Best Practices: How one doctor helps patients with medication reconciliation

Changes to prescriptions and incomplete records can increase the risk of adverse reactions, particularly after a hospital discharge.

One physician addresses this issue by following up with all patients after hospitalization and making sure they bring all their current prescriptions to their follow-up visits.

“Most of my patients are admitted through St. Joe’s [St. Joseph Mercy] and their inpatient team is good at getting us a discharge summary before the patient arrives at my office,” said Bruce Cicone, M.D., who practices in Ypsilanti.

“One important part of the follow-up visit is to review medications and make sure patients understand why they’re taking certain medications, how to take them and to make sure they take them,” said Dr. Cicone.

Reminder: Here’s what you need to know about providing up-to-date demographic data

At Blue Care Network and Blue Cross Blue Shield of Michigan, we’re continually improving the quality of information in our provider directories.

Members need to know how to get in contact with physicians who participate with their insurance plan and where practices are located. All insurance plans are tasked with providing members with accurate, up-to-date physician information.

In fact, last year, the Centers for Medicare & Medicaid Services mandated that Medicare Advantage health plans provide complete and accurate information regarding physicians to members.

Please see Demographic data, continued on Page 3
“Most patients are honest if they haven’t taken their medications because they were waiting for their follow-up visit,” said Dr. Cicone. “But if the patient’s blood pressure or diabetes isn’t under control, for example, I’ll start digging deeper,” he continued. “I’ll ask if they’re taking their medications as prescribed. And I ask them to bring the medications next time they come. We’re now asking patients to bring all their medications at every office visit.”

Most of Dr. Cicone’s patients are managed by consultants working with St. Joe’s hospital and they use the same electronic medical record system that his practice uses. “So if there are any changes in medications, I’m looking at the same list as the specialists.”

Even so, he and his medical assistant review all a patient’s medications at each follow-up visit because their office protocol is to double-check all medications.

There are some challenges with patients who have more than one chronic condition and are taking multiple prescriptions. Even when insurance copayments are low, expenses can add up, said Dr. Cicone. “So we always look at alternatives to drugs based on price and what the patient can tolerate,” he said.

Dr. Cicone related an example of one patient who learned at the pharmacy that his drug was removed from a formulary. “I spent that visit on the phone with the patient’s insurance company finding an alternative that would be adequate for him and something he could afford,” said Dr. Cicone.

Elderly patients can present unique challenges. “We sometimes see problems where patients are not taking their prescriptions correctly so we may ask visiting nurses and the patient’s family to get involved,” said Dr. Cicone. In one instance, he asked an elderly patient to bring in all her medications because her blood pressure was not controlled. He learned that she kept all her pills in one vial, so it was apparent she was taking her medications randomly. That’s when the office made the decision to have patients bring the medications to each visit.

Dr. Cicone’s office prints a medication list and new instructions from the electronic medical record for each patient.

It’s also helpful to review the medication list and the instructions for taking them. “When they leave here, I always point out to patients that they will get a new medication list from us that’s going to show their current drugs,” said Dr. Cicone. “We tell them they should check at home to make sure the medications I have on their list coincide with the ones they have at home.

“It’s time consuming,” concedes Dr. Cicone. “But you have to give it the attention it deserves or there are going to be errors.”

See related article about how to meet the HEDIS criteria for medication reconciliation on page 28.
Demographic data, continued from Page 1

Here are answers to some frequently asked questions:

What are Blue Cross and Blue Care Network doing to make it easier for providers to attest to their demographic data?

Currently, we’re using Atlas System’s PRIME-Hub online tool to collect practitioner attestations. However, we’ll be transitioning to DirectAssure™, a CAQH Solution® in mid-2017. DirectAssure will work with CAQH’s ProView® program to improve provider directory data. Our goal is to help you avoid frequent outreach for the same information by multiple health care plans, which creates a significant burden on your staff’s time and resources.

Through DirectAssure®, Blue Cross and BCN providers can confirm their directory information in one place, where it can be shared with participating health plans and will meet our quarterly directory attestation requirement. We’ll incorporate the DirectAssure® information into our provider files to give our members the most up-to-date, accurate information.

What do Blue Cross and BCN providers need to do this year?

For the first half of 2017 (until we transition to DirectAssure), all providers or their provider groups will need to attest to their current demographic data through Atlas System’s PRIME-Hub tool at primeatlas.com.

What do I do if my demographic information is incorrect in PRIME-Hub?

To update your demographic information, go to the Enrollment and Changes section of bcbsm.com/providers.

How should I prepare for the move to CAQH’s DirectAssure?

We strongly recommend you continue to update your directory information in CAQH ProView to help ensure a smooth transition when we adopt DirectAssure mid-year.

What happens if I don’t comply?

You may be excluded from our provider directories and no longer be eligible to participate in the Physician Group Incentive Program.

Blue Care Network changing practitioner fees July 1

Blue Care Network will update fee schedules, effective with dates of service on or after July 1, 2017. This change applies to services provided to Blue Care Network commercial members.

We’ll use the 2017 Medicare resource-based relative value scale for most relative value unit-priced procedures for dates of service on and after July 1.

In alignment with Blue Cross Blue Shield of Michigan, the conversion factor used to calculate anesthesia base units for anesthesia procedures will increase and be aligned at $58.65 throughout Michigan. Also, effective July 1, the percentage weight for the QK or QY modifier will be adjusted from 56 percent to 55 percent, and the QX modifier will be adjusted from 44 percent to 45 percent.

Blue Cross conducts a comprehensive analysis of professional provider performance and current economic indicators annually to calculate practitioner fees with consideration for corporate and customer cost concerns. Blue Cross and BCN remain committed to reviewing professional provider performance to determine the need for increases or decreases in our maximum payments.

Only claims submitted with dates of service on or after July 1 will be reimbursed at the new rates.

Please note that the Blue Cross Blue Shield Physician Group Incentive Program allocation (formerly known as the physician organization component) of professional fees remain the same this year. This component continues to be excluded from BCN professional fees.

For more information, contact your provider consultant.
Clarification on newborn claims

Blue Care Network now requires a newborn be added to the contract in order for claims to be paid. We no longer automatically add the newborn to an existing contract for a period of time.

We are receiving requests for authorizations from providers for claims for newborn babies not yet eligible for benefits.

Providers should tell their patients that they must add their newborn to their coverage within the timeframe allotted by their particular coverage in order for claims to be paid.

BCN holds newborn claims for 20 days to allow time for newborns to be added to coverage; after this time they’ll be denied. We will reconsider claims that were initially denied then resubmitted after the baby was added to the coverage within the appropriate timeframe.

Providers should check benefits and eligibility at every visit.

Subscribers have the right to appeal rejected claims according to our standard process.

Newborns that haven’t been added to the subscriber’s contract within the number of days allowed by the subscriber’s certificate can be added to the subscriber’s contract during the next open enrollment period.
Blue Care Network to participate in CAQH VeriFide project to streamline credentialing

Blue Care Network and Blue Cross Blue Shield of Michigan are working with CAQH to improve the primary source verification process by eliminating redundant functions and aligning provider recredentialing cycles across health plans.

CAQH is now certified as a National Committee for Quality Assurance credentials verification organization and is developing a solution to streamline the primary source verification process for the health care industry. The goal is to decrease duplication of requests for information from practitioners. BCN and Blue Cross will start using CAQH VeriFide data this summer for M.D. and D.O. practitioners that are due for recredentialing.

It is essential that you keep CAQH ProView application data current. That means you need to reattest to the data on an ongoing basis to ensure its accuracy. To assist us with ensuring the accuracy of your degree information published in our provider directory, your degree type (not your provider type) must be entered in the “Degree Awarded” field under the Professional/Medical School section of your CAQH ProView Application. For example, a Certified Nurse Practitioner should enter his or her Master’s degree in the “Degree Awarded” field and not Certified Nurse Practitioner as their degree.

For residents: Get an early start with credentialing

Practitioners completing their residency this summer are welcome to submit their Blue Cross Blue Shield of Michigan provider enrollment application 60 days prior to their training completion date. The CAQH ProView application must be completed in order to begin the credentialing process with Blue Cross and Blue Care Network.

Visit the CAQH ProView website for more information.
We’re making some changes in how we process high-cost claims

We’re implementing several enhancements to our current process for handling high-cost claims to better meet the needs of our provider partners and customers.

Enhancements include expediting prospective payments and expanding pre-payment high dollar reviews.

Health care providers have told us they’re dissatisfied with the timeliness of the prospective payment process for high-cost claims and the disruption caused by post-pay audits. They’re also seeking pre-pay solutions to improve payment accuracy, avoid overpayment recoveries and control unnecessary costs.

To help us address these challenges, we’ve established a strategic relationship with Equian, an industry leader in pre-pay solutions. Starting May 1, Equian will review certain types of high-cost inpatient claims to detect and resolve errors before payment. Equian’s advanced analytics and service delivery model help ensure their reviews are completed within five days, using only an itemized bill for input.

We’ve already made several enhancements to our process. For example, the process of identifying outliers for review will occur weekly versus monthly starting in mid-April, 2017. And we’ve streamlined internal processes and approval workflows. These changes should accelerate prospective payments by at least four weeks.

The result we hope to achieve by these changes is that all claims will be paid right the first time. This will reduce administrative costs and the need for multiple adjustments, speed up claims payments and help build trust with our provider partners about the integrity of our payment process.

We’re collaborating extensively with health care providers to make sure these changes are implemented to meet their needs and the needs of our members.

If you have any questions, contact your provider consultant.
New online application replaces Provider Enrollment and Change Group Change Form

The Group Change Form found on bcbsm.com/providers under Provider Enrollment and Change, will no longer be available to make group changes in the near future. Authorized individuals will need to make any group changes using the Provider Enrollment and Change Self-Service online application.

If you aren’t currently registered for online enrollment and change processing, here’s how to register:

1. Go to bcbsm.com/providers.
2. Hover your mouse over Join Our Network then click on the Enrollment and Changes link that appears.
3. Click on self-service FAQ.
4. Click on How do I sign up?

If you don’t have access to Provider Secured Services, you will need to register. You’ll find instructions under the How do I sign up? link. This only applies to professional group providers and professional group providers’ billing services regardless of what Blue Cross Blue Shield of Michigan or Blue Care Network coverage members may have.

Please note that all authorized individuals in your office need to request their own individual user ID for Provider Secured Services.

Once you receive Provider Enrollment and Change Self-Service access, you can sign into the application to submit group changes electronically.

For more information, please contact Provider Enrollment and Data Management at 1-800-822-2761.

Provider forums coming to a town near you

Blue Cross Blue Shield of Michigan and Blue Care Network provider forums are coming to you. We’ve scheduled a series of provider forums across the state focusing on topics of interest to providers. A forum scheduled for hospitals is noted at the end of the list.

The forums will cover topics such as:

- 2017 coding and documentation updates for ICD-10 CM, CPT and HCPCS (morning)
- HEDIS® updates (morning)
- Patient experience (morning)
- Blue Cross Complete update (afternoon)
- Review of Blue Cross and BCN authorizations (afternoon)
- Products at a glance (afternoon)
- Who to contact at Blue Cross and BCN (afternoon)
- Blue Card update (afternoon)
- Provider enrollment updates (afternoon)

Schedule of events:

- Registration begins at 7:30 a.m. The morning session starts at 8 a.m. and includes a continental breakfast. The afternoon session begins at noon and includes lunch.
- You can register for the full day, or attend just the morning or afternoon session.

We look forward to seeing you.

Please see Provider forums – Schedule of events, continued on Page 8
### Provider forums – Schedule of events

<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
<th>Registration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Port Huron</strong></td>
<td><strong>Date Change!</strong></td>
<td><strong>Click here</strong> for both sessions</td>
</tr>
<tr>
<td>Double Tree by Hilton</td>
<td>Thursday, June 15, 2017</td>
<td><strong>Click here</strong> for a.m. session only</td>
</tr>
<tr>
<td>800 Harker St.</td>
<td></td>
<td><strong>Click here</strong> for p.m. session only</td>
</tr>
<tr>
<td>Port Huron, MI 48060</td>
<td></td>
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</tr>
<tr>
<td><strong>Ann Arbor</strong></td>
<td>Monday, May 15, 2017</td>
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</tr>
<tr>
<td>Courtyard Marriott</td>
<td></td>
<td><strong>Click here</strong> for a.m. session only</td>
</tr>
<tr>
<td>3205 Boardwalk Drive</td>
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<td><strong>Click here</strong> for p.m. session only</td>
</tr>
<tr>
<td>Ann Arbor, MI 48108</td>
<td></td>
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<tr>
<td><strong>Novi</strong></td>
<td>Wednesday, May 17, 2017</td>
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</tr>
<tr>
<td>Novi Oaks</td>
<td></td>
<td><strong>Click here</strong> for a.m. session only</td>
</tr>
<tr>
<td>27000 Karevich Drive</td>
<td></td>
<td><strong>Click here</strong> for p.m. session only</td>
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<tr>
<td>Novi, MI 48377</td>
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<td><strong>Pontiac/Auburn Hills</strong></td>
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<tr>
<td>Hilton Suites</td>
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<td><strong>Click here</strong> for a.m. session only</td>
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<tr>
<td>2300 Featherstone Road</td>
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</tr>
<tr>
<td>Auburn Hills, MI 48326</td>
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<tr>
<td><strong>Grand Rapids</strong></td>
<td>Tuesday, May 23, 2017</td>
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<tr>
<td>DoubleTree by Hilton</td>
<td></td>
<td><strong>Click here</strong> for a.m. session only</td>
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<tr>
<td>4747 28th St. SE</td>
<td></td>
<td><strong>Click here</strong> for p.m. session only</td>
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<tr>
<td>Grand Rapids, MI 49512</td>
<td></td>
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<tr>
<td><strong>Kalamazoo</strong></td>
<td>Wednesday, May 24, 2017</td>
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<tr>
<td>Four Points by Sheraton</td>
<td></td>
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<tr>
<td>3600 E. Cork Street Court</td>
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<td><strong>Click here</strong> for p.m. session only</td>
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<tr>
<td>Kalamazoo, MI 49001</td>
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<td><strong>Frankenmuth</strong></td>
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<td>Bavarian Inn Lodge</td>
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</tr>
<tr>
<td>1 Covered Bridge Lane</td>
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<td><strong>Click here</strong> for p.m. session only</td>
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<td>Frankenmuth, MI 48734</td>
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<td><strong>Sterling Heights</strong></td>
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<td>34911 Van Dyke</td>
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<tr>
<td>Sterling Heights, MI 48312</td>
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<tr>
<td><strong>Traverse City</strong></td>
<td>Tuesday, June 13, 2017</td>
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<tr>
<td>West Bay Beach</td>
<td></td>
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<tr>
<td>Traverse City, MI 49686</td>
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<td><strong>Okemos</strong></td>
<td>Tuesday, June 20, 2017</td>
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<tr>
<td>Holiday Inn Express &amp;</td>
<td></td>
<td><strong>Click here</strong> for a.m. session only</td>
</tr>
<tr>
<td>Suites</td>
<td></td>
<td><strong>Click here</strong> for p.m. session only</td>
</tr>
<tr>
<td>2209 University Park Drive</td>
<td></td>
<td></td>
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<tr>
<td>Okemos, MI 48864</td>
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</tr>
<tr>
<td><strong>Marquette</strong></td>
<td>Tuesday, June 27, 2017</td>
<td><strong>Click here</strong> for both sessions</td>
</tr>
<tr>
<td>Holiday Inn</td>
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<td><strong>Click here</strong> for a.m. session only</td>
</tr>
<tr>
<td>1951 US-41</td>
<td></td>
<td><strong>Click here</strong> for p.m. session only</td>
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<tr>
<td>Marquette, MI 49855</td>
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<tr>
<td><strong>Marquette</strong></td>
<td>Wednesday, June 28, 2017</td>
<td><strong>Click here</strong> for all-day session</td>
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<tr>
<td>Holiday Inn</td>
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<tr>
<td>1951 US-41</td>
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<tr>
<td>Marquette, MI 49855</td>
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</tbody>
</table>

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Blue Care Network offices will be closed May 29 for Memorial 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.

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

As a reminder, when an admission occurs through the emergency room, we ask that you contact the primary care physician to discuss the member’s medical condition and coordinate care before admitting the member.
Award recognizes providers’ roles in star ratings success ★★★★★

Providers who have made outstanding contributions to the BCN Advantage℠ and Blue Cross Medicare Plus Blue℠ PPO plans’ 2016 star ratings were recently honored with Provider Distinction Awards. This is the fourth year we have recognized Medicare Advantage providers for their contributions to our star quality measures. Our partnership with providers is critical to our star-ratings success.

The Centers for Medicare & Medicaid Services measures the quality to drive improvements in accountability with the health plans, physicians and hospitals. This rating system applies to all Medicare Advantage lines of business. The star rating includes 44 metrics that span five broad categories:

- Outcomes
- Intermediate outcomes
- Patient experience
- Access
- Process

The award criteria include the following that supports the star rating. This includes achieving 83 percent or higher for joint contracts on the below measure or 85 percent or higher for single contracts BCN Advantage℠ or BCBSM Medicare Plus Blue℠.

- Outcomes (Staying healthy: Screenings, etc)
  - Breast cancer screening
  - Colorectal cancer screening

- Intermediate outcomes (Managing long-term conditions)
  - Diabetes measurements
    - Eye
    - Kidney
    - Blood sugar control

Providers must have a minimum of five services that count toward the star rating (for example, a diabetes test, colorectal screening). [The number of services completed divided by the number of eligible services equals the quality score.]

- Providers must be currently credentialed and contracted with Blue Cross Medicare Plus Blue PPO or BCN Advantage and in good standing.

- Providers may not be in the low quality score rating program. (Providers with low quality scores will be eligible for future awards once they have completed the QSR program.)

The plaque is perpetual; we add stars to it as the physician groups continue to achieve impressive scores. The providers who received plaques also receive gifts for office staff that handled the administrative work. We appreciate their support.
Blue Care Network measures progress of Chronic Care Improvement program

We’ve completed the fourth year in our Chronic Care Improvement program, designed to prevent cardiovascular disease in BCN Advantage℠ members. If you’re a frequent reader, you’ll remember that we’ve adopted the clinical interventions championed by Million Hearts™.

Million Hearts is a public initiative led by the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services to prevent one million heart attacks and strokes in the United States over the next five years by focusing the nation on evidence-based community and clinical prevention actions.

Fourth annual update
Blue Care Network completed medical record audits to measure our progress toward meeting our Million Hearts goals. Using a list of all BCN Advantage members who met criteria for inclusion in our program (40 years of age or older with a diagnosis of cardiovascular disease or with Type 1 or 2 diabetes during 2015), we selected a random sample of 425 members.

Registered nurses from our Quality Management department reviewed medical records at provider offices or requested medical records by fax to obtain clinical data for the member sample. We’re happy to report that we’ve made some progress toward reaching our goals.

Please see Chronic Care Improvement, continued on Page 12
Chronic Care Improvement, continued from Page 11

The table below is a summary of our audit findings.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator/Denominator</th>
<th>Percent</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of diabetic members represented in the sample</td>
<td>240/425</td>
<td>56.47%</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Diabetic measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the diabetic patient have HgA1c testing?</td>
<td>207/240</td>
<td>86.25%</td>
<td>97%</td>
</tr>
<tr>
<td>Was the diabetic patient’s HgA1c level below 9 percent?</td>
<td>195/207</td>
<td>94.2%</td>
<td>95%</td>
</tr>
<tr>
<td><strong>Tobacco cessation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there documentation of tobacco screening in the record?</td>
<td>312/425</td>
<td>73.41%</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of tobacco users</td>
<td>153/425</td>
<td>36%</td>
<td>N/A</td>
</tr>
<tr>
<td>Was there documentation of counseling on the importance of quitting smoking in the record?</td>
<td>48/153</td>
<td>31.37%</td>
<td>44%</td>
</tr>
<tr>
<td><strong>Aspirin use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there documentation that aspirin use was not appropriate for the member?</td>
<td>166/425</td>
<td>39.06%</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of medical records with documentation that daily aspirin was ordered</td>
<td>192/259</td>
<td>74.13%</td>
<td>56%</td>
</tr>
<tr>
<td>Number of medical records that contained evidence of aspirin counseling</td>
<td>184/259</td>
<td>71.04%</td>
<td>31%</td>
</tr>
<tr>
<td><strong>Blood pressure control</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For members under 59 years: BP below 140/90</td>
<td>7/10</td>
<td>70%</td>
<td>N/A</td>
</tr>
<tr>
<td>For members over 60 years BP below 150/90</td>
<td>336/415</td>
<td>80.96%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

↔️ Outcome equal to baseline  
↓ Outcome lower than baseline  
↑ Outcome higher than baseline

Please see Chronic Care Improvement, continued on Page 13
Chronic Care Improvement, continued from Page 12

Opportunities for improvement

Diabetic measures
Both diabetic measures were below threshold. However, our efforts will continue to improve both. BCN’s Performance Recognition Program will continue in 2017 by providing rewards to practitioners who encourage their patients to control their blood sugar levels by getting HgA1c testing done at least annually and by keeping their HgA1c below 9 percent.

Tobacco cessation
The goal for tobacco cessation counseling wasn’t met. While 73 percent of the records audited contained evidence of screening for tobacco use, only 31 percent contained documentation of counseling on the importance of quitting. Quitting smoking is hard and may require several attempts.1,2 People who stop smoking often start again because of withdrawal symptoms, stress and weight gain.1,2,3 Don’t stop counseling your patients about the health benefits they can reap if they quit smoking. Members can enroll in BCN’s free online smoking cessation program powered by WebMD.

Aspirin use
We exceeded our goals for aspirin use and counseling. Aspirin use for high-risk patients, unless contraindicated, is one of the preventive actions recommended by the Million Hearts initiative and the Michigan Quality Improvement Consortium Guideline for the Management of Diabetes Mellitus.

BCN Advantage’s CMS Million Hearts Incentive Program and BCN’s Performance Recognition Program reward practitioners for the roles you play in helping us achieve our goals of preventing cardiovascular disease in BCN Advantage members. Information about these programs is available on BCN Health e-BlueSM in the Resources section under Incentive Documents.

In the coming year, we’ll continue to work on this very important initiative by focusing on recommending aspirin for those who need it, maintaining blood pressure control and quitting smoking. You can get more information on the Million Hearts website.

Here are some simple things that you can do for your patients that will help us reach our goals and more importantly save lives by preventing heart attacks, strokes and related deaths in BCN Advantage members.

- Talk to your BCN Advantage patients about the CMS Million Hearts initiative and how to reduce their risk of heart attack and stroke.
- Prescribe aspirin or antiplatelet therapy for those who would benefit from it and document it in the patient’s chart.
- Ask your patients about their smoking habits and provide smoking cessation counseling and tools to help smokers quit. Document your interaction with the patient in the medical record.
- Recommend our free online tobacco cessation program to help BCN Advantage members quit smoking.
- Emphasize the importance of getting prescribed lab work drawn and follow up with those members who don’t get lab work drawn as ordered.

We all still have a lot of work to do and we know we can’t achieve our goals without your help. As health care professionals, you play a key role in helping patients reduce their risk for heart disease and stroke and lead longer, healthier lives. In 2017, we’ll conduct another medical record audit to check on our progress. In the meantime, watch for updates on our Chronic Care Improvement Program in future issues of BCN Provider News.

Reminder: BCN Advantage new incentive encourages Basic and MPSERS plan members to visit their doctors

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

BCN will give the member a gift card upon receiving a completed attestation form as well as receipt of a claim from the primary care physician. The claim must include one of the wellness codes specified in the right hand column.

The wellness visit and evaluation must occur between Jan. 1, 2017 and Dec. 31, 2017. BCN Advantage will validate the form against claims and look for specific procedure codes.

Doctors will receive an incentive through the current star ratings program.

Wellness and physical exam codes

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

See the full article in the March-April issue for details.

*CPT codes, descriptions and two-digit modifiers only are copyright 2016 American Medical Association. All rights reserved.
What you need to know about Medicare fraud, waste and abuse

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

Definition of fraud
Fraud is intentional deceit or misrepresentation of the truth that results in some unauthorized benefit.

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

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

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

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

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

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

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

Fraud, waste and abuse prevention

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

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

You may also contact the Office of Health Services Inspector General at 1-800-HHS-TIPS (1-800-447-8477) or online at Medicare.gov/fraud.

In writing, contact:
Office of Inspector General
Attention: OIG Hotline Operations
P.O. Box 23489
Washington, D.C. 20026
The benefits of a whole-foods, plant-based diet

By Felecia Williams, M.D.

A whole-foods plant-based diet is becoming more popular as research validates its benefits and individuals consider more natural interventions. A plant-based diet can be used as a preventive measure along with other therapeutic lifestyle interventions or as an add-on to traditional therapies. The high cost of health care and medications and the benefits of decreasing animal products in our diet are prompting many individuals to explore a whole food plant-based or semi-vegetarian diet.

There are significant health, wellness, and environmental benefits to adopting plant-based diets that are rich in fruits, vegetables, tubers, whole grains, legumes, herbs and spices, nuts and seeds and exclude or minimize meat (including poultry and fish), dairy products and eggs, as well as highly refined foods like bleached flour, refined sugar and oil. With the exception of B12 and possibly Vitamin D, a plant-based diet contains most of the macro and micronutrients required for well balanced nutrient-dense meals.

Plant-based products contain nutrients and ingredients that have significant health benefits such as fiber, carotenoids, glucosinolates and flavonoids. Plant-based diets are typically high in antioxidants and have anti-inflammatory benefits. They are considered anti-cancer foods, and can enhance the immune system and protect against heart disease. Plant-based diets also tend to have a high fiber content. Although there are proven benefits to increasing fiber in the diet, most Americans don’t meet the minimum daily recommendations for fiber intake.

While pharmaceuticals are often important, there is value in using food as medicine. At Blue Care Network we are focused on improving health care outcomes and decreasing health care costs. We believe that physicians and health care providers can motivate and encourage patients to implement lifestyle changes that will enhance their quality of life. The time is ripe for incorporating discussions about whole food plant-based diets, especially during preventive services and wellness visits.

The benefits of this type of diet include:

- Promotes weight loss
- Reduces medication needs
- Decreases risk for cancer
- Decreases the risk or severity of chronic conditions such as Type II diabetes, coronary artery disease, arthritis and hypertension as well as other conditions

Felecia Williams is a medical director for Blue Care Network.
From the medical director, continued from Page 16

Preventive services and wellness visits are an opportunity for physicians to encourage their patients to increase fruits, vegetables, whole grains and fiber in their diets since most Americans don’t eat the minimum daily-recommended allowances of these food groups. Our busy lifestyles can lead to eating on the run at fast food and other restaurants. These meals are often low in fiber and high in sodium and saturated fats.

Consider offering these recommendations to your patients:

- Set goals and make small changes.
- Plan meals and make meal preparation fun. Try new recipes, increase variety in meals and try new items in order to avoid boredom.
- Read and understand nutrition labels.
- Limit processed and fast foods in the diet.
- Start with meatless meals once a week and gradually increase the number of meatless days.
- Eat at least two servings of vegetables and one serving of fruit with lunch and dinner and consider including fruits and vegetables at breakfast. Frozen fruits and vegetables are perfectly acceptable.
- Take lunch to work instead of purchasing processed or unhealthy meals in the workplace cafeterias or buying snacks from vending machines.
- Consider plant-based options when eating out.
- Keep healthy snacks such as nuts or fruit or vegetables in the car or office to avoid eating unhealthy snacks during stressful or busy days.
- Use spices to add flavor to meals.

Physicians can read the summer 2016 issue of The Permanente Journal for more information.

Provider satisfaction survey shows room for improvement in referrals and appeals processes

An online provider satisfaction survey we conducted last fall to gauge provider satisfaction with Blue Care Network’s care management services showed that you are generally satisfied with our clinical review process and complex case management programs. But, you also told us there is room for improvement in admission and concurrent review processes, referrals and our appeals process.

Here’s what we found:

Satisfaction ratings (which included very satisfied and satisfied responses) ranged from 54 percent satisfaction with the clinical review process to 83 percent satisfaction with our complex case management programs.

We also offered you the chance to tell us what BCN could do to improve your satisfaction with its care management programs. Your comments provide valuable information about your experience with us and guide us in our efforts to improve our services.

Here are the topics that received the most comments and our responses to your suggestions:

- **Admission and concurrent review processes**: We strive for expedient member care, while ensuring the delivery of an appropriate level of care. As we continue to improve on the timeliness of the admission and concurrent review processes, we encourage you to use questionnaires. Users who submit requests using questionnaires receive real time approvals if criteria are met.

- **Referrals in general**: We’re conducting further research to determine what works well and what could work better on the site. You may have taken a short survey that we made available on the e-referral home page. The results will give us more direction of what’s needed to improve the e-referral website and your experience with it.

- **Clinical review process**: We’re always spreading awareness of the tools and resources available on BCN’s e-referral home page. There you’ll find:
  - BCN’s referral and clinical review program grid
  - The medical necessity criteria/benefit review requirements tool
  - Sample questionnaires
  - Clinical review procedures managed by eviCore
  - Behavioral Health tools and resources

Go to the [ereferral home page](#) to view these and other tools and resources.

- **Appeals process**: We’re conducting further research to determine how to ensure clarity and effortless use of the appeals process. Instructions on the appeals process are available in denial letters and in the *BCN Provider Manual*.

We value your opinion and welcome your feedback.

About the survey

The 2016 Physician Satisfaction survey was available electronically on our website during October, November and December 2016. More than 800 people answered our survey and all were placed in our drawing to win one of two $250 gift cards. We awarded two lucky winners. Your responses help us evaluate our efforts and determine other improvements to enhance our care management processes.

The survey questions were designed to gather information about how you use care management services and to measure your satisfaction with each of the functional units within Care Management. A five-point response scale allowed you to rate your satisfaction as very satisfied, satisfied, neutral, dissatisfied or very dissatisfied. We also allowed an “opt out” response of no opinion/don’t know. We didn’t include the no opinion/don’t know responses in the totals.
Providers should provide counseling on childhood BMI

The **Michigan Quality Improvement Consortium** guidelines recommend that the body mass index of children age 2 or older be assessed at each periodic health exam, using the CDC BMI-for-age growth chart (for either girls or boys) to obtain a percentile ranking.

A BMI assessment uses height and weight to screen children for possible overweight and obesity issues, but it isn’t a diagnostic tool. To determine if excess fat is a problem, a health care provider must perform additional tests that could include skin fold measurements, evaluations of diet, physical activity and family history and other appropriate health screenings.

Providers can counsel parents to help children maintain a healthy weight by doing the following:

- Serving five portions of fruits and vegetables a day
- Limiting screen time to two hours a day
- Encouraging at least one hour of physical activity per day
- Offering drinks that have no added sugar

**BMI assessment is one method for determining body fat**

Evaluating body mass index for adult patients is an inexpensive and easy screening method.

Providers looking for other ways to estimate body fat percentage in their adult patients can look into these most common methods:

- **Skinfold measurements.** Percent body fat can be estimated by using calipers to measure skinfold thickness at various sites on the body. The sum of the skinfolds taken at various sites is then converted to calculate percent body fat (American College of Sports Medicine, 2012). This technique is reasonably quick and usually accurate. Invalid values are the result of incorrect measurements or an incorrect formula used to calculate measurements.

- **BOD POD body composition assessment measurements.** A more advanced method is the BOD POD. These fiberglass pods are intended to measure body weight and body volume. Because fat is less dense than lean tissue, the weight-to-volume ratio can be used to predict percent body fat (ACSM, 2012).

- **Bioelectrical impedance analysis.** Another technique frequently used in gyms is bioelectrical impedance analysis, or BIA. The principle behind this technique is that fat contains little water; most of the body’s water is in the lean components of the body. Therefore, when an electrical current goes through fat, there is more resistance. By evaluating how simply a current moves through the body, body fat can be estimated.
Blue Care Network offers continuity of care in certain circumstances

Continuity of care is available for members whose primary care physician, specialist provider or behavioral health provider voluntarily or involuntarily disaffiliates from Blue Care Network or for members who are new to the plan and require an active course of treatment.

Members can’t see their current physician if he or she was terminated from BCN for quality reasons. The member is required to receive treatment from an in-network provider. BCN provides notification to members within 15 days after learning of the effective date of the practitioner’s disaffiliation.

BCN permits the member to continue treatment in the situations described below provided that the practitioner:

• Continues to accept as payment in full, reimbursement from BCN at rates applicable prior to the termination
• Adheres to BCN standards for maintaining quality health care and provides the necessary medical information related to the care
• Adheres to BCN policies and procedures regarding referral and clinical review requirements

Primary care physicians may offer continuity of care for a member in the situations described in the table below. Specialty providers may offer continuity of care for a member receiving an ongoing course of treatment in the situations described in this table.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Length of continuity of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>General care</td>
<td>90 days after the date of the practitioner notification to the member of the practitioner’s disaffiliation</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Through postpartum care directly related to the pregnancy, if the member is in the second or third trimester of pregnancy at the time of the practitioner’s disaffiliation</td>
</tr>
<tr>
<td>Terminal illness</td>
<td>For the remainder of the member’s life for treatment directly related to the terminal illness, if the member was being treated for the terminal illness prior to the practitioner’s disaffiliation</td>
</tr>
</tbody>
</table>

An active course of treatment is defined as:

• An ongoing course of treatment for a life-threatening condition: a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted
• An ongoing course of treatment for serious acute condition: a disease or condition requiring complex ongoing care, which the covered person is currently receiving, such as chemotherapy, postoperative visits or radiation therapy
• An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes
• The second or third trimester of pregnancy, through the postpartum period

A physician who is no longer affiliated with the network who desires to offer a member continuity of care must notify BCN and the member who desires approval of continuity of care. If approved, that provider must provide care in accordance with the conditions of payment and BCN policies. Providers may contact BCN’s Care Management department at 1-800-392-2512 to arrange for continuity of care services. Members should contact Customer Service by calling the number on the back of their member ID card.

A nurse provides written notification of the decision to the member and practitioners. Newly enrolled members must select a primary care physician before requesting continuity of care services and within the first 90 days of their enrollment.
Blue Care Network promotes continuity and coordination of care

Blue Care Network promotes continuity and coordination of care among specialists and primary care physicians.

We collect and analyze data each year to assess the exchange of information between the specialist and primary care physician following both inpatient and outpatient consultations. Many studies have identified fragmentation of care as a problem within today’s medical system. This information is important as we work together to improve continuity and coordination of care within our network.

Patient care that isn’t coordinated between providers and across settings results in confusion for members, increased risks to patient safety due to errors and unnecessary costs due to duplication of testing. The collaboration between practitioners can greatly improve both member satisfaction and health outcomes.

Our goal for exchange of information between the specialist and the primary care physician is 100 percent. We encourage primary care providers to make sure specialists have your information at the time of the visit. Likewise, specialists should forward post-visit information to the appropriate primary care provider.

We encourage all providers to enhance the information exchange across the continuum of care.

Know member rights and responsibilities

Blue Care Network members have certain rights and responsibilities. Providers should be aware of these rights. They are available at our website.
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:
A patient has a documented urinary tract infection with a temperature >99.4 and white blood count (WBC) >12,000. Would it be appropriate to use General Medical Intermediate criteria “SIRS and hemodynamic stability” to meet for an inpatient admission even though there is no documented systemic inflammatory response syndrome diagnosis?

Answer:
SIRS should actually be documented within the medical records.

1. There is a knowledge item regarding use of diagnosis in reviews.

   The question is, “Does the diagnosis need to be documented in the patient’s chart in order to apply diagnosis-specific criteria?”

   The response is, “To apply criteria related to a specific diagnosis or “rule out” diagnosis, the diagnosis must be documented in the medical record.

2. A patient with a UTI, a fever and high white blood count would not be appropriate for criteria within the General Medical subset.

   The General Medical subset can’t be used for issues addressed in Condition Specific subsets. This is stated in the review process, and in the General Medical subset note. Only the Infection GI/GU/GYN subsets can be used to review infections of the urinary tract. If the patient doesn’t have pyelonephritis, the case should be sent for secondary review for a determination regarding the medical necessity of hospitalization.

   Sepsis due to an infection of the GI, GU or GYN system is also included in this subset at both the Intermediate and Critical levels of care.
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
- Endovenous mechanochemical ablation for the treatment of varicose veins (ClariVein)
- Extra-aortic counterpulsation ventricular assist system (C-Pulse Heart Assist)
- Fecal incontinence – Investigational treatments
- Focal treatments for prostate cancer

Covered services
- Artificial pancreas device systems
- Gene expression profiling for uveal melanoma
- Genetic testing for cardiac channelopathies
- Skin and tissue substitutes

Celebrate men’s health June 12-18

Blue Care Network encourages providers to discuss recommended screenings with their male patients.

Men’s Health Week is a time to heighten the awareness of preventable health problems in men and boys.

Women are more likely than men to visit the doctor for annual exams and preventive services. Some tips for your male patients:

• **Eat healthy.** Start by taking small steps like saying no to supersizing and yes to a healthy breakfast. Eat many different types of foods to get all the vitamins and minerals needed. Add at least one fruit and vegetable to every meal.

• **Get moving.** Play with the kids or grand kids. Take the stairs instead of the elevator. Do yard work. Play a sport. Keep comfortable walking shoes handy at work and in the car. Most importantly choose activities that you enjoy to stay motivated.

• **Make prevention a priority.** Many health conditions can be prevented or detected early with regular check-ups. Regular screenings may include blood pressure, cholesterol, glucose and prostate health.

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• **Make prevention a priority.** Many health conditions can be prevented or detected early with regular check-ups. Regular screenings may include blood pressure, cholesterol, glucose and prostate health.
Referral to BCN not needed for diabetic retinopathy exam

Blue Care Network encourages its members who have diabetes to have a yearly exam for retinopathy. BCN providers don’t need to submit a referral to BCN for the annual eye exam when a contracted BCN provider performs the exam. A referral between the primary care physician and specialist must be documented in the member records at both offices.

If the member exceeds the one exam per year, a referral must be on file in your office for reference. If you have questions regarding provider referrals, contact your provider representative.

BCN also encourages diabetic members to talk to their physicians about:

- A yearly physical exam, including foot exam, blood and urine tests
- Special blood tests including hemoglobin A1c blood glucose tests at least twice a year and urine testing for kidney damage at least once a year
- Diabetes education classes (members need a referral from their primary care physician.)

Claims will pay for contracted providers (ophthalmologists and optometrists) when billed with these diagnosis and procedure codes: *92002, *92004, *92014, *92226, *92250, S3000, S0620, S0621

There are many more codes for diabetic retinopathy when billing ICD-10 codes. Use this CMS link to look up the equivalent ICD-10 codes for the following ICD-9 codes that we previously accepted: 249.5x, 250.xx, 648.0x

Another resource for ICD-10 is CDC.gov.
Quality corner: Follow-up after hospitalization

What is the follow-up after hospitalization for mental illness (seven days) measure, according to the Healthcare Effectiveness Data and Information Set® guidelines?

The percentage of members 6 years or older who were hospitalized for treatment of a selected mental disorder and who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within seven days of discharge.

**Recent changes to measure guidelines**

In the past, visits occurring on the date of discharge would count toward the numerator. However, for HEDIS 2018 (measurement year 2017), follow-up visits on the date of discharge will no longer count.

**Why is it important?**

Getting a follow-up in a timely manner may:

- Lower the chance of re-hospitalization
- Detect adverse responses to medications early on
- Ensure progress made during hospitalization is retained
- Provide continued support

**How can I ensure my patients are getting follow-up visits?**

- If you are the discharging hospital, make sure the patient has a follow-up visit scheduled before leaving your facility.
- If you are the mental health practitioner accepting the patient for follow-up, make sure that your office has capacity to see the patient within seven days.

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

**Resources for you**

Blue Care Network is offering an incentive for this measure as part of its Behavioral Health Incentive Program. Each time an office completes the measure according to HEDIS guidelines, they qualify to receive $100. To learn more about the incentive program, please see the article on page 27.

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1 https://www.harvardpilgrim.org/portal/page?_pageid=253,277266&_dad=portal&_schema=PORTAL
2 http://www.qualitymeasures.ahrq.gov/content.aspx?id=48642&search=follow+up+after+hospitalization

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

Quality corner: Antidepressant medication management

What is the antidepressant medication management measure, according to the Healthcare Effectiveness Data and Information Set (HEDIS) guidelines?

The percentage of members 18 years or older with a diagnosis of major depression, who are newly treated with antidepressant medication and who remained on the medication for at least:

• 84 days for the acute phase
• 180 days for the continuation phase

Why is it important?
Major depressive disorder:
• Can impair daily activities, as well as disrupt eating habits, sleep patterns, and concentration
• Affects nearly 15 million adults in the United States
• Results in lost work productivity
• Can lead to suicide or attempted suicide1

How can I ensure my patients adhere?
Know the common barriers to adherence:
• Regimen complexity
• Medication beliefs
• Cost2

Educating your patient is very important. Advise patients on when and how antidepressants should be taken, and how long they can expect to take them. Be prepared for questions about cost as well. Please remember that the members pay the least for drugs on the lowest tier of their drug list. Drugs on higher tiers cost the member more and may require prior authorization.

Resources for your patient
Blue Care Network has an informational guide on the member portal of bcbsm.com. Please direct them to the WebMD Health Services page on our website. Members will need to log in to their accounts and click on WebMD Health Services on the right hand side.

Provider incentive
Blue Care network is offering an incentive for ensuring the member completes the acute phase and the continuation phase, as part of its Behavioral Health Incentive Program. Each time the member adheres to his or her antidepressant medications according to HEDIS guidelines and completes the measure, the behavioral health provider (the psychiatrist) is qualified to receive $75 for the acute phase completion and $100 for the continuation phase completion. To learn more about the incentive program, please see the article on page 27.

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1 http://www.qualitymeasures.ahrq.gov/content.aspx?id=48934&search=antidepressant+medication+management

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Find information on Blue Care Network’s Behavioral Health Incentive Program for 2017

The Behavioral Health Incentive Program documents for 2017 are posted on web-DENIS. We have updated and posted the revised version. We’ve also created a summary flyer with quick references to measure details.

To find the booklet:
- Go to BCN Provider Publications and Resources.
- Click on Behavioral Health under Resources.
- Scroll down to Behavioral Health Incentive Program.

We encourage providers to submit electronically to receive a higher incentive payment. Instructions are on web-DENIS.

The Frequently Asked Questions document will be posted in May. It contains answers to questions your behavioral health colleagues have asked about the program.
How to meet the HEDIS criteria for medication reconciliation post-discharge

When patients are taking several medications, they need to be monitored for negative consequences. Approximately 1.5 million preventable adverse drug events occur in the United States each year, according to the Institute of Medicine.

The HEDIS® measure is the “percentage of discharges from January 1 to December 1 of the measurement year for patients 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.”

The measure, a critical piece of the follow-up care associated with care coordination for the patient’s post-hospital discharge, looks to accomplish the following:

• Address medication errors.
• Help patients understand how and when to take medications.
• Look for potential adverse interactions.

Implementing routine medication reconciliation after discharge ensures that a patient understands their medication regimen (new, changed and discontinued) and is critical in care coordination and transitions of care.

Here’s some information to help you understand the steps to take on medication reconciliation and how to bill.

What steps should be taken in medication reconciliation for a patient?

1. Collect a list of the patient’s current home medications, including all prescription and over-the-counter medications, including vitamins and supplements.
2. Review the list of medications that the patient has been prescribed upon hospital discharge.
3. Compare these lists – look for omissions, duplicates, interactions and gaps in therapy and dosages.
5. Communicate the reconciled list to the patient and caregiver both orally and in writing.

What are the criteria for the HEDIS measure?

• Denominator:
  - Members 18 years of age and older
  - Discharges from hospital between Jan. 1 through Dec. 1 of the measurement year
• Numerator:
  - Members for whom medications were reconciled on the date of discharge through 30 days after discharge (31 total days)
• HEDIS 2016:
  - BCN Advantage score : 26.8%
  - No benchmarks established (first year for reporting)

Please see Medication reconciliation, continued on Page 29
How do I bill for medication reconciliation?
The medication reconciliation may be conducted by a prescribing practitioner, clinical pharmacist or registered nurse.

Transition of Care codes may be used for billing:
- BCN reimburses primary care physicians only.
- CPT coding guidelines must be followed.
- Fee is based on locality.
- Use appropriate billing codes: *99495, *99496, 1111F

What should physicians do?
Communicate directly with patients and caregivers within two business days of discharge. Providers should also have a face-to-face visit within 14 days of discharge.

What are the documentation requirements?
- When CPT codes are not billed, health plans will look for evidence of medication reconciliation in the member’s outpatient chart.
- The medical record must include evidence of medication reconciliation and the date when it was performed.
- Medication reconciliation must be performed on the date of hospital discharge through 30 days after discharge.
- Any of the following meets criteria for this measure:
  - Documentation that the provider reconciled the current and discharge medications
  - Documentation of the current medications with a notation that references the discharge medications (for example, no changes in medications since discharge, same medications at discharge, discontinue all discharge medications)
  - Documentation of the member’s current medications with a notation that the discharge medications were reviewed
  - Documentation of a current medication list, a discharged medication list and notation that both lists were reviewed on the same date of service
  - Notation that no medications were prescribed or ordered upon discharge

What are the details of the BCN Advantage pharmacy medication reconciliation program?
The BCN Advantage pharmacy department completes medication reconciliation for members discharged from partner hospitals.

Our partner hospitals include: McLaren Flint, McLaren Greater Lansing, Genesys Regional Medical Center, St. Joseph Mercy Hospital, Ann Arbor, William Beaumont Hospital, Dearborn, University of Michigan Health System and Sparrow Hospital.

- BCN Advantage pharmacist calls the member at home within seven days of discharge.
  - Pharmacist completes a medication reconciliation report and mails it to the primary care physician.
  - The report should be placed in the member’s chart and can be used for documentation of medication reconciliation.
  - Providers may still perform medication reconciliation and bill.

Can medication reconciliation be provided for one of my patients that has been recently discharged from a hospital not currently in the medication reconciliation program?
Yes, a BCN Advantage pharmacist will conduct a medication reconciliation at a doctor’s request, for patients who have been discharged at non-partner hospitals.

If you have a member who you think could benefit from a BCN Advantage pharmacist medication reconciliation, contact us at the “Take My Meds” phone line at 1-855-815-9414.
Health care disparities reports focus on racial and socioeconomic factors

The National Healthcare Disparities Report is a government report that focuses on health care disparity issues in the United States. Each year since 2003, the Agency for Healthcare Research and Quality has reported on progress and opportunities for improving health care quality and reducing health care disparities. As mandated by the U.S. Congress, the National Healthcare Quality Report focuses on national trends in the quality of health care provided to the American people.

The National Healthcare Disparities Report focuses on prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations.

Please see Socioeconomic factors, continued on Page 31
Socioeconomic factors, continued from Page 30

The NHDR focuses on disparities related to race, ethnicity, and socioeconomic status as shown in the chart below.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Disparities Improving</th>
<th>Disparities Worsening</th>
</tr>
</thead>
<tbody>
<tr>
<td>65+ compared with 18-44</td>
<td>Cancer deaths per 100,000 population per year (CC)</td>
<td>Maternal deaths per 100,000 live births</td>
</tr>
<tr>
<td></td>
<td>Deaths per 1,000 adult hospital admissions with acute myocardial infarction (HD)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prostate cancer deaths per 100,000 male population per year (CC)</td>
<td></td>
</tr>
<tr>
<td>Black compared with White</td>
<td>Hospital admissions for congestive heart failure per 100,000 population (HD)</td>
<td>Breast cancer diagnosed at advanced stage per 100,000 women age 40 and over</td>
</tr>
<tr>
<td></td>
<td>Incidence of end stage renal disease due to diabetes per 100,000 population (DC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Long-stay nursing home residents who were assessed for pneumococcal vaccination (CMS)</td>
<td></td>
</tr>
<tr>
<td>Asian compared with White</td>
<td>Hospital patients with pneumonia who received pneumococcal screening or vaccination (CMS)</td>
<td>Children 0-40 lb for whom a health provider gave advice about using car safety seats</td>
</tr>
<tr>
<td></td>
<td>Hospital patients with heart failure discharged home with written instructions (CMS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital patients with pneumonia who received influenza screening or vaccination (CMS)</td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaska Native compared with White</td>
<td>Incidence of end stage renal disease (ESRD) due to diabetes per 100,000 population (DC)</td>
<td>Adults age 50 and over who ever received a colonoscopy, sigmoidoscopy, or proctoscopy</td>
</tr>
<tr>
<td></td>
<td>Infant deaths per 1,000 live births, birth weight &lt;1,500 grams</td>
<td>People with difficulty contacting their usual source of care over the telephone (AC)</td>
</tr>
<tr>
<td></td>
<td>Patients who received surgical resection of colon cancer that included at least 12 lymph nodes pathologically examined</td>
<td></td>
</tr>
<tr>
<td>Hispanic compared with non-Hispanic White</td>
<td>Hospital admissions for congestive heart failure per 100,000 population (HD)</td>
<td>Adults age 50 and over who never received a colonoscopy, sigmoidoscopy, or proctoscopy</td>
</tr>
<tr>
<td></td>
<td>Hospital patients with pneumonia who received pneumococcal screening or vaccination (CMS)</td>
<td>Adults who did not have problems seeing a specialist they needed to see in the last year (AC)</td>
</tr>
<tr>
<td></td>
<td>Hospital patients with pneumonia who received influenza screening or vaccination (CMS)</td>
<td></td>
</tr>
<tr>
<td>Poor compared with high income</td>
<td>Hospital admissions for asthma per 100,000 population (2-17, 18-64, 65 and over)</td>
<td>People without a usual source of care who indicated a financial or insurance reason for not having a source of care (AC)</td>
</tr>
<tr>
<td></td>
<td>Hospital admissions for long-term complications of diabetes per 100,000 population age 18+ (DC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients who received surgical resection of colon cancer that included at least 12 lymph nodes pathologically examined</td>
<td></td>
</tr>
</tbody>
</table>

**Key:** CMS = CMS publicly reported measures; CC = cancer care; DC = diabetes care; HD = heart disease; AC = access

Please see Socioeconomic factors, continued on Page 32
Most of us recognize that it makes a difference in people’s lives when breast cancer is diagnosed early; when a patient having a heart attack gets the correct lifesaving treatment in a timely manner; and when medications are correctly administered.

In an increasingly diverse country, it’s important that we listen to our patients and their families so we get a better understanding of how their culture, beliefs and life circumstances may affect their health and compliance. With the publication of this 11th report, the Agency for Healthcare Research and Quality continues to contribute to efforts which encourage and support the development of national, state, tribal and local solutions using national data and achievable benchmarks of care. With the future uncertainty of the Affordable Care Act, it is clear that the financial burden is high for uninsured individuals; almost 50 percent of personal bankruptcy filings are due to medical expenses (Jacoby, et al., 2000). Uninsured individuals report more problems getting care, are diagnosed at later disease stages and get less therapeutic care. They are sicker when hospitalized and more likely to die during their stay (Hadley & Holahan, 2004). This results in a significant decrease in quality of life.

Blue Care Network is striving to capture more member self-reported data on language, race and ethnicity to help improve access to care and reduce disparities. This data will help us partner with the provider community in identifying and acting upon disparities present within our population.

BCN has identified health care disparities among certain ethnic groups and has a committee to develop actions to address identified health care gaps. We encourage all contracted providers to identify member demographics in Health e-Blue.

References:


Blue Care Network medical record guidelines support CMS and NCQA standards

Blue Cross Blue Shield of Michigan and Blue Care Network maintain a policy for content of medical records. Please make yourself familiar with our requirements.

A clinical record must be maintained for each our members. The clinical record should:

- Be contemporaneous and organized so it can be easily accessed and reviewed for reporting purposes
- Be stored or electronically secured to ensure compliance with HIPPA regulations.
- Include the following about the member’s care:
  - Demographics
  - Health assessment
  - Reason for visit
  - Diagnoses
  - Documentation of discussion about advanced directives, preventive health and maintenance, follow-up plan, consultation review and referred services review

Our medical record-keeping policies support the Centers for Medicare & Medicaid Services and National Committee for Quality Assurance standards and contain elements from the Michigan Quality Improvement Consortium Guidelines.

BCN’s Quality Management Department’s nurses conduct medical record reviews on a random sample of our contracted primary care, internal medicine, OB/GYN and behavioral health provider offices to monitor compliance with our policies. We also conduct annual reviews for providers who are credentialing or recredentialing, providers who are identified as non-credentialed and providers with three or more substantiated complaints. The performance expectation is an overall score of at least 80 percent. We have medical record checklists available to assist practitioners with medical record guidelines.

Feedback from the 2016 medical record review summary reflects an overall improvement from 2015. All providers reviewed achieved an overall score of 80 percent or higher.

Opportunities for improvement for individual clinical elements that did not meet the 80 percent compliance threshold in 2016 include:

- Documentation regarding advance directives
- Intimate partner screening
- Hepatitis C screening
- HIV screening
- Lung cancer screening

These screening guidelines can be found at the MQIC website.

MQIC updates guidelines

The Michigan Quality Improvement Consortium has updated the guidelines listed below. They are available on the MQIC website.

- Adolescent and Young Adult Health Risk Behavior Assessment clinical practice guideline and alert
- Diagnosis and Management of Adults with Chronic Kidney Disease clinical practice guideline and alert
- Acute Pharyngitis in Children 3-18 Years Old clinical practice guideline and alert
- Adults with Heart Failure with Reduced Ejection Fraction clinical practice guideline and alert

Please note: The pharyngitis and heart failure guidelines have new titles and the URLs on the website have changed. If you have any bookmarks for these guidelines, you’ll need to update them.
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 [bcbsm.com/providers](http://bcbsm.com/providers). 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, distribution 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 the variability in physician practice and medical care delivery.

Our Quality Improvement Program encourages adherence to MQIC guidelines and offers interventions to improve health outcomes for BCN members. Some examples include member and provider incentives, reminder mailings, telephone reminders, newsletter articles and educational materials. We monitor compliance with the preventive health guidelines by conducting 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

We are focusing improvement efforts on the following areas:

- 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
In 2016, BCN Advantage℠ received four or five stars in the CMS star rating and the NCQA 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 our members have appropriate access to care, BCN has access and availability standards for the following types of appointments: preventive care, routine primary care, non-life threatening emergent and urgent care and after-hours access. Access monitoring is conducted throughout the year by quality management staff.

Physicians who are noncompliant with access standards have the opportunity to make improvements. More information is available in the BCN Provider Manual. Log in to web-DENIS, click on Provider Manual and open the Access to Care chapter.

If you’d like additional information about our programs or guidelines, please email our Quality Management department at BCNQIQuestions@bcbsm.com, or call 1-248-350-6242.
RC Claim Assist Tool is now available to Blue Care Network providers

RC Claim Assist, created by RJ Health Systems, is now available to Blue Care Network providers. This tool can assist in accurately converting level units for HCPCS and CPT® codes to National Drug Code-level billable units. The RC Claim Assist tool should be used only for claims submitted to Blue Cross Blue Shield of Michigan and BCN.

Benefits of RC Claim Assist
- It provides a comprehensive crosswalk of HCPCS and CPT drug codes, product names and national drug codes.
- It offers complete drug information on package-size billable units and reference pricing.

Things to know
- The tool should be used as a general reference only. It should be used along with other sources such as applicable fee schedule.
- The data in the tool are real time and not date-of-service specific.
- The tool doesn’t reflect any benefit, payment or medical policy.

How do I access RC Claim Assist?
1. Visit ereferrals.bcbsm.com and click the BCN tab.
2. In the BCN Authorizations/Referrals section, click Medical Benefit Drugs – Pharmacy.
3. Under the Billing/pricing information – for BCN commercial members only” heading, click RC Claim Assist log-in.

Note: First time users will have to register to obtain their log-in information.

You can find more information, including an instructional video, on the RC Claim Assist website under the About tab.

Other questions?
- If you have any questions concerning the data on RC Claim Assist, send an email to info@rjhealthsystems.com.
- If you have questions regarding billing or claims, contact Provider Inquiry at 1-800-255-1690.
- If you have questions about a claim that is contractual or complex in nature, contact your provider consultant.

Blue Cross Blue Shield of Michigan and Blue Care Network 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.
BCN expanding site of care optimization program on July 1, 2017

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

To help manage these costs, starting July 1, 2017, BCN will add the drugs listed below to its site of care optimization program. This program redirects members receiving select injectable or infusible drugs in the outpatient hospital setting to a lower cost, alternate site of care such as the physician’s office or member’s home.

<table>
<thead>
<tr>
<th>Brand name</th>
<th>J Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benlysta®</td>
<td>J0490</td>
</tr>
<tr>
<td>Cimzia®</td>
<td>J0717</td>
</tr>
<tr>
<td>Cinqair®</td>
<td>J2786</td>
</tr>
<tr>
<td>Entyvio®</td>
<td>J3380</td>
</tr>
<tr>
<td>Ilaris®</td>
<td>J0638</td>
</tr>
<tr>
<td>Nucala®</td>
<td>J2182</td>
</tr>
<tr>
<td>Xolair®</td>
<td>J2357</td>
</tr>
</tbody>
</table>

Effective July 1, 2017, all BCN commercial members receiving these drugs in the outpatient hospital setting require review for site of care requirements. This includes administration to first-time and current users of these medications.

These changes do not apply to BCN AdvantageSM members.

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

To get a list of drugs in the program and how to request authorization, visit the Medical Benefit Drugs – Pharmacy web page in the BCN section of ereferrals.bcbsm.com.

Additional medical drugs will require prior authorization, clinical review effective July 1, 2017

Starting July 1, 2017, BCN AdvantageSM will require prior authorization/clinical review for the medications listed below before these drugs will be covered under the member’s medical benefits.

<table>
<thead>
<tr>
<th>Medication</th>
<th>J Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eylea®</td>
<td>J0187</td>
</tr>
<tr>
<td>Macugen®</td>
<td>J2503</td>
</tr>
<tr>
<td>Lucentis®</td>
<td>J2778</td>
</tr>
<tr>
<td>Kyprolis®</td>
<td>J9047</td>
</tr>
<tr>
<td>Yervoy®</td>
<td>J9228</td>
</tr>
<tr>
<td>Rituxan®</td>
<td>J9310</td>
</tr>
</tbody>
</table>

Providers must submit authorization requests for these drugs using the NovoLogix web tool and must include the following clinical information to support the request:

- Diagnosis
- Lab results
- Names of medications previously used to treat the member’s condition, including dose, regimens, dates of therapy and response

Information about using the NovoLogix web tool is available on the Medical Benefit Drugs – Pharmacy web page on the e-referral website.
BCN requires approval for testosterone products covered under members’ medical benefits

Over the past several years, the market for testosterone products has grown and is projected to reach $5 billion this year. With no new medical indication for testosterone therapy, this increase may be linked to overuse and misuse, driven in part by patient demand.

To ensure that our members receive appropriate, safe and cost-effective drug therapies, Blue Care Network implemented prior authorization guidelines in July 2016 on most testosterone products covered under commercial members’ medical benefits. The new criteria are in response to the new practice guidelines and potential safety concerns.

BCN authorized continued use for 12 months for male members who used one of these products. This authorization provided physicians with adequate time to evaluate members who currently use the therapy and determine whether the member meets BCN’s criteria.

Starting July 1, 2017, all commercial members must meet prior authorization criteria for selected testosterone products on the medical benefit. These changes won’t apply to BCN AdvantageSM members.

BCN doesn’t cover testosterone for use as testosterone replacement therapy for our female members.

BCN’s prior authorization criteria align with the Endocrine Society Clinical Practice Guidelines to promote cost-effective and high quality drug therapy. Practice guidelines support the use of testosterone replacement only in men who have consistent signs and symptoms of deficiency and unequivocally low serum testosterone levels.

When considering prescribing testosterone products for BCN members, please keep these criteria in mind:

- Males with a diagnosis of androgen deficiency syndrome
  - Two morning testosterone levels below the normal range (free testosterone levels may be required)
  - At least two clinical signs or symptoms specific to androgen deficiency
    » Incomplete or delayed sexual development, eunuchoidism
    » Breast discomfort, gynecomastia
    » Loss of body (axillary and pubic) hair, reduced shaving
    » Height loss, low trauma fracture, low bone mineral density
    » Hot flushes, sweats
- Dose titrations based on clinical response and testosterone levels
- Clinical assessment and monitoring per Endocrine Society Clinical Practice Guidelines
- Requires treatment failure of or intolerance to a preferred agent
- Annual authorization to confirm appropriate use and therapeutic response

These testosterone products will require prior authorization:

<table>
<thead>
<tr>
<th>J code</th>
<th>Generic name</th>
<th>Brand name</th>
<th>Quantity limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>J3145</td>
<td>testosterone undecanoate</td>
<td>Aveed®</td>
<td>750mg (3ml) every 10 weeks</td>
</tr>
<tr>
<td>S0189</td>
<td>testosterone pellet</td>
<td>Testopel®</td>
<td>450mg (six pellets) every three months</td>
</tr>
</tbody>
</table>

References:
When is it appropriate to use a ‘history of’ code when reporting cancer?

As you’ve read in “Coding corner” before, selecting the code that best captures a patient’s condition at the time of his or her visit can be a challenge, but keeping some basic guidelines in mind can help. Here’s what you need to know about coding for cancer.

Your documentation should always specify one of the following:

- The cancer is active and still being treated.
- The cancer is no longer active or there’s no recurrence and no further treatment is necessary.

When coding for active malignancy versus coding for a person with a history of malignancy, ICD-10 coding guidelines are specific. Section I.C.2.m. states:

“When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

“When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85, personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.”

Scenario one:

A patient with a history of breast cancer and mastectomy of the right breast — but who has no evidence of cancer or isn’t currently receiving treatment — comes in for an office visit. The provider documents that there are no presenting problems that may affect the overall plan of care and that the patient isn’t receiving active adjuvant therapy. In this scenario, a personal history code should be used. Example: Z85.3 Personal history of malignant neoplasm of breast

Patients who currently have cancer

In the scenarios below, the condition is still being actively managed, so a current malignancy code should be used. Example: C50.111 Malignant neoplasm of central portion of unspecified female breast

Scenario two:

A patient diagnosed with breast cancer returns to the office for a visit after a mastectomy and is currently receiving radiation therapy.

Scenario three:

A patient, diagnosed with breast cancer last year, had a mastectomy followed by radiation and chemotherapy. She was hormone receptive and is currently taking Arimidex®.

In summary

To ensure best documentation practices, refer to the ICD-10-CM guidelines to assist with the code selection that clearly supports the documentation. Clinical evidence needs to be documented to support an active diagnosis of cancer. The documentation must clearly state that the cancer is currently and actively being treated and managed. If the cancer has been excised or eradicated and there’s no evidence of recurrence and no further treatment is needed, then it’s appropriate to use a “personal history” code.

Coding tip

If a cancer is active and being treated, it shouldn’t be considered “past medical history” until the cancer is no longer active.

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 all applicable state and federal laws and regulations.

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**Billing Q&A**

**Question:**
What is the filing limit for a secondary and tertiary claim? If there is any other new claim information for 2017 that may not be listed on your site could you please include that information as well?

**Answer:**
Information on claims submissions is located in the BCN Provider Manual in the Claims chapter.

The filing limit is 18 months from the date of service or discharge when another carrier is primary, when those claims have been submitted initially to the primary carrier. Otherwise the limit for submission of new claims is 12 months from the date of service or discharge.

**Question:**
I’m unable to find any information on billing J codes to Blue Care Network. How should we bill for J3301, J7321 and J7324?

**Answer:**
There are no special billing instructions for the listed J codes. While certain drug codes require specific authorization, these services don’t currently require specific authorization and are allowed under a global referral.

We’d expect that these drugs will be used in accordance with approved guidelines and may be subject to clinical editing guidelines.

**Question:**
Our cardiology office does the ambulatory ECG testing, not the Holter, but the ambulatory monitoring goes beyond 48 hours, sometimes up to 14 days. I am unsure about the authorization or billing process. Can you advise?

**Answer:**
As noted in a related article (See Page 44), the services for external ECG monitoring devices that are used for continuous recording and storage of data on a long-term basis (greater than 48 hours), such as Zio Patch® and LifeStar ACT no longer require an authorization or referral. The service must be ordered and coordinated by the patient’s cardiologist and provided by a contracted provider. The services are then reported to BCN, preferably on an electronic claim form using the appropriate procedure code or codes for the services performed.

The procedure codes we have identified for this service include *0295T, *0296T, *0297T and *0298T.

**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.

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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:

- Assistant at surgery
- Fluoride varnish

Ambulance providers – Tips for billing mileage

Ambulance claim billing differs based on whether the trip is less than 100 miles.

**For trips under 100 miles:** Include actual mileage down to the tenth of a mile. Please do not round miles up or down. This will be important when we implement a new system update on or after June 1, 2017. To receive accurate payment, make sure your claims include actual mileage in the ambulance section (the CR 106 element of the CR1 segment on the 837 professional claim).

**For trips 100 miles or more:** The mileage should be rounded up to the nearest whole number mile in the ambulance section. Do not use tenths of a mile.

Here are some examples:

- If the trip mileage is 28.7 miles, use 28.7 on your claim. Because this is below 100 miles, don’t round the units to 29.
- If the trip mileage is 101.3 miles, round up to 102 miles on your claim.
Submit authorization requests electronically for services eviCore reviews

For services reviewed by eviCore healthcare, using the eviCore electronic provider portal is the quickest, most efficient way to initiate authorization requests and check the status of an existing request.

Here are some benefits of using eviCore’s provider portal:
• Create an authorization request in minutes.
• Save your progress.
• Print the information.
• Access 24/7.

Accessing and registering to use the portal
Here’s how to access the portal:
2. Click Providers (top of the page).
3. Log in.

If you haven’t registered to use the portal, click Register on the login page and sign up.

What eviCore reviews
As a reminder, eviCore healthcare reviews the following services for BCN HMO℠ (commercial) and BCN Advantage℠ members:
• Cardiology
• Interventional pain management
• High-tech radiology
• Radiation therapy
• Outpatient physical, occupational and speech therapy
• Physical medicine services by chiropractors (for BCN commercial members only)

It’s important to note that authorization requests for outpatient physical, occupational and speech therapy services and physical medicine services by chiropractors are initiated in the e-referral system but are continued through eviCore’s provider portal.

Look for additional information on eviCore’s review of services atereferrals.bcbsm.com. Click BCN and then click eviCore-Managed Procedures.

BCN reviews inpatient readmissions within 14 days effective Jan. 19, 2017

Blue Care Network is reinstating our previous inpatient readmission review guidelines in response to feedback from our providers.

Effective Jan. 19, 2017, BCN is reviewing inpatient readmissions as follows:
• BCN reviews readmissions that occur within 14 days of discharge for the same or a related condition.
• Readmission reviews are conducted according to the Guidelines for Bundling Admissions document dated November 2013. That document is now available on BCN’s Provider Publications and Resources website in Provider Secured Services.

Readmissions within 30 days of discharge that were reviewed from Oct. 1, 2016 through Jan. 18, 2017 will not be revisited, but we will conduct additional research before implementing any further changes.

You can access the Guidelines for Bundling Admissions document by completing the following steps:
1. Visit bcbsm.com/providers and click Login.
2. Log in as a provider, using your user name and password.
3. Click BCN Provider Publications and Resources.
4. Click Billing / Claims.
5. Click Guidelines for Bundling Admissions.

The 14-Day Readmission Checklist is also available again. You can access the checklist by completing the following steps:
1. Visit bcbsm.com/providers and click Login.
2. Log in as a provider, using your user name and password.
3. Click BCN Provider Publications and Resources.
4. Click Forms.
5. Click 14-Day Readmission Checklist.
Hospitals must use form to submit clinical information for BCN initial inpatient admissions through e-referral

Effective June 1, hospitals are required to submit certain clinical information for initial inpatient admissions through the e-referral system to meet InterQual® criteria or BCN’s Local Rules for Blue Care Network HMO℠ (commercial) and BCN Advantage℠ members. Hospitals must complete the Request for Review of Initial Inpatient Admission form and attach it to the case in e-referral.

About the form
The form is located at ereferrals.bcbsm.com. Click BCN and then click Clinical Review & Criteria Charts. Look under the heading “Referral / clinical review information.”

Hospitals should submit only the clinical information that is required on the form to ensure timely processing of the request. This information includes an assessment of whether InterQual criteria or BCN’s Local Rules (as applicable) are met.

Additional information
If a BCN nurse contacts the hospital to request additional information, the hospital needs to add the information through e-referral. If the case is already decided, any additional information would be considered concurrent and should be faxed to us.

As a reminder, all inpatient admission requests must be submitted through e-referral except for sick and ill newborn requests, which must be faxed to BCN. See the guidelines for submitting to BCN for additional information.
Blue Care Network updates authorization guideline for external ECG monitoring

Blue Care Network has updated its authorization guideline for external ECG monitoring devices that are used for continuous recording and storage of data on a long-term basis (greater than 48 hours), such as Zio Patch® and LifeStar ACT.

Effective immediately, the following procedure codes will no longer require clinical review for either BCN HMO® or BCN Advantage® members when ordered and provided by a cardiologist:

- *0295T
- *0296T
- *0297T
- *0298T

Patients are still expected to meet the criteria for coverage which specify that external ECG monitoring is an alternative to Holter monitoring in patients:

- Who experience symptoms suggestive of cardiac arrhythmias (for example, palpitations, dizziness, presyncope or syncope)
- With atrial fibrillation who have been treated with catheter ablation, and in whom discontinuation of systemic anticoagulation is being considered
- With cryptogenic stroke

The external ECG monitoring is excluded from coverage in the following situations:

- Real-time outpatient cardiac telemetry (also known as mobile cardiac outpatient telemetry, or MCOT) as a diagnostic approach in patients who experience infrequent symptoms (less frequently than every 48 hours) suggestive of cardiac arrhythmias (palpitations, dizziness, presyncope or syncope). This technology isn’t considered medically necessary. Direct evidence for improved health outcomes with the use of continuous, real-time monitoring for suspected arrhythmias is lacking. Evidence for a significant incremental improvement in outcomes with the continuous, real-time monitoring, compared with standard monitoring, is also lacking.

- Other uses of ambulatory event monitors, including outpatient cardiac telemetry, are considered experimental, including but not limited to:
  - Detection of myocardial ischemia by detecting ST segment changes (intracardiac ischemia monitoring systems)
  - Monitoring effectiveness of antiarrhythmic medications that haven’t met other inclusionary criteria

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