, practice guidelines and criteria that support the appropriate use of clinical resources
- Adjudicate provider appeals
- Work with physicians and other health care providers to improve performance with regard to clinical outcomes, appropriate use of clinical resources, access to services, effectiveness of care and costs
- Serve as a liaison with the physician community

Clinical review decisions are based solely on appropriateness of care

Utilization decisions regarding care and service are based solely on the appropriateness of care prescribed in relation to each member’s medical or behavioral health condition. BCN’s clinical review staff doesn’t have financial arrangements that encourage denial of coverage or service that would result in underutilization. BCN-employed clinical staff and physicians don’t receive bonuses or incentives based on their review decisions. Review decisions are based strictly on medical necessity within the limits of a member’s plan coverage.

Providers may discuss decisions with BCN physician reviewers

Blue Care Network demonstrates its commitment to a fair and thorough process of determining utilization by working collaboratively with its participating physicians.

BCN’s plan medical directors may attempt to contact the treating health care practitioner for more information in regard to any review. When BCN doesn’t approve a request, we send written notification to the appropriate practitioners and providers, as well as the member. The notification includes the reason the service wasn’t approved and the contact numbers for BCN’s plan medical directors. Practitioners may discuss any decision with a plan medical director.

If you’re a practitioner and would like to discuss your patient’s condition or treatment with one of our plan medical directors, call 248-799-6312 between 8 a.m. and 4:30 p.m. Monday through Friday. To discuss an urgent case with one of our plan medical directors after normal business hours, call 1-800-851-3904.

How to obtain a copy of Care Management criteria

Upon request, Blue Care Network provides the criteria used in the decision making process. Call Care Management at 248-799-6312, from 8 a.m. to 4:30 p.m., weekdays for more information.

Due to licensing restrictions, BCN can’t distribute complete copies of the InterQual® criteria to all practitioners and providers. However, all contracted hospitals have copies of the criteria as part of BCN’s licensing agreement.

For more information about purchasing copies of InterQual criteria, call McKesson Health Solutions, InterQual Support, at 1-800-274-8374.

Staff available to members for utilization management issues

Did you know that we’re available for our members to discuss utilization management issues during normal business hours and after hours? Our staff identifies themselves by name, title and organization when receiving or returning calls. We also provide language assistance free of charge to discuss utilization management issues to our members. We offer TTY/TDD assistance for the hearing impaired. Please tell your patients to call the number on the back of their ID card for information about our communication services.
Blue Care Network is closed April 14

Blue Care Network offices will be closed April 14 for Good Friday.

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.

Don’t 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.

Blue Care Network making changes to PARS

Coming soon, claims information will be available through our Provider Automated Response System, or PARS, allowing providers to complete inquiries faster.

Stay tuned for updates on the claims information that will be available.
BCN Advantage new incentive encourages Basic and MPSERS plan members to visit their doctors

BCN AdvantageSM has expanded its member incentive for BCN AdvantageSM HMO-POS Basic to include MPSERS members to encourage them to visit their primary care physicians for an annual physical.

Our goal is to get members focused on visiting their doctor earlier in the year. BCN wants doctors to document their diagnoses and close their HEDIS® gaps. Doctors will receive an incentive through the current Stars program.

Members will receive a $50 gift card choice — Meijer, Walmart, CVS or Amazon — if they visit the doctor and one of the wellness and physical exam visit codes is entered on the claim. Members will be required to complete an attestation form confirming that they visited the doctor. The form needs to be signed by the member and the primary care physician.

In the meantime, BCN Advantage is also reminding these members about the importance of preventive services, such as mammograms, diabetes testing, flu vaccines and retinal eye exams, by mailing them letters and by including information about the procedures in the incentive program materials.

Wellness and physical exam codes

*99385
*99386
*99387
*99395
*99396
*99397
G0438
G0439
G0402

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*CPT codes, descriptions and two-digit modifiers only are copyright 2016 American Medical Association. All rights reserved.
Aspirin use prevents heart attacks and strokes

Our Chronic Care Improvement program, designed to prevent cardiovascular disease in BCN Advantage℠ members, is in its fifth and final year. This program is using clinical interventions promoted by Million Hearts® to prevent 1 million heart attacks and strokes in the United States by 2017. Million Hearts is a national public initiative led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services.

Improving heart health includes optimizing care in the clinical setting by managing the “ABCS” – Aspirin for high-risk patients, Blood pressure control, Cholesterol management and Smoking cessation. High performance on these measures leads to fewer disabling and deadly cardiovascular events.

Aspirin for high-risk patients

The Million Hearts initiative and the Michigan Quality Improvement Consortium guideline for the management of diabetes mellitus both recommend aspirin use for high-risk patients unless contraindicated.

We’re dedicated to the Million Hearts goal of increasing aspirin use when appropriate to reduce disabling and deadly cardiovascular events. Please talk to your patients about aspirin use and prescribing it when indicated.

For more information about the initiative, visit the Million Hearts website.

BCN Advantage’s CMS Million Hearts Incentive Program is available for practitioners to achieve the goals of preventing cardiovascular disease in BCN Advantage members. Aspirin or antiplatelet therapy is included in the 2017 Performance Recognition Program for BCN Advantage Million Hearts members. This program is available on BCN Health e-Blue web.

Heart disease is the leading cause of death in the United States according to the CDC. Physicians are crucial to improving cardiac disease health outcomes. We value your commitment to positively affecting the health and well being of members.
Integrating fall prevention into practice

The risk of falling and sustaining an injury increases with age. Falling once doubles the chances of falling again. Among older adults, falls are the leading cause of both fatal and nonfatal injuries. One in 4 adults age 65 and older fall each year, but less than half talk to their health care providers about it, according to the Centers for Disease Control and Prevention. It’s an important conversation to have and since fall risk prevention is a HEDIS® measure, please be sure to document your discussions and interventions related to fall risk and prevention in the patient’s medical record.

Falls aren’t only associated with morbidity and mortality in the older population, but are also linked to poorer overall functioning and early admission to long term care facilities. For the older population, effective fall prevention initiatives have the potential to reduce serious fall-related injuries, emergency room visits, hospitalizations, nursing home placements and functional decline. Health care providers can lower a person’s risk for falling by reducing or minimizing an individual’s modifiable risk factors in the following ways:

• Be proactive; ask all patients 65 and older if they have fallen in the past year.

• Identify and address fall risk factors such as:
  - Lower-body weakness
  - Gait and balance problems
  - Chronic medical conditions such as diabetes, stroke, urinary incontinence and dementia
  - Psychotropic medication use and polypharmacy
  - Postural dizziness
  - Poor vision
  - Problems with feet or shoes
  - Home safety

• Refer, as needed, to specialist or community programs.
• Follow up with the patient within 30 days.

Please see Fall prevention, continued on Page 11
Fall prevention, continued from Page 10

Key fall prevention interventions may include one or more of the following:

- Provide patient education and information on fall prevention.
- Enhance strength and balance through a customized exercise program.
- Minimize medications, if appropriate, to include reduction or discontinuation of any psychotropic medications.
- Manage postural hypotension.
- Supplement vitamin D and calcium, as needed.
- Manage foot and footwear problems.
- Treat visual impairment.
- Optimize home safety by discussing with the patient safety measures such as reducing clutter in the home, installing handrails on stairways and grab bars in the bathroom, and improving lighting in the bedroom and hallways.

Staying active and participating in an exercise program is a good way for your elderly patients to prevent falls. Your BCN Advantage members may have access to basic fitness services at gyms and fitness centers located around the state. SilverSneakers® is a fitness program available to some BCN Advantage members. SilverSneakers offers amenities such as exercise equipment and fitness classes designed specifically for older adults and taught by certified instructors. Personal advisers assist members to create a plan designed to meet their needs.

BCN Advantage members can check to see if they have access to the SilverSneakers program by calling 1-866-584-7352.

While you may not be able to prevent all falls, you can reduce the risk of fracture in some patients by screening for and managing osteoporosis effectively. Osteoporosis increases the risk for fractures from falls and bumps that wouldn’t hurt a person with healthy bones. Osteoporotic fractures, or fragility fractures, occur as a result of a fall from a standing height or less without major trauma.¹

BCN endorses Michigan Quality Improvement Consortium’s evidence based clinical practice guidelines for the management and prevention of osteoporosis. For more information on the MQIC guidelines for assessment and management of your patients to reduce fracture risk due to osteoporosis, go to the MQIC website.

For more information on fall risk prevention and additional tools you can use to assess your patient’s risk for falls, refer to the Stopping Elderly Accidents, Deaths and Injury (STEADI) toolkit, designed specifically for health care providers.

Hospitals must give BCN Advantage members receiving outpatient observation services the Medicare Outpatient Observation Notice

The Centers for Medicare & Medicaid Services requires hospitals to give a Medicare Outpatient Observation Notice to Medicare beneficiaries receiving outpatient observation services for more than 24 hours.

BCN Advantage™ encourages providers to start giving these notices immediately. A copy of the Medicare Outpatient Observation Notice customized for BCN Advantage members and the instructions for using it are available on the web. To get to these documents, complete the following steps:

2. Click BCN.
3. Click Forms.
4. Look under the BCN Advantage heading.

The Medicare Outpatient Observation Notice is a standard notice that lets the member know that:

- He or she is an outpatient receiving observation services, not an inpatient of the hospital
- The reasons he or she is receiving observation services
- How the observation services affect his or her cost-sharing obligations and post-hospitalization eligibility for coverage of skilled nursing facility services

The notice must be delivered no later than 36 hours after observation services begin, or sooner if the member is transferred, discharged or admitted.

The BCN Advantage chapter of the BCN Provider Manual has been updated with this information. The revised chapter is available on the Provider Manual Chapters page in the BCN section at ereferrals.bcbsm.com.

More information about this requirement is available on the Beneficiary Notices Initiative page of the CMS website.
Smoking is in retreat: Keep up the pressure

By Duane DiFranco, M.D.

Blue Care Network appreciates all of the effort our providers make in our collective efforts to reduce the amount of harmful tobacco use in our great state. We should applaud our gains, but stay in the fight. We still have work to do.

The most recently available data on smoking rates comes to us from our annual Consumer Assessment of Healthcare Providers and Systems, or CAHPS, survey. The results help us benchmark our performance as a health plan against the nation and against other Michigan health plans.

The national smoking rate, according to the most recent CAHPS data, is 16.2 percent. For the past three years BCN has been mounting a relentless anti-smoking campaign. It seems as though our efforts may be starting to pay off. From 2015 to 2016, the smoking rate among our members fell by almost 20 percent — from 16 percent to 12.8 percent. That is the largest drop among any Michigan plan in the last three years.

Our providers deserve most of the credit. You’re well aware of the importance of smoking prevention and you know how even briefly stated advice and information can increase a patient’s chances of successfully quitting.

According to the Centers for Disease Control and Prevention, smoking is responsible for 20 percent of all deaths in the U.S., including 90 percent of all deaths related to chronic obstructive pulmonary disease and 85 percent of lung cancer deaths. Smoking increases a person’s risk of developing both coronary artery disease and stroke by up to 400 percent and it increases a person’s risk of developing many forms of non-lung cancer by up to 3,000 percent. Men and women who smoke are more likely to be infertile and the children of mothers who smoke are more likely to be born prematurely, to suffer from low birth weight and die of sudden infant death syndrome.

The good news is that studies have shown that the advice to quit, when delivered in a health care setting and especially when coupled with information regarding medications and strategies, improves a patient’s chance of success.*

Because the advice to quit that you give to your smoking patients is so important, CAHPS also measures the rate at which the advice to quit is delivered. Our providers consistently tell us that they advise smokers to quit at each and every visit. There must be ways to make those encounters even more memorable, since only 87 percent of our smoking members who have had office visits in the preceding year indicate that their doctor or other health care professional advised them to quit.

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

We want to help. Last year we added a smoking advice measure to our Performance Recognition Program. Unfortunately, it was a bit unwieldy and uptake was lower than desired. This year we’re examining the possibility of fee increases for smoking cessation counseling. We’re also going to be distributing office materials — posters and waiting room pamphlet dispensers — to help get advice into our members’ hands. We recently launched a new social media campaign and in its first month it has reached more than 25,000 Michiganders.

Due in large part to your strong efforts, BCN’s campaign to reduce smoking among its members has had success. We still have a way to go together, so make those advice sessions memorable and look to us for help.

References
CDC Online Reference: https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm


Blue Care Network’s Adult Kidney Health Management Program offers support to members diagnosed with chronic kidney disease. The program emphasizes screening members at risk for developing CKD (including those with hypertension or diabetes), monitoring and treatment to prevent or delay disease progression and to facilitate referral of patients to nephrologists when indicated for treatment of progressive or advanced disease.

The program is based on the Michigan Quality Improvement Consortium’s Guideline for the Diagnosis and Treatment of Adults with Chronic Kidney Disease. The guideline is posted on the MQIC website at mqic.org

Program goals include:
- Increase annual assessments of glomerular filtration rate in members at risk for kidney disease or with kidney disease (identified as having hypertension or diabetes or GFR <45 ml/min/1.73m²)
- Annual assessment of urine albumin or protein in members with diabetes not filling prescriptions for ACE-1 or ARB medications
- Increase use of ACE inhibitors or angiotensin receptor blockers to slow progression of CKD in members with GFR between 44-15 ml/min/1.73m²
- Increase referrals to nephrologists for members with advanced disease GFR <30 ml/min/1.73m² who aren’t receiving renal replacement

Please see Kidney health, continued on Page 15
Kidney health, continued from Page 14

BCN identifies members for the program through the following:
- Medical and pharmacy claims related to hypertension, diabetes, CKD
- Laboratory results for serum creatinine tests
- Claims for urine albumin/protein tests

We also accept referrals to the program from physicians, other BCN departments, member health assessments and member self-referral. Identified members are automatically enrolled in the program, but may opt out by notifying BCN’s Chronic Condition Management department.

We implement interventions based on MQIC criteria:
- **Members with diabetes and hypertension at risk for developing stage 1 and 2 CKD** should be encouraged by their primary care physician to have an annual GFR and work with their physician to keep their blood pressure under control. Physicians should encourage members to avoid nonsteroidal anti-inflammatory drugs.
- **Members with stage 3A CKD and a GFR 45-59ml/min/1.73m²** receive self care educational booklet about kidney health management, a personal health card and a CKD management plan. They also receive reminders about needed and available services such as annual assessment of GFR, urinary and albumin excretion (if not on ACE-I or ARB) as well as program newsletters.
- **Members with stage 3B CKD and GFR between 30-44ml/min/1.73m² and members with stage 4 CKD with GFR between 15-29ml/min/1.73m²** receive a program introductory letter and packet, reminders for needed services including ACE-I or ARB treatment, blood pressure control, lipid management, smoking cessation and glycemic control (if diabetic). They also receive information about avoiding nephrotoxic drugs, including nonsteroidal anti-inflammatory drugs and iodine contrast.

BCN’s Kidney Health program, in concordance with MQIC guidelines, recommends that members with stage 4 or unstable stage 3B CKD be referred to a nephrologist for counseling and management including assessment of calcium and phosphate balance, bone health, anemia, vaccinations, ESRD planning and advance directives. A reminder letter is sent to the primary care physician about referring the member to a nephrologist. These members may also be enrolled in BCN’s Case Management Program.

- **Members identified with stage 5 CKD (GFR <15 ml/min/1.73m²) on dialysis** are referred to a BCN specialty case management program for dialysis management.

When your member is enrolled in the adult kidney health program, you receive the following support from BCN:
- Notification of your individual patients meeting the above criteria via Health e-Blue® reports
- Health e-Blue reports display of members overdue for testing and medication refill
- Program assistance from a registered nurse chronic condition management specialist at 1-800-392-4247, from 8:30 a.m. to 5 p.m., Monday through Friday, (holidays excluded)
- Case management nurse assistance at 1-800-392-2512, from 8 a.m. to 5 p.m., Monday through Friday (holidays excluded)
- Customer service assistance at 1-800-662-6667, from 8:30 a.m. to 5 p.m., Monday through Friday, (holidays excluded)
- Chronic condition management information at bcbsm.com
- Personal health management website
- BCN’s pharmacy benefit manager performs concurrent evaluation to identify potential drug related interactions

To learn more about BCN’s Kidney Health Management program or to refer a member, call the Chronic Condition Management department at 1-800-392-4247, from 8:30 a.m. to 5 p.m., Monday through Friday, (holidays excluded).
Discussing low back pain treatments with patients

Low back pain is a common problem for many adults. In fact, as many as 80 percent of all adults will have low back pain at some point in their lifetime, according to the National Institute of Neurological Disorders and Stroke. It’s the most common cause of job-related disability and a leading contributor to missed work days.

Causes of low back pain
The most common causes of low back pain are muscle strains and sprains. These injuries often happen from improper lifting, twisting or overstretching.

In many cases, low back pain will get better on its own after a few days or weeks without the need for any imaging tests, such as an X-ray, MRI or CT scan, unless they’ve had:
- Back pain for longer than six weeks
- Weight loss
- Fever
- Loss of bladder or bowel control
- Loss of feeling or strength in the legs
- Problems with reflexes
- History of cancer

Treatments for low back pain
In most cases, starting with self-care and medicines is all that’s required to treat low back pain. If these treatments don’t relieve your patient’s pain, he or she may need another type of treatment.
- **Heat or ice.** Hot or cold packs can help reduce swelling and relieve pain.
- **Rest.** A day or two of rest may be good for back pain, but more than this may cause more harm than good. Instruct your patients to try lying on their back with pillows propped up under their knees to relieve the pressure on the back.
- **Exercises or physical therapy.** Prescribing specific exercises to help stretch and strengthen the back muscles may also be helpful, as well as a physical therapy program.
- **Pain relievers.** You may want to suggest starting with over-the-counter medicines to help relieve the pain and inflammation of low back pain. These include nonsteroidal anti-inflammatory drugs, such as ibuprofen, naproxen sodium and ketoprofen. If NSAIDs don’t help, stronger pain relievers may be necessary.
- **Surgery.** This may be an option if other treatments don’t work. In most cases, surgery is only used to repair serious injuries or relieve a compressed nerve.

As we’ve discussed in previous issues of the BCN Provider News, Choosing Wisely is a great place to look for information on health topics. They have valuable information on treating low back pain and imaging tests for low back pain. Visit choosingwisely.org for low back treatment and imaging tests for low back pain information.

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

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

**Blue Care Network uses McKesson’s InterQual Level of Care to conduct 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. This issue, we clarify the criteria and documentation BCN needs to review certain neurological admissions.

**General Medical Neurologic Page 614**

Acute criteria for Neurologic deficit, new onset (excludes TIA/Stroke):

**Under Finding:**

1. Documentation must include the presenting neurological deficit.
2. If using *paresis or paralysis*, documentation must indicate the reduction in voluntary movement or the complete loss of movement. General weakness or inability to move limbs from a non-neurologic cause are excluded from this criteria.

**BCN local rule**

In applying InterQual® criteria to different benefit packages, BCN has adopted local rules. These local rules apply to all BCN commercial and BCN Advantage members statewide. Our local rule for the above InterQual criteria states that BCN can approve up to 48 hours of observation to complete workup and obtain a definitive diagnosis or stabilize the member for discharge.

This means that if the member presents and has one of the neurological deficits noted under findings and both interventions are met, the member must be in observation status for 48 hours.

- If after the 48 hours the member still requires treatment for a known diagnosis, then an inpatient stay may be approved.
- If the member has a diagnosis, doesn’t require further treatment, and is stable for discharge within 48 hours or less, then the observation stay will remain authorized.

**Members benefit from Chronic Condition Management Programs**

Members identified with select chronic illnesses are automatically enrolled in one or more of the following Blue Care Network Chronic Condition Management programs:

- Asthma (adult and child)
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Ischemic heart disease
- Heart failure
- Kidney health management

The goal of chronic condition management is to help members understand and manage their condition and identify gaps in care. We mail educational materials to members that include information about self-management, preventive health issues, relevant medical tests, lifestyle issues and medication compliance. Registered nurses, acting as case managers, make outreach calls to identified members.

We welcome referrals to our programs from providers and can help improve your members’ health by working as part of your team. Membership is voluntary and members can opt out of the program at any time. Call 1-800-392-4247 for more information. For information on the Depression program call Behavioral Health at 1-800-482-5982.

BCN commercial and BCN Advantage™ HMO-POS members can also get help quitting tobacco use by calling our tobacco cessation program powered by WebMD® at 1-855-326-5102.

*WebMD Health Services is an independent company supporting Blue Care Network by providing health and wellness services.*
March is colorectal cancer month

March is designated as colorectal cancer month to promote screening.

There are resources available for primary care physicians who want to provide education and support to members who are eligible for colorectal cancer screening.

- The Michigan Quality Improvement Consortium website has a clinical practice guideline printed on a single page template.
- The Centers for Disease Control and Prevention has a campaign called Screen for Life. This site has educational written materials you can download and print. These include fact sheets, brochures and posters. The materials are available in English and Spanish.

Both commercial and BCN Advantage℠ plans are included in the NCQA HEDIS® colorectal cancer screening measure. The description of the measure is the percentage of members from ages 50 to 75 who had appropriate screening for colorectal cancer.

Appropriate screening is defined by one of the tests below:

- Fecal occult blood test during the measurement year
- Flexible sigmoidoscopy during the measurement year or the four years before the measurement year
- Colonoscopy during the measurement year or the nine years before the measurement year

Digital rectal exams don’t count as evidence of a colorectal screening.

Colorectal cancer screening is included in the Performance Recognition Program in 2017.

BCN promotes colorectal cancer screening with FOBT kits

In the fourth quarter of 2016, Blue Care Network initiated a program to promote colorectal cancer screening. We mailed a fecal occult blood test kit to members who were due for colorectal screening. There were 12,660 Medicare members who were eligible for the FOBT initiative. Of those eligible, 7,229 members participated in the program and kits were mailed to their homes. The results were communicated to BCN and primary care physicians so that the doctors could provide any required follow up.

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March is National Kidney Month

The National Kidney Foundation has designated March as National Kidney Month to raise awareness and promote kidney health. Blue Care Network wants to share a few reminders with you.

People with diabetes, high blood pressure and a family history of kidney disease are at risk of developing chronic kidney disease. African-Americans, Hispanics and senior citizens have a much higher risk of developing chronic kidney disease.

As a BCN physician you can do your part by monitoring the blood pressure of diabetic and hypertensive members and evaluating their kidney function annually by performing tests such as urine albumin and glomerular filtration rate. Additionally, you can promote and encourage healthy lifestyle changes pertaining to diet, exercise and symptom management, such as a stable hemoglobin A1C and cholesterol level.

BCN has registered nurses available to support your treatment plan for members with CKD and answer member questions. You and your patients may contact a chronic condition management specialist by calling 1-800-392-4247. For more information regarding kidney disease, visit the National Kidney Foundation website.

We want to stress the importance of educating your at-risk patients about CKD early on. Through early detection of CKD and member education, patients can slow the progression of the disease and minimize other medical conditions associated with CKD, such as heart disease and stroke. For additional information about chronic kidney disease guidelines, go to the Michigan Quality Improvement Consortium website at mqic.org.
Medication compliance in cardiac disease treatment: Physicians are key

Heart disease is the leading cause of death in the United States, according to the Centers for Disease Control and Prevention. Patient compliance in managing cardiac disease is an important factor in reducing hospitalization.

Blue Care Network offers the following tips for providers to help patients manage their care.

- Reinforce for members who have had an acute myocardial infarction that beta-blocker medication therapy is for life unless contraindicated.
- Instruct members not to discontinue any medication without discussing with you first.
- To keep the member on the prescribed therapy, try lowering the dosage or using a different beta-blocker if the member isn’t tolerating his or her current medication.
- Order cardiac rehabilitation and encourage the member to attend. This increases the likelihood the prescribed medication regimen will be followed.
- Discuss adherence to cardiac medications and smoking cessation as an essential part of every outpatient visit. Our smoking cessation program is available at no cost to members by calling 1-855-326-5102.
- Use of a highly effective statin can help reduce member’s risk of a subsequent myocardial infarction.

Use our Health e-Blue℠ website reports to help you identify the screenings your patients need. (To obtain access to the website, you must be registered for Provider Secured Services at bcbsm.com.)

BCN case managers continue to work with you, your office staff, and our members to help ensure that members comply with treatment plans. To reach a BCN case manager call 1-800-392-2512.

Mending MI Hearts program covers drug costs for certain members after a heart attack

Blue Care Network introduced Mending MI Hearts on July 1, 2016. The program provides coverage of certain drugs at no member cost share after an acute myocardial infarction when certain criteria are met. The member cost share for drugs included in this program bypasses the member’s deductible, copayment and coinsurance.

For details, see the article in the July-Aug. 2016 issue.

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
- Scintimammography and gamma imaging of breast and axilla

Covered services
- BMT — Hematopoietic stem-cell transplantation for plasma cell dyscrasias, including multiple myeloma and POEMS syndrome
- Analysis of human DNA in stool samples as a technique for colorectal cancer screening
- Genetic testing-whole exome and whole genome sequencing for diagnosis of genetic disorders
- Invasive prenatal (fetal) diagnostic testing
- Genetic testing-molecular markers in fine needle aspirates of the thyroid
Quality corner: Initiation and engagement of alcohol and other drug dependence treatment

What does this measure focus on?
Initiation and engagement of alcohol and other drug dependence treatment is a HEDIS® measure. It looks at the percentage of patients ages 13 or older with a new episode of alcohol or other drug dependence.

Two parts are examined:

- Initiation of AOD treatment — Treatment must be initiated within 14 days of the diagnosis. Treatment can be initiated through:
  - An inpatient alcohol or other drug admission
  - An outpatient visit
  - An intensive outpatient encounter
  - A partial hospitalization
- Engagement of AOD treatment — Considered complete if both of the following are done:
  - Member initiated treatment (above) and
  - Member received two or more additional services with a diagnosis of AOD dependence within 30 days of the initiation visit

Why is this important?
More morbidity and mortality are associated with substance abuse than any other preventable health problem. The treatment costs of health conditions caused by substance abuse are a strain on the health care system, totaling more than $165 billion each year in health care expenditures alone. Unfortunately, even though treatment of AOD dependence leads to improved health and productivity, only 10 percent of the 23.1 million Americans who need treatment actually receive it, according to a 2012 estimate from the National Institute on Drug Abuse.

Ensuring patients get care and it counts
Many providers do administer the care, but HEDIS looks at specific timeframes and circumstances to ensure the best quality. Providers could be doing much of the work, but have to keep timing in mind.

- If you diagnose a patient with AOD dependence, schedule a visit at your own practice or refer them to a behavioral health provider as soon as possible so treatment can be started within 14 days of the diagnosis.
- Schedule at least two follow-up visits within 30 days of the initiation visit.

HEDIS also specifies certain stipulations when looking at what does and does not count. These two important tips can really affect whether the service is considered complete by HEDIS standards:

- The index episode start data and the initiation visit can be on the same day, but must be with two different providers.
- The patient can complete more than one engagement visit on the same day, but the visits must be with different providers.

Resources for you
For more information about this HEDIS measure, see the references cited below.


HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Behavioral health providers may discuss decisions with BCN physician reviewers

Blue Care Network is committed to a fair and thorough process of determining utilization by working with its participating behavioral health practitioners. Our behavioral health physician reviewers may contact practitioners for more information about their patients during their review of all levels of care, patient admissions, additional hospital days and requests for services that require medical policy and benefit interpretations.

When BCN doesn’t approve a service request, we send written notification to the requesting practitioner. The notification includes the reason the service wasn’t approved as well as the phone number to call BCN’s behavioral health physician reviewers to discuss the decision.

Practitioners may discuss any decision with a BCN behavioral health physician reviewer. If you’re a practitioner and would like to discuss your patient’s condition or treatment with one of our physician reviewers, call Behavioral Health at 734-332-2567 from 8 a.m. to 5 p.m. Monday through Friday. To discuss an urgent case after business hours with one of our behavioral health physician reviewers, call 1-800-482-5982.

How to obtain a copy of behavioral health criteria

Upon practitioner request, Blue Care Network provides the behavioral health criteria used in the decision-making process. Call Behavioral Health at 734-332-2567 from 8 a.m. to 5 p.m. weekdays to request a copy of the criteria.

Clinical review decisions are based solely on appropriateness of care

Utilization decisions regarding care and service are based solely on the appropriateness of care prescribed in relation to each member’s medical or behavioral health condition. BCN’s clinical review staff doesn’t have financial arrangements that encourage denial of coverage or service that would result in underutilization. BCN-employed clinical staff and physicians don’t receive bonuses or incentives based on their review decisions. Review decisions are based strictly on medical necessity within the limits of a member’s plan coverage.

Blue Care Network Behavioral Health Incentive Program 2017

Blue Care Network has finalized the 2017 Behavioral Health Incentive Program. The documents are posted on web-DENIS. Please follow the steps below to access the booklet, forms, and instruction guides:

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

We have made changes to the 2017 program. Some of the highlights include the following:

- Antidepressant medication management (acute) incentive has increased from $50 to $75.
- Therapeutic alliance electronic submission incentive has increased from $30 to $35.
- Primary care physician contact electronic submission incentive has increased from $45 to $50.
- A new BCN-assessed measure has been added: First-line Psychosocial Care for Children and Adolescents on Antipsychotics.
- For the Appropriate Lab Monitoring measure to be considered complete, the diabetes screenings must include a baseline test and follow-up monitoring, and no longer a baseline test, initial monitoring and follow-up monitoring.

We encourage all providers to review the instructions to submit electronically on web-DENIS. As noted above, incentive payments for electronic submissions are higher than for manual submissions.
Quality corner: Appropriate glucose monitoring

What are the risks for those taking antipsychotics?
The American Diabetes Association has noted that those taking antipsychotics are at an elevated risk for dyslipidemia, weight gain, obesity and Type 2 diabetes.

What should be monitored if patients are taking antipsychotics?
Blue Care Network has reviewed the literature presented by the American Diabetes Association. The ADA suggests monitoring the following:

- Personal history (at baseline and annually)
- Weight (at baseline, four weeks, eight weeks, 12 weeks, quarterly and annually)
- Waist circumference (at baseline, 12 weeks and annually)
- Blood pressure (at baseline, 12 weeks and annually)
- Fasting plasma glucose/A1c (at baseline, 12 weeks and annually)
- Fasting lipid profile (at baseline, 12 weeks and annually)

What is considered appropriate glucose monitoring to receive incentives?
For the Behavioral Health Incentive Program, BCN has included the screening via fasting plasma glucose or hemoglobin A1c at baseline and a follow-up monitoring test (to be completed by the end of the year).

BCN offers an incentive for this measure. Each time an office completes the measure according to the specifications provided in the program booklet, the office is qualified to receive $100.

Why is it important?
Regular monitoring of fasting plasma glucose or A1c ensures that:

- Physical health and metabolic issues are taken into account.
- Patients can get help early on.
- Medications are adjusted accordingly.
- In the long term, it leads to decreased morbidity and increased life expectancy.*

Resources for you
Have questions? Contact your provider consultant for questions related to the BHIP program. If you don’t know your consultant, go to bcbsm.com/providers.

* http://professional.diabetes.org/clone-clinical-corner

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Lansing pediatric office emphasizes the importance of HPV vaccines

Pediatric Care of Lansing treats HPV vaccines as a part of all adolescent immunizations. That philosophy, along with checking patient immunization records at each visit, helps the practice maintain a high rate of HPV vaccination among both male and female adolescent patients.

“We pull MCIR records on every patient regardless of whether they’re coming in for a sick visit or a physical,” says Tina Stevens, medical assistant for the practice. “We also give reminder cards to parents when their children get a first dose to remind them of when the second and third doses are due.”

For patients the practice doesn’t see regularly, the medical assistants sometimes mail reminder cards telling them which immunizations are due. “Sometimes parents who don’t bring their children regularly aren’t aware that their kids didn’t receive all their immunizations,” says Stevens.

"Sometimes the state of Michigan sends immunization records to parents to inform them of immunizations their child hasn’t received," she continued.

“We receive calls from parents who believed their child was up-to-date on his or her shots. We explain that even though HPV vaccine is not required, it is still highly recommended by our doctors. These reminders can start a dialogue about the HPV vaccine."

The pediatric practice and its doctors maintain a focus on immunizations. Doctors and medical assistants educate parents by giving them a brief overview and making sure they have information sheets on the vaccines that are due. It’s not an overly aggressive push. “But we are doing something right,” says Stevens. “More than half of our adolescent patients have received all three doses of the vaccine.”

Stevens says the practice hasn’t experienced any barriers to vaccinating for HPV because they promote several vaccines together. “We tell parents, ‘Your child is due for meningococcal, HPV and Tdap.’ We ask if they know what those vaccines are and sometimes we get questions specifically about the HPV vaccine. It’s a little easier now that the HEDIS® measure looks at those three vaccines together instead of the HPV as a separate measure.”

Stevens says providing the HPV vaccine is also easier now that the recommendations have changed for HPV and only two doses are required if the child gets his or her vaccine at the recommended age between 9 and 14.

When a parent is unsure about starting the vaccine series for a child, one of the doctors in the practice, David Lipsitz, M.D., says he personalizes the conversation.

“I emphasize this is one of the few vaccines to prevent cancers. ‘Wouldn’t you want your child to receive a vaccine that could help prevent cancer,’ he explains. Dr. Lipsitz also noted that studies done over the past 10 years that the vaccine has been available show a decrease in cervical cancer.
ACIP recommends two doses for HPV vaccine

The Advisory Committee on Immunization Practices now recommends a two-dose schedule for girls and boys who initiate the vaccination series at ages 9 through 14. Three doses remain recommended for those who initiate the vaccination series at ages 15 through 26 and for immunocompromised patients.

HPV is the most common sexually transmitted infection in the United States. Nearly all sexually active men and women will get HPV at some point in their lives, according to the Centers for Disease Control and Prevention. HPV is associated with certain cancers, including cervical, anal and oropharyngeal cancers and accounts for about 26,000 new cancer cases in the U.S. each year.

Since its introduction in 2006, the HPV vaccine has reduced the prevalence of HPV infections in adolescent females (ages 14-19) by 56 percent. The vaccine is more than 98 percent effective in preventing new cases of cervical pre-cancer caused by strains of HPV.

Reminder: 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.”

For details, see the complete article in the November-December 2016 issue.

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Appropriate treatment for upper respiratory infections in children and adults

At least 2 million people in the United States are infected each year with bacteria where antibiotic treatment is ineffective, according to the Centers for Disease Control and Prevention. At least 23,000 people die each year as a result of infections that are resistant to antibiotics.

HEDIS® has three measures that focus on reducing antibiotic use.

- Appropriate testing for children with pharyngitis
  - The percentage of children ages 3 to 18 who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

- Appropriate treatment for children with upper respiratory infection
  - The percentage of children ages 3 months to 18 years old who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription.

- Avoidance of antibiotic treatment in adults with acute bronchitis
  - The percentage of adults ages 18 to 64 with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Blue Care Network participates in HEDIS annually. To support success in these three measures, we have two clinical practice guidelines for antibiotic utilization that are available at the Michigan Quality Improvement Consortium website. The guidelines address the following:

- Acute pharyngitis in children 2-18 years old
- Management of uncomplicated acute bronchitis in adults

These guidelines are printed on a one-page template for convenient reference.

It’s challenging to work with a patient who is requesting an antibiotic when it isn’t appropriate for them or their child. Both the Centers for Disease Control and Prevention and Michigan Antibiotic Resistance Reduction websites offer resources to help with this discussion.

A list of the top 18 drug resistant threats to the United States and other activities to combat antimicrobial resistance is also available at the CDC website.

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Drugs added to prior authorization list

On Jan. 1, 2017, Blue Care Network added the drugs listed below to the prior authorization program for drugs covered under a member’s medical benefit.

<table>
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<th>Drug name</th>
<th>Procedure code</th>
<th>Authorization required?</th>
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<td>For BCN HMO&lt;sup&gt;SM&lt;/sup&gt; (commercial) members</td>
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Providers must submit authorization requests for these drugs using the NovoLogix web tool and must include the following clinical information to support the authorization request:
- Diagnosis
- Lab results
- Names of medications previously used to treat the member’s condition, including dose, regimens, dates of therapy and response.

Providers may also be required to submit additional clinical information and documentation related to the specialty of the prescribing physician and the member’s age.

These drugs previously required authorization because they were assigned not-otherwise-specified procedure codes. Starting Jan. 1, 2017, these drugs require authorization under the new assigned codes.

Need information about using the NovoLogix web tool? Visit the Medical Benefit Drugs – Pharmacy web page in the BCN section of ereferrals.bcbsm.com.

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 do not have coverage for Tier 3 drugs.
Members can get medications synchronized at the pharmacy starting March 15

Blue Cross Blue Shield of Michigan and Blue Care Network are launching our medication synchronization program with Express Scripts for all commercial (non-Medicare) lines of business, starting March 15, 2017. This program will allow your patients’ medications to be refilled on the same day. The member gets the convenience of fewer trips to the pharmacy and it may increase medication adherence.

We’re adding this program in response to Michigan Public Act 38 of 2016, which requires insurers to allow members to synchronize multiple maintenance drug prescriptions for chronic long-term care conditions. The medication synchronization legislation was signed into law by the governor on March 15, 2016, and it takes effect on March 15, 2017.

Which drug claims apply to the program?
The program allows:
- Medication synchronization of maintenance drugs for chronic long-term care conditions, with the exception of:
  - Most Schedule 2-5 controlled substances (anti-epileptic prescriptions allowed)
  - Select prescription drugs that are limited to certain fill requirements
- Medication synchronization on prescriptions that have authorized refills remaining

Mail-order prescriptions do not qualify for the synchronization program.

How will we synchronize prescription drugs?
- When a participating pharmacy submits a claim for a member that meets the criteria, our claims processor, Express Scripts, will apply a prorated, daily cost-sharing rate to the maintenance prescription drugs. The claims processing system will allow a pharmacist to dispense up to 29 days of acceptable drugs.
- Participating pharmacies will collect from the member the applicable cost share and receive a dispensing fee for each synchronized prescription claim submitted.

BCN adds Cabometyx to the 15-day fill specialty drug list

Blue Care Network added Cabometyx™ to the 15-day specialty drug list in December 2016. Drugs on this list are limited to a 15-day supply each time the drug is filled at the pharmacy. This includes first fills and refills. Members pay half of their copayment for a 15-day supply.

Limiting these drugs to a 15-day supply helps members save on copayments and reduces the amount of drugs wasted if a member switches to a different medication during the course of treatment.

Members can fill prescriptions for specialty drugs at most network retail pharmacies or have their prescriptions delivered by mail.

This change doesn’t apply to members who were already taking this drug. The information in this article does not apply to BCN AdvantageSM members.

The 15-day specialty drug list currently includes 33 drugs and is regularly updated. Visit bcbsm.com/pharmacy for the current list.

Blue Cross and Blue Care Network no longer cover EpiPen® brand drugs, starting March 1

Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans will no longer cover EpiPen® 0.3 mg and EpiPen Jr® 0.15 mg auto-injector drugs, effective March 1, 2017. Blue Cross and BCN will provide coverage for the authorized generic epinephrine auto-injectors.

For details, see the March issue of The Record.
Health departments: Use place of service code 71 on claims and laboratory services

Health departments must use place of service code 71 on all claims including laboratory services. Our system has been updated to allow health departments that are certified under the Clinical Laboratory Improvement Amendments to provide the same in-office laboratory services as in a physician’s office.

See the document below, *In-office laboratory procedures billable to BCN* for details. All other laboratory services should be sent to JVHL.

If you previously received a rejection for payable in-office laboratory services, please contact Provider Inquiry at 1-800-255-1690 to have your claim reprocessed.

Correction: Coding for morbid obesity with comorbid conditions

The “Coding corner” article on morbid obesity in the November-December 2016 BCN Provider News contained a misleading example of how to code for a patient with a BMI over 40 and a comorbid condition.

It should have read:

“In circumstances where the medical record shows a final assessment of obesity with a BMI of 40 or more and comorbid conditions, such as uncontrolled diabetes and hypertension with a plan of care, the BMI value can be coded along with a code for obesity.”

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:

- Clinical editing appeals: A refresher
- Medical record documentation
- Bundled services
Billing Q&A

**Question:**
We have been having trouble with screening colonoscopies being paid at 100 percent. Can you send an example of how you expect the claim to look?

**Answer:**
For most BCN commercial members, screening colonoscopies and the associated services should be covered without cost sharing. This is one of the preventive services that was mandated for full coverage under the Affordable Care Act.

If a screening colonoscopy is performed and no other treatment is required, such as biopsy or polyp removal, then you should report the appropriate screening colonoscopy procedure code. There are two codes, G0105 and G0121. One is for a patient at normal risk and the other is for a patient at high risk, but both indicate a screening colonoscopy. While there is not a specific diagnostic requirement, it should be reported with the screening diagnosis code as well. Further, any ancillary services, such as anesthesia, should be reported with the screening diagnosis code to indicate the purpose of those services.

If the patient requires other services and the screening colonoscopy becomes diagnostic, it requires a procedure code and diagnosis code combination to waive cost sharing. In this situation, you would report the appropriate procedure code to indicate the type of colonoscopy, such as a colonoscopy with a biopsy. In that case, the diagnosis would include as a primary diagnosis, such as Z12.11 or Z12.12, which indicates the diagnosis is screening for a malignant neoplasm of the colon.

**Question:**
I received a referral for a procedure, but then the procedure was denied because it was not the appropriate location. If I go through the process of getting an authorization or referral, shouldn’t you ensure the location where it is performed is accurate?

**Answer:**
For both commercial and BCN AdvantageSM lines of business, we follow the Medicare indicators for appropriate place of service. If Medicare indicates a service is rarely or never done in a location — typically outpatient or the office — then if that service is reported in the respective setting, it will receive an edit, even if there is a referral or authorization.

For example, a lumbar arthrodesis with a laminectomy is considered a procedure that would rarely or never be done in the outpatient setting. Therefore, if the procedure is reported in an outpatient or ambulatory surgery center, the code would most likely receive an edit. Other procedures considered appropriate in the outpatient location may receive similar edits if reported in the office location. An example of this would be the removal of a lesion of the tendon of the wrist.

In either of these situations, if a referral or authorization had been received, the provider can submit a clinical editing appeal. We review the documentation and make a determination specific to the case. If you believe the edit should be changed and the code should no longer be subject to the edit, we will update the system.

We are always reviewing appeals and edits and work to ensure the edits and determinations are current.

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.
Use new PT, OT codes when billing BCN for physical and occupational therapy

On Jan. 1, 2017, new procedure codes went into effect for physical and occupational therapy evaluations for BCN HMO (commercial) and BCN Advantage members. The new codes are indicated in bold below.

- **Physical therapy (physical therapists):**
  - Service 1: *97110 for treatment
  - Service 2: *97161, *97162 or *97163 for evaluation
  (These codes cannot be used by chiropractors.)

- **Occupational therapy:**
  - Service 1: *97535 for treatment
  - Service 2: *97165, *97166 or *97167 for evaluation

The document Procedures that require clinical review by eviCore healthcare has been updated with these codes.

*CPT codes, descriptions and two-digit modifiers only are copyright 2016 American Medical Association. All rights reserved.

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.
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