Teen suicide: Factors that influence adolescent behavior and how they may be mitigated

By Dr. Beecroft, M.D.

Teenage and adolescent suicide is a very serious issue in the United States. Suicide is the second leading cause of death for young people 12 to 18.¹ Each day in the U.S. there are, on average, more than 5,240 suicide attempts by young people grades 7-12. The National Center for Health Statistics, in 2003, reported the suicide rate was 7.3 per 100,000 among youth aged 15-19, making it the third leading cause of death among adolescents at that time showing an increasing frequency.²

Please see Medical Director, continued on Page 2

PARS now provides claims information

You can now get claims or benefits and eligibility information when you call the Provider Automated Response System, also known as PARS, starting July 14.

If you choose the benefits/eligibility option, you’ll receive the current information for your patient, just like today. If you choose claims option, you can get the status of a claim, payment and rejection details, check information and member liability. Claims information is available through PARS 24 hours a day, seven days a week.

Selecting “Claims Information” provides options for Claims Status or Claims Inquiry. Claims Status includes information on a claim you’ve already submitted. Claims Inquiry offers additional information about a remittance you have already received.

Please see PARS, continued on Page 4

Inside this issue...

11 Chronic Care Improvement Program focuses on blood pressure control
27 Best practices: Managing medication compliance helps patients with depression
31 Coding corner: What to know when coding for vascular disease
38 Blue Care Network requires prior authorization for excisional breast biopsy
Medical Director, continued from Page 1

During a recent continuing medical education conference sponsored by Harvard medical school, Marisa Silveri, Ph.D., a behavioral neuroscientist at McLean Hospital, shared some insights about why adolescents may be particularly vulnerable to suicidal thoughts and actions. We develop additional myelination of neurons as we age and for this age group this enhances the connection between the amygdala and the frontal lobe, Silveri said. This connection enhancement helps modulate the impulsiveness and “right now” thinking that characterizes adulthood. This helps us think through the consequences of actions rather than just act.

Having more life experiences and learning from consequences of earlier decisions also helps us problem-solve the options available to us as we age, she explained. This experience isn’t usually available to teenagers as they haven’t been exposed to as many life lessons and, therefore, have fewer options to choose from. The stresses on teenagers are immense. Pressure from peers, parents, siblings, bullying, news media, social media, as well as educational and vocational expectations can seem overwhelming. This is especially true if there is an unforeseen circumstance that occurs to derail future plans.

Prediction of suicidal behavior has been the subject of multiple studies over the past 50 years, but there’s no definitive method of determining with certainty if a person is going to attempt suicide. The Columbia-Suicide Severity Rating Scale has become the gold standard for the assessment of suicidal ideation and behavior in clinical trials. This evidence suggests that the Columbia-Suicide Severity Rating Scale is conceptually and psychometrically flawed and doesn’t map to the U.S. Food and Drug Administration’s new standards. A new gold standard for assessment of suicidality may be warranted. So how are we to predict adverse outcomes of adolescents when it comes to suicide assessment?

One promising method of assessing and detecting suicide risk is the Signs of Suicide program, or SOS. This is a detection and prevention program primarily used in schools. It was developed by the same group organizing the National Depression Screening Day.

The two-year study involves more than 2100 students in five schools. It utilizes a curriculum that educates about suicide issues and risks along with screening tools for depression and other mental health issues.

Although in your practice there is no definitive tool that can measure suicide intent or predict suicide completion, information from the SOS suicide prevention program shows you can identify members at risk. Often, signs of concern mimic typical teenage behaviors. However, if multiple signs persist over a period of time and the behavior is a significant change in usual behavior, then closer attention is warranted.

Look for family patterns of mood disorder. Listen to what your patients are saying. Stories of bullying or social media pressure may not be easy to elicit.

Please see Medical Director, continued on Page 3
Using depression and anxiety screening tools for all of your patients can be the start of a dialogue with them about their mental health needs. Inferring family stress or communications difficulty by listening independently to different members of the family could clue you in to one or more members that need some type of intervention. This may warrant a longer session to explore what is happening in their lives and possibly paving the way for a more specialized psychological or psychiatric evaluation. You may have a psychiatrist, psychologist or therapist that could give you a ‘curbside’ consult as to next steps while waiting to have them evaluated.

The use of antidepressants in adolescents has its place, despite black box warnings that use of these medications by adolescents can increase suicide risk.

A review article in a recent American Journal of Psychiatry compared the industry-funded studies and the National Institutes on Mental Health-funded studies and concluded, “The NIMH-funded studies demonstrate a good efficacy for antidepressant medications in pediatric depression and should be heavily weighted in any review of the literature.”

Each person’s treatment plan needs to be individualized, recognizing the risks and benefits of treatment. Therapy as a primary treatment and no treatment each carry risks in the vulnerable patient. Clozaril and lithium have been known in the medical lore to decrease suicide risks but aren’t generally considered first line treatments for depression or mood disorders and have significant risks themselves.

Generally, initial treatments of mood disorders still include psychotherapy with or without antidepressants. If you suspect bipolar illness, you might consider prescribing a mood stabilizer before an antidepressant.

Referral to a specialist is a good idea but can take some time. If it’s obvious that the member can’t wait for an outpatient appointment, there are partial hospitalization programs around the state that can see the member relatively quickly and provide intensive diagnosis and treatment interventions while the patient is still living at home and potentially going to school. The amount of therapeutic work a patient can achieve in a partial hospital program in a week is about what can be achieved in an outpatient setting in a month.

Family therapy is another very helpful tool especially if communication has been strained or broken down within the family unit. Short-term residential treatment may be of help but only if the program involves families early and often and provides comprehensive treatments including group, individual and medication assisted treatments.

Suicide detection and prevention takes a lot of interested individuals to facilitate. The primary care provider is a pivotal resource person for the individual patient and the entire support system of the individual. Initial interventions and screening are very important. Listening to your patients and looking for veiled requests for help are crucial. Don’t hesitate to use BCN Behavioral Health services, available 24 hours a day, seven days a week. We can assist you with referrals and suggestions to get your patients the care they need.

1 https://www.cdc.gov/injury/wisqars/
4 AM. J. Psychiatry 174:5 May 2017; pp430-437
When checking on either Claims Status or Claims Inquiry, provide the following information:

- Provider information billed on the claim
  - Facility Code or Professional Provider ID, National Provider Identification, or Tax Identification Number for ancillary services

  You must authenticate with your provider information to obtain any claims information. We can’t provide protected health information without this verification.

- Patient contract number
- Patient name
- Patient date of birth
- Date of service
- Member’s enrollee ID number (nine digits)
- Charged amount on the claim
- Procedure code or revenue code (if additional claim detail is requested)

Claim status

If a claim has already been submitted, but a response has not been received, select Claims Status. PARS will find the claim in the system and provide applicable information.

For finalized claims, the following information is available:

- Paid claims
  - ICN number (internal claim number)
  - EFT Trace number (for electronically paid providers) or the check number
    - EFT payment date or the check date & check posting date
  - Total amount paid on the claim
  - Member cost share applied
    - Deductible
    - Coinsurance
    - Copayment
  - PARS will tell you if the claim was processed to the subscriber, and payment date, if applicable.

- Rejected claims
  - ICN number
  - Denial reason
  - Date the claim was finalized

Specific, detailed information is also available for each claim line; you will be asked to provide the procedure code or revenue code. PARS will then provide the following at claim-line level:

- Charged amount
- Allowed amount
- Payment amount
- Rejection/denial reason
- Member liability (deductible, coinsurance, copay) if applicable

A hard copy of this claim status information will also be available upon request. This hard copy will include applicable payment or rejection/denial information but it is not intended as a replacement for provider vouchers. Hard copies won’t be available for Federal Employee Program or Blue Care Network.

For pending claims, the following information is available:

- ICN number (internal claim number)
- Date claim was received
- Message indicating the claim is pending
  - If the claim has been pending less than 30 days, please allow additional time for the claim to finalize.
  - If the claim has been pending for more than 30 days, you’ll have the option to transfer to a call center.

If no claim is found, there is no claim on file. You’ll need to resubmit it.

Claims inquiry

If a remittance has already been received, but further discussion is needed, PARS offers options to speak to a customer service representative. However, calls can only be transferred to a Customer Service call center during the hours the call center is open.

- Call PARS using the appropriate number.
- Select the Claims Information option
- Say "no" when PARS asks if you’re calling about the status of a claim.
- Say "yes" when PARS asks if you have received a Remittance Advice.
**PARS, continued from Page 4**

- Select from among the following additional options:
  - Payment other than anticipated
  - Clarify a rejection/denied claim
  - Discuss account receivables/account payables
  - Follow-up on a previously submitted inquiry or dispute
  - Obtain status on a previously submitted medical-surgical preauthorization request (only for Blue Cross policies)
  - Preauthorization requests are not handled through the call centers. However, if a medical-surgical preauthorization request has already been submitted in writing, the status of this request will be available.
  - Initiate a recovery (for Blue Cross commercial and Blue Cross Medicare Plus Blue only)
  - Check status (for BCN Advantage and Blue Cross Medicare Plus Blue only)
  - Appeals (only for BCN HMO and BCN Advantage policies)

PARS will provide claims information for the following lines of business:
- Professional
- Facility
- Vision
- Dental (FEP only)
- Hearing

The following products will be available for claims information on PARS:
- Blue Cross Blue Shield of Michigan Commercial
- Blue Cross Medicare Advantage
- BCN Commercial
- BCN Advantage
- Federal Employee Program

The following claims information won't be available on PARS:
- Pharmacy
- Dental (FEP Dental claims information will be available)
- Payments made via manual check writing
- MESSA paid claims

**Provider Inquiry is joining PARS**

**Call PARS starting July 14**

Effective July 14, we’re combining our Provider Inquiry phone lines with our Provider Automated Response System, known as PARS. You’ll have one set of phone numbers that will offer you automated information you can access 24 hours per day, seven days per week. Plus, when you need to speak to a Provider Inquiry representative, you’ll be able to do that too from the same phone number*.

Beginning July 14, use the PARS numbers below for:
- Benefits and eligibility information
- Claims status and inquiry
- Any Provider Inquiry request

Our Provider Inquiry phone lines (1-800-255-1690 for medical and 1-800-688-3290 for behavioral health) will be retired later this year. If you call Provider Inquiry directly beginning July 14, you’ll be transferred to the new phone number.

*During Provider Inquiry business hours

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**Use these numbers for benefits and claims information beginning July 14**

The current PARS benefit phone numbers should be used for both benefits/eligibility and claims information.

**PARS professional and facility providers (Medicare Advantage, including BCN Advantage):**
- 1-866-309-1719

**Professional providers (non Medicare Advantage):**
- 1-800-344-8525

**Facility providers (non Medicare Advantage):**
- 1-800-249-5103

**All vision and hearing service providers:**
- 1-800-482-4047

**Federal Employee Program:**
- 1-800-840-4505
Requests for ColoGuard test must be submitted to JVHL for review

Providers are required to contact JVHL, Blue Care Network’s laboratory partner, for ColoGuard® tests.

If you want to order a ColoGuard test for your patient, do the following:

Call JVHL 1-800-445-4979 and provide the following information:

- Diagnosis code
- Patient information (name, address, date of birth and contract number)
- Provider information

The following information will need to be provided to obtain authorization:

- Is the patient at average risk for colon cancer?
- Has the patient had a colonoscopy or Cologuard test in the last 36 months?
- Does the patient have any current signs or symptoms of colorectal disease, such as lower gastrointestinal pain or bloody stools?
- Date of the specimen (if it is a retro-authorization)

If the criteria aren’t met, JVHL will send the request to BCN to review.

Providers can view the BCN medical policy by logging in to web-DENIS. Go to BCN Provider Publications and Resources. Click on Medical Policy Manual under Other Resources.

Additional information about colorectal cancer screening is available in the Sept.-Oct. 2016 issue.
We’ve made changes to Ambulance Provider Participation Agreement

A new ground and air Ambulance Provider Participation Agreement — a combined Blue Cross Blue Shield of Michigan and Blue Care Network agreement — has been approved by the Michigan Department of Insurance and Financial Services. It includes changes to the existing Medical Necessity Criteria and Confidentiality Policy. View the agreement, which has been posted on bcbsm.com.

Enrollment materials will be available electronically from bcbsm.com/providers by June 1, 2017. Follow these steps to enroll:

- Visit the Enrollment and Changes section.
- Click on Provider Enrollment Form.
- Select Physicians and Professional.
- Select Enroll a New Provider.
- Select Allied Providers – Ambulance.
- Select BCBSM agreements and signature documents.
- Select BCBSM Ambulance Provider Participation Agreement.

Effective dates

- For newly enrolled providers, the agreement will be effective immediately upon enrollment.
- For providers who signed a Letter of Agreement prior to the Michigan Department of Insurance and Financial Services granting their approval, the effective date was Jan. 1, 2017.
- For providers who agreed to the terms of the previous Ambulance Provider Participation Agreement, the effective date is Sept. 1, 2017.

BCN may request clinical documentation over the weekend

Hospital staff should be aware that Blue Care Network may request that clinical documentation be submitted on the weekends or holidays to meet the 72-hour requirement in responding to urgent requests.

If the member has not been discharged at the time BCN is notified of the admission, the BCN nurse may ask the facility or attending physician for more information within 24 hours of receipt of request and will make a determination within 72 hours from receipt of request for both commercial and BCN Advantage.

The Centers for Medicare & Medicaid Services require three attempts to obtain clinical documentation from the providers to make a decision on urgent requests for our BCN AdvantageSM members. If the provider doesn’t respond to our requests by the third day, we’ll send it to BCN’s plan medical director for a decision to ensure the request is reviewed within the appropriate timeframes.

For more information, see the Care Management chapter in the BCN Provider Manual.
Support charity by participating in physician survey

Blue Cross will donate $15,000 to a charity serving Michigan on behalf of survey respondents.

Blue Cross Blue Shield of Michigan wants to learn more about your experience as a health care provider and how Blue Cross can be a better partner to you. That’s why we’re working with Gongos Research, an independent company, to facilitate a research study.

M.D.s and D.O.s will be invited to provide their opinions about health care industry topics, including experiences with Blue Cross. Randomly selected physicians will receive a letter or email inviting them to participate in an online survey in July or August 2017.

We value your opinion and encourage you to complete the survey if you receive an invitation. In appreciation, Blue Cross will donate $15,000 to a charity serving Michigan on behalf of survey respondents. The charity will be chosen by survey respondents.

If you have questions about this study or Gongos Research, call 248-239-2300 and reference the BCBSM Physician Feedback. To learn more about Gongos Research, go to gongos.com.

Providers can order tobacco cessation tools

Blue Care Network has created new tobacco cessation posters and notepads to help providers educate patients about tobacco use and give them resources to help them quit.

The BCN Quit Guide is a 16-page brochure offering strategies to help patients quit using tobacco, as well as medication alternatives and resources.

The notepad is 5 ¼ x 4 in. and contains 50 sheets. The provider can tear off a page each time he or she sees a patient. Resources to help members get support are printed on each page.

An office poster summarizes the benefits of quitting tobacco use from 20 minutes after quitting to benefits up to 10 years.

To order, download the order form below.
BCN Provider News redesign

The results are in.

Ninety-three percent of respondents to our recent survey said they like the new look of BCN Provider News.

- Ninety-six percent of our readers said the articles are the right length.
- Ninety-one percent said the newsletter has information they need to do business with Blue Care Network.
- Ninety-three percent said the articles are easy to read (both style and font size).

The three best-read features are medical policy updates, clinical editing billing tips and coding corner.

Here are the things our readers said they like best about the newsletter:

- Very good at communicating regular updates
- Up-to-date information
- Clinical editing billing tips and billing questions and answers

We introduced a redesign in the May-June 2016 issue with a cleaner look and somewhat larger type, while keeping our traditional sections and navigation. We also kept regular features like Best practices and From the medical director.

An earlier readership survey before the redesign indicated that readers liked the newsletter (89 percent said information they need is easy to find). We used that feedback to make small changes.

At that time, 92 percent of our readers said they read most of every issue. Ninety-three percent said the newsletter is easy to read and helps them keep up with important network news and updates.

We hope you continue to find our newsletter useful. We welcome your feedback and article suggestions. Just send an email to BCNProviderNews@bcbsm.com and type “feedback” in the subject line.

We thank our readers for responding to our readership survey. The winner of the $25 gift certificate is Kathy Kinney at Ferrara Dermatology Clinic, Grosse Pointe Woods.
Blue Care Network is closed July 3 and 4

Blue Care Network offices will be closed July 3 and 4 for Independence 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: Calls for clinical review for admissions to skilled nursing facilities and other types of transitional care services should be made 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.
Chronic Care Improvement Program focuses on blood pressure control

BCN Advantage’s Chronic Care Improvement program, designed to prevent cardiovascular disease in BCN AdvantageSM members, is entering its final year. The five-year program that started in 2012 highlights member self-management strategies and partnership with physicians.

Clinical interventions – championed by Million Hearts®, a public initiative led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services to prevent one million heart attacks and strokes in the United States by 2017 – are the core of our program.

The Million Hearts clinical interventions focus on improved management of the ABCS:

- Aspirin for high-risk patients
- Blood pressure control
- Cholesterol management
- Smoking cessation

We’re focusing on blood pressure control in this article.

We all know that having high blood pressure is a risk factor for heart disease and stroke. According to the Centers for Disease Control and Prevention, there are many missed opportunities to prevent heart disease and stroke. Here are a few facts from the CDC Vitalsigns September 2012 edition about blood pressure:

- Nearly one in three adults (about 67 million) have high blood pressure.
- About 36 million adults don’t have their high blood pressure under control.
- High blood pressure contributes to nearly 1,000 deaths a day.
- Most people with uncontrolled high blood pressure know they have high blood pressure, see their doctor and take prescribed medicine.

Please see Chronic Care Improvement, continued on Page 12
You can visit the CDC website to learn more about how you can improve blood pressure control. The Million Hearts website is also a good resource and has free tools designed to help you treat your patients with high blood pressure. Learn more about the Million Hearts project and download resources that you can share with your patients, including fact sheets about blood pressure.

**Blood pressure control**

At Blue Care Network, we support your efforts to control blood pressure in your BCN Advantage patients. Through the BCN Million Hearts Incentive program, practitioners can earn payments for BCN Advantage members whose blood pressure is controlled. You can earn payment for patients who meet the eligibility requirements for the incentive and have blood pressure readings within the set parameters.

The requirements are (members age 40 and over as of December 31, 2017) who meet both the systolic and diastolic blood pressure reading requirements below:

- Members 18-59 years of age whose blood pressure was less than 140/90 mm Hg
- Members 60-85 years of age as of December 31, 2017 with a diagnosis of diabetes whose blood pressure was less than 140/90 mm Hg
- Members 60-85 years of age as of December 31, 2017 without a diagnosis of diabetes whose blood pressure was less than 150/90 mm Hg
- Systolic blood pressure value: report one of the systolic codes
  - 3074F—Systolic blood pressure less than 130
  - 3075F—Systolic blood pressure 130-139
  - Systolic blood pressure greater than 140 and less than 150 (Needs to be documented in the electronic medical record or in Health e-BlueSM. No CPT Cat II codes are available.)
- Diastolic blood pressure value report one of the diastolic codes
  - 3078F—diastolic blood pressure less than 80
  - 3079F—diastolic blood pressure between 80-89

The 2017 CMS Million Hearts Incentive Program document that explains this program in detail is available in BCN’s Health e-BlueSM. The document is in the Resources section under Incentive Documents. If you have any questions, please contact your medical care group leadership or your BCN provider consultant. We appreciate your continued support of our physician incentive programs.
Provider Distinction Awards delivered to provider offices

Here’s a sampling of photos from provider offices that received Provider Distinction Awards from BCN Advantage. Click on the PDF for the full list of recipients. You can also read the article in the May-June issue, Page 10.

**Alli Med, PLLC**

From left: Karen Kujawa, Melissa Chineuere, Desiree Kennedy, Amanda Weaver

**Lawrence LaLonde, M.D., PC**

From left: Laura LaLonde, Lawrence LaLonde, MD, Mary Jones, Ceal Stroebel, Ruth Stanke, Dee Harvey, Ann Hernick, RN, Becky Goretzki

**St. Mary’s Family Physicians of Frankenmuth**

From left: Janet Bach, D.O., Becky Boensch, nurse practitioner, Carmen Szilagy, M.D., Patrick Botz, D.O.

**St Mary’s Medical Center of Saginaw, Inc.**

From left: Jennifer Moreno, Adam Kandulski, M.D., Shontorria Edwards
Notice of Medicare Non-Coverage is required for BCN Advantage members

Medicare regulations require providers to use the Medicare-approved form, Notice of Medicare Non-Coverage, to notify BCN AdvantageSM members in writing, that BCN Advantage or the provider has decided to end their covered skilled nursing facility or home health agency care. The Notice of Medicare Non-Coverage form also provides notification to the member of the right to fast-track the appeal if they disagree with the decision to end covered services.

The provider must send copies of all forms signed by the member to Blue Care Network.

We are required to provide copies of signed Notice of Medicare Non-Coverage forms during Medicare audits. As we prepare for the audits, we find that not all providers have a complete understanding of Medicare regulations or our process to ensure compliance.

Medicare regulations require that providers deliver the form to members at least two days before covered services end at skilled nursing facilities and at least two days before the last services end from home health agencies.

The form should only be given to members when skilled nursing facility criteria are no longer met and no further days are authorized by BCN, or two days prior to a scheduled discharge date.

It is important to use the correct form approved by Medicare that includes:

- The date that covered services are expected to end
- The date that the member’s financial liability begins
- A description of special appeal rights for members that allow a fast-track appeal if the member disagrees with the decision to end covered services
- Detailed instructions about how the member may request an immediate appeal directly to KEPRO (Michigan’s quality improvement organization) including their address and phone number
- Instructions to the member about how to request an expedited review from BCN if they miss the deadline to file for review from KEPRO
- The date of the member’s signature

BCN may issue a next review date when authorizing skilled nursing services. The next review date doesn’t mean BCN is denying further coverage. Please submit an updated clinical review on the next review date. If we issue a denial upon review of the updated clinical information, BCN allows for two additional days for the provider to supply the member with the Notice of Medicare Non-Coverage form.

Please see Notice, continued on Page 15
Notice, continued from Page 14

If there is a change in the member’s condition after the form is issued, both BCN Advantage and providers should consider the new clinical information. If the effective date of coverage end date changes, providers should inform the member that services will continue. The provider must then inform the member of the new coverage end date either through delivery of a new or amended form at least two days before services end.

BCN values our partnership with our contracted providers. We trust that our providers will adhere to the provisions in our contract and continue to provide us with the forms required by the Centers for Medicare & Medicaid Services.

Note: Contracted facilities should be using the appropriate forms. They’re available in PDF or Word format on BCN’s e-referral home page or on web-DENIS.

Providers should insert their name, address and phone number in the spaces provided at the top of the form. NOMNC forms with the BCN Advantage logo at the top should not be used by skilled nursing facility or home care agency providers.

Here are more important facts about the Notice of Medicare Non-Coverage form:

- BCN is required to ensure compliance to Medicare regulations by BCN Advantage contracted providers.
- Medicare requires that skilled nursing facility and home health agency providers deliver the NOMNC form to all members at least two days before covered services end, whether the member agrees with the plan to end services or not.
- BCN encourages providers to deliver the NOMNC no earlier than four days prior to the last day that covered services end.
- Members are requested to sign and date the form, acknowledging its timely delivery. If members refuse to sign the form, the facility must document the time and date it was delivered to the member.
- Providers should keep a copy of the signed Notice of Medicare Non-Coverage form and fax a copy to BCN Care Management at 1-877-372-1635, Attention: Medical Records.

For more information about the form see the BCN Advantage chapter of the BCN Provider Manual.

Aspire Health to offer home visits for members with serious illness

BCN Advantage and Blue Cross Medicare Plus Blue are working with Aspire Health on a pilot program for homebound members with serious illnesses such as advanced cancer, congestive heart failure, chronic obstructive pulmonary disease, kidney failure and advanced dementia.

Starting this summer, Aspire Health physicians, nurse practitioners, social workers and other specialists will work with patients’ existing physicians to help manage symptoms and gain access to resources.

The service is slated to run through 2018. It’s currently available for patients in the Grand Rapids area, Indianapolis and Kansas City. Services will also be available for members in St. Louis on August 1.

Enrollment for the pilot is limited. Aspire Health will contact patients who may benefit from the program. If your patient agrees to participate, Aspire Health will provide you with a summary report after each home visit. The Aspire Health clinical team will also consult with you regularly to discuss any significant changes to the patient’s care plans or medications.
Blue Care Network’s Care Transition program helps BCN Advantage patients transition to home

Our Care Transition program helps BCN Advantage℠ patients transition from hospital to home. It also provides education and support to help your patients get well and stay healthy. The Care Transition program is a free service offered by BCN.

Returning home from the hospital can be overwhelming and stressful. People have questions about their care and are unsure of how to take care of themselves and manage their illness after they return home. By providing care coordination, education and support, our care coordinators can help your patients safely transition from hospital to home and avoid returning to the hospital or emergency department.

After we’re notified of your patient's hospitalization, our care coordinators may contact the patient during their hospital stay to introduce the program and discuss next steps. Through follow-up calls upon the patient’s return to home, the care coordinator can:

- Arrange timely follow-up with the doctor and obtain transportation, if needed
- Provide tips to manage medications
- Explain hospital discharge instructions and how to manage any conditions
- Discuss signs and symptoms of possible complications and what to do next
- Coordinate needed tests, services or equipment, or arrange home health care
- Offer other health services and related programs to support the member in the home
- Provide available community resources
- Recommend preventive health screenings, lab tests and other services the patient may need

To learn more about our Care Transition Program or to speak to a care coordinator, call 1-800-728-3010 from 8 a.m. to 5 p.m. Monday through Friday.
Back-to-school tips for children with asthma, diabetes

As kids prepare to return to school, there are important steps primary care physicians and staff can take to ensure students are well-prepared to manage chronic conditions. The following checklists can help you do just that.

For children with asthma

Establish an Asthma Action Plan and provide the school with a copy for the child’s record. The plan can be developed to fit the needs of the child.

- Obtain a copy of the Asthma Action Plan template. It’s available on web-DENIS. Go to BCN Provider Publications and Resources. Click on Forms (under Resources) and scroll down to the Asthma Action Plan for Children/Teens in the Chronic Condition Management section.

- Instruct the child and parents on all medications and the importance of having access to those medications – especially rescue inhalers – at all times. Refill prescriptions as needed.

- Discuss asthma condition and triggers that may occur.

- Provide the necessary documentation for the school support staff to keep on file in the event of an emergency. Information should be accessible to teachers, coaches and other adults who supervise children at school.

- Talk with the child about how to manage his or her asthma while at school. Sometimes a child can become overwhelmed with managing his or her condition and needs to discuss the changes he or she is experiencing.

- Instruct the child to wear a medical alert bracelet, if necessary.

Please see Back-to-school tips, continued on Page 18
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:

Covered services

- Minimally invasive lumbar interbody fusion (-LIF) with one exclusion
- SPECT/CT fusion imaging
- Instruct the child and parents on eating healthy meals and refer to registered dietitian as necessary.
- Encourage parents to pack healthy snacks that can be eaten between meals to prevent low blood sugar occurrences.
- Instruct the child to wear a medical alert bracelet, if necessary.
- Provide the necessary documentation for the school support staff to keep on record in the event of an emergency. Information should be accessible to teachers, coaches and adults that interact with the child at school.
- Talk with the child about his or her diabetes. Sometimes a child can become overwhelmed with managing his or her condition and needs to discuss the changes he or she is experiencing.

The Michigan Quality Improvement Consortium guidelines include information on assessment and treatment of acute and chronic conditions and preventive services.

For children with diabetes

- Establish a Diabetes Care Plan and provide the school with a copy for the child’s record. The plan can be developed to fit the child’s needs.
  - To obtain a copy of the plan, log in to web-DENIS. Go to BCN Provider Publications and Resources. Click on Forms (under Resources). Scroll down to the Diabetes Care Plan for School in the Chronic Condition Management section.
  - Instruct the child and parents on diabetes medication, storage and having access to medication and monitoring supplies at all times. Refill prescriptions as needed.
  - Ensure the child knows how and when to check blood sugar if he or she is old enough to learn or advise parents to ensure that school is aware of the Diabetes Care Plan. A Diabetes medical management plan template is available from the American Diabetes Association.
  - Have the child write down his or her blood sugar levels in a diary. A school nurse may be able to assist younger children.
  - Ensure the child knows what the symptoms are for low blood sugar and high blood sugar.
  - Reinforce that the child should have a rapid sugar release type of food available such as juice, hard candy or glucose tablets for symptoms of low blood sugar.
  - Instruct the child and parents on eating healthy meals and refer to registered dietitian as necessary.
  - Encourage parents to pack healthy snacks that can be eaten between meals to prevent low blood sugar occurrences.
  - Instruct the child to wear a medical alert bracelet, if necessary.
  - Provide the necessary documentation for the school support staff to keep on record in the event of an emergency. Information should be accessible to teachers, coaches and adults that interact with the child at school.
  - Talk with the child about his or her diabetes. Sometimes a child can become overwhelmed with managing his or her condition and needs to discuss the changes he or she is experiencing.

The Michigan Quality Improvement Consortium guidelines include information on assessment and treatment of acute and chronic conditions and preventive services.
Case management program helps you care for patients

Your patients who have complex medical needs can get personalized support from Blue Care Network’s Case Management department. Our registered nurse case managers work with you and your patients to develop a case management plan of care and promote self-management.

Our case managers contact members by phone to provide education on disease, nutrition, medication and managed care processes. We also help patients access BCN and community resources as needed.

We identify members for case management through a variety of sources, including inpatient admissions, physician and physician group referrals, member and caregiver referrals, chronic condition management referrals and employer group referrals. We may also identify BCN Advantage members through member health assessments. BCN also uses a predictive modeling approach to identify BCN and BCN Advantage members who may benefit from case management.

Members who are enrolled in case management consistently report high satisfaction with the program and a willingness to recommend the program to other members.

We offer case management services as a benefit at no cost to BCN commercial and BCN Advantage members. The following programs are available for adult and pediatric members:

- Asthma – commercial members only
- Complex conditions
- Chronic obstructive pulmonary disease
- Diabetes
- Heart failure
- High risk pregnancy
- Ischemic heart disease
- Kidney health management – adult only
- Oncology
- Transplants – bone marrow, stem cell and solid organ

Case management in 2017

We encourage our members to be active in managing their health and promote a collaborative relationship with you. Case managers work with you, your staff and your patient to support positive health outcomes.

You can find information about your members enrolled in complex case and chronic condition management on Health e-Blue℠, your secured clinical support tool. To learn more about BCN’s case management program or refer a member to one of our programs, call us at 1-800-943-9744. We’re available from 8:30 a.m. to 5 p.m., Monday through Friday.

BCN values and recognizes the importance of provider’s rights. We respect your right to:

- Have information about BCN’s case management programs, case management staff and staff qualifications relative to the management of your patient when requested
- Be informed of how BCN coordinates its interventions with treatment plans for individual patients
- Know how to contact the person responsible for managing and communicating with your patients
- Communicate complaints to the organization
- Be supported by the organization to make decisions interactively with patients regarding their health care
- Receive courteous and respectful treatment from the organization’s staff

Note: Case managers may receive requests for services specifically excluded from the member’s benefit package. Member benefits are defined by the limits and exclusions outlined by the individual member’s certificate and riders. BCN doesn’t make benefit exceptions and informs the member of alternative resources for continuing care and how to obtain care, as appropriate, when a service isn’t covered or when coverage ends.
COPD diagnosis should include spirometry

Caring for patients with chronic obstructive pulmonary disease begins with diagnosing the condition through spirometry. It’s necessary to periodically assess the disease, manage exacerbations and provide smoking cessation support. Pharmacologic therapy is pivotal as it provides important options for improvement of symptoms and treatment of exacerbations.

COPD remains underdiagnosed. Consider testing for COPD in smokers with symptoms or a history of exposure to other COPD risk factors. This includes smokers older than 60 presenting with a chronic cough, or smokers with diagnosis and treatment for respiratory tract infections or asthma.

A written COPD management plan can facilitate COPD care in your office and helps patients manage their symptoms. BCN asks physicians to complete the management plan during office visits and provide a copy to the member.

To obtain a copy of BCN’s COPD management plan:

- Log in to web-DENIS.
- Go to BCN Provider Publications and Resources.
- Click on Forms under Other Resources.
- Click on COPD Action Plan in the Chronic Condition Management section.

Spirometry

Spirometry is necessary to establish a diagnosis of COPD, according to BCN’s clinical practice guidelines for the diagnosis and management of COPD. Spirometry also provides a useful diagnostic tool for those patients with symptoms suggestive of COPD. (See table below). A post bronchodilator FEV1/FVC less than 70 percent confirms the presence of airflow limitation.

**BCN’s Guidelines for the Diagnosis and Management of Chronic Obstructive Pulmonary Disease** recommend that you consider COPD in any patient 18 years of age or older with respiratory symptoms and those with a history of exposure (for example, occupational exposure) to risk factors for the disease, especially smoking. Characteristic symptoms include cough, sputum production that can be variable from day to day and chronic or progressive dyspnea.

<table>
<thead>
<tr>
<th>I: Mild COPD</th>
<th>II: Moderate COPD</th>
<th>III: Severe COPD</th>
<th>IV: Very Severe COPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEV1/FVC &lt;0.70</td>
<td>FEV1/FVC &lt;0.70</td>
<td>FEV1/FVC &lt;0.70</td>
<td>FEV1/FVC &lt;0.70</td>
</tr>
<tr>
<td>FEV1 ≥ 80% predicted</td>
<td>FEV1 50% ≤ and &lt; 80% predicted</td>
<td>FEV1 30% ≤ and &lt; 50% predicted</td>
<td>FEV1 &lt; 30% predicted or FEV1 &lt; 50% with deoxygenating</td>
</tr>
</tbody>
</table>

The 2017 Healthcare Effectiveness Data and Information Set measures the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis. CPT codes used to identify spirometry testing for this measure include **94010, **94014-94016, **94060, **94070, **94375 and **94620.

Source

**BCN Guidelines for the Diagnosis and Management of Chronic Obstructive Pulmonary Disease (COPD) QM 2071**

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Criteria corner

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

Question:
In the criteria subset, General Medical: Hypokalemia, one of the criteria selections is “hospital-acquired.” In screening cases for appropriateness of inpatient stay, what does McKesson consider hospital-acquired when referring to hypokalemia?

Answer:
Hospital-acquired refers to a condition that developed during the patient’s current hospitalization. Criteria referring to conditions that were acquired during the current hospitalization can’t be applied for patients who’ve been either discharged to home or transferred to a post-acute facility.

Question:
Can beta-hydroxybutyrate be applied in the Diabetic Ketoacidosis (DKA) criteria in place of serum ketones?

Answer:
Beta-hydroxybutyrate is useful in confirming the diagnosis of diabetic ketoacidosis, or DKA. This compound is one of several ketones liberated during the genesis of ketoacidosis. InterQual criteria require that the presence of ketonemia or ketonuria be present to confirm the diagnosis of DKA. InterQual doesn’t mandate which laboratory test is utilized to establish this. The presence of beta-hydroxybutyrate satisfies the required documentation for establishing the presence of ketonemia.
Prenatal and postpartum care

It’s important for primary care physicians, family practice providers, pediatricians and gynecologists to educate members about the importance of receiving prenatal and postpartum care within recommended timeframes.

For prenatal care, women should visit a provider within the first trimester of pregnancy or within 42 days of enrollment. You can remind patients considering pregnancy to make an appointment as soon as they suspect they’re pregnant.

You should document the following in the patient’s medical record at prenatal visits:

- Education about nutrition
- Prescribing of prenatal vitamins with folic acid
- Education about substance abuse and alcohol consumption
- Education about tobacco cessation
- Information about expectant parent classes and the importance of postpartum care

Blue Care Network case management nurses can provide support to members who are identified as high risk for complications during the perinatal period. These interventions include:

- Initial assessment and care plan development
- Ongoing telephone support
- Written educational materials about identified risks, condition, medications and other interventions
- Referral to home health care, social worker or behavioral health

For postpartum care, guidelines recommend visits any time between 21 and 56 days after delivery for both vaginal and cesarean deliveries.

Documentation in the patient’s medical record at postpartum visits should include:

- A physical exam, including a breast and pelvic exam
- Measurement of weight, vital signs including blood pressure
- Discussion of contraceptive options
- Education about the prevention of sexually transmitted diseases
- Screening and assessment for postpartum depression (Use a valid screening tool, such as the Edinburgh Depression Screening tool, when conducting the depression screening.)

Resources

We have several resources available to members.

- **Maternal (or paternal) substance abuse** — BCN members should call 1-800-482-5982.
- **Maternal (or paternal) tobacco use** — BCN’s smoking cessation program is available on bcbsm.com; it’s administered by WebMD. Members need to log in to their account to access Web MD.
- **Nutrition and weight management after delivery** — BCN members receive more than a 20 percent discount on Weight Watchers® program membership. Call 1-800-651-6000 to find a nearby Weight Watchers location
- **Postpartum depression** — BCN’s Depression Management Program focuses on member education about depression and the importance of adhering to a prescribed medication regimen. Providers and members can speak to registered nurse about the program. Call 1-800-392-4247, from 8 a.m. to 5 p.m., weekdays. The 24-hour nurse advice line number is 1-855-624-5214.
August is National Immunization Awareness Month

National Immunization Awareness Month is an annual observance to highlight the value of immunization across our lifespan. Activities focus on encouraging people of all ages to protect their health and the health of their loved ones by getting vaccinated against vaccine-preventable diseases.

We’d like to encourage providers to discuss the importance of immunization with parents of children, pre-teens and adolescents and to discuss booster shots and flu immunization with their adult patients.

Immunization schedule

The recommended vaccination schedule is updated every 12 months by the Centers for Disease Control and Prevention. For the latest on immunization recommendations, Vaccine Information Statement forms and catch-up schedules, go to the CDC website.
BCN’s mental health and substance abuse treatment providers should use JVHL labs for their toxicology testing

All providers contracted with Blue Care Network are expected to use only laboratories that are part of the Joint Venture Hospital Laboratories network to perform outpatient laboratory testing for BCN HMO℠ (commercial) and BCN Advantage℠ members. This includes BCN’s mental health and substance abuse treatment providers who order toxicology and drug-of-abuse testing for these members.

To meet the needs of contracted mental health and substance abuse treatment providers, BCN has partnered with JVHL to establish a local network of toxicology testing laboratories. JVHL is BCN’s exclusive outpatient laboratory network and offers high-quality, cost-efficient toxicology testing services to BCN providers through its network of more than 120 hospital laboratory providers.

In March 2017, JVHL mailed letters to BCN’s mental health and substance abuse treatment providers reminding them to use only JVHL labs for their toxicology testing needs and included contact information for the JVHL laboratories in their area.

JVHL also provided their network laboratories with information about the BCN-contracted mental health and substance abuse treatment providers in their area. JVHL is encouraging their laboratories to contact and work with these providers to meet their testing needs.

If you are a BCN mental health or substance abuse treatment provider who uses a laboratory that isn’t currently part of the JVHL network, you must select a JVHL laboratory for your testing needs. If you need assistance in locating a local JVHL laboratory, call the JVHL Customer Service center at 1-800-445-4979. JVHL will also work with you to address any unique testing needs you may have.

Teen suicide: Factors that influence adolescent behavior and how they may be mitigated

Suicide detection and prevention takes a lot of interested individuals to facilitate. The primary care provider is a pivotal resource person for the individual patient and the entire support system of the individual. Initial interventions and screening are very important. Listening to your patients and looking for veiled requests for help are crucial.

See the complete medical director column on Page 1.
We’re updating qualification standards for freestanding substance abuse facility agreement

Effective Sept. 1, 2017, Blue Cross Blue Shield of Michigan and Blue Care Network are updating the credentialing requirement for residential facilities performing medical detoxification. Currently, Addendum A of our Freestanding and Hospital-Based Substance Abuse Facility Traditional Participation Agreement requires a substance abuse facility to maintain certain minimums to participate with Blue Cross.

Specifically, all residential facilities are currently required to have registered nursing personnel on-site “on a 24-hour basis.”

Substance abuse facilities that perform medical detoxification will still need registered nursing personnel on-site 24 hours per day, seven days per week.

But effective Sept. 1, substance abuse facilities that don’t perform medical detoxification:

• Will still be credentialed as substance abuse facilities
• Won’t be required to have nursing personnel on-site on a 24-hour basis as long as there are registered nursing personnel on call and able to respond in 60 minutes or less. So, they may have registered nursing personnel on-site or on call 24 hours per day, seven days per week.

This update will differentiate between residential facilities performing medical detoxification and those that don’t deliver those services. And it allows our requirements to keep pace with the evolution of treatment.

Currently, many facilities don’t deliver medical detoxification and instead focus primarily on behavioral treatment of the patients. These facilities do administer medication when appropriate. But the medications typically used to address depression or anxiety, or to reduce cravings, don’t require close medical supervision. These facilities continue to have nursing personnel on-site during the day and on call 24 hours per day. When not on-site, the nursing personnel’s response time to the facility must be 60 minutes or less.
Quality corner: Primary Care Physician Contact

Primary care physician contact is when the behavioral health provider and the primary care physician reach out to one another to discuss the patient’s health. This may occur when the patient begins therapy, starts a new medication, has a significant change in condition or experiences a comorbidity issue.

Unfortunately, contact between behavioral health providers and PCPs isn’t widespread,¹ especially when compared to other specialties.

**Why is it important?**
Contact and collaboration is imperative. Up to 70 percent of visits to primary care physicians may be due to psychological issues.² Underlying psychological problems can also complicate and contribute to physical problems, such as obesity, hypertension and chronic pain.³ When regular contact occurs, providers can ensure the greatest impact and value for patient health.

**What can behavioral health providers do?**
We encourage you to reach out to PCPs. To reward behavioral health providers who do, BCN is offering an incentive as part of its Behavioral Health Incentive Program. Each time an office completes the measure, according to the details provided in the incentive program booklet, you’re qualified to receive $35 when submitting by fax or $50 when submitting electronically.

**What does it mean to reach out?**
For the purposes of the incentive program, contact should be “meaningful contact”. This includes a behavioral health assessment, rudimentary treatment plan and member-specific recommendations. More details are in the Behavioral Health Incentive Program booklet on web-DENIS.

**What if I’m not participating in BHIP?**
We still highly encourage those behavioral health providers not submitting documentation for incentives to keep primary care physicians updated to enhance quality of care. The PCP contact form used for BHIP incentives is a great resource that can be used by offices, regardless of incentive program participation.

References
² http://www.bhintegration.org/services/primary-care.aspx
³ http://www.bhintegration.org/services/primary-care.aspx
Managing medication compliance helps patients with depression

It’s generally accepted that discontinuing antidepressant medication before six months is associated with a higher rate of recurrence. The key to helping patients accept long-term medication is communicating with patients, setting expectations and lending support through follow-up visits, says Shelley Drew, D.O., who practices in Walker.

“It’s important during the initial phase to get the patient past that first two weeks,” says Dr. Drew. “One of the things I talk about for the long-term is to set expectations and let the patient know that this is going to be a long-term medication – anywhere from eight months to a year,” she says.

“A lot of times they don’t want to take the medication that long,” continues Dr. Drew. “At that point, I talk about the idea of serotonin in the brain and the fact that you have to adjust those levels. I tell them it’s just like a diabetic who requires insulin.”

Frank discussions about medication are also necessary. “I also talk to them about not stopping their medication in the winter,” says Dr. Drew. “I let them know that at the end of the summer they will feel much improved due to medication and increased light and they will think they no longer need meds. If they stop medication in October, they feel terrible by February or March. I encourage them to stay on medication until spring when we can wean them off medication,” she says.

Dr. Drew helps patients come to terms with the fact that depression is a chemical imbalance. “I ask patients when they started feeling this way,” she explains. “Sometimes they say they have been depressed since their teen years. It’s sometimes hard to start those patients on medication because they think they way they feel is normal. They are reluctant to start medication because they think it will make them feel worse.

“I let them know we can always wean them off the medication if it does,” continues Dr Drew. They often want to use lifestyle changes alone to treat their depression, but have been trying for years to make those changes without success. I let them know medication may help them feel good enough to start making those changes.”

Followup is critical to keeping patients on medication over the long term. “If a patient is severely depressed, I might see him or her the next week and make the patient commit to not hurting themselves,” says Dr. Drew. “I explain to everyone that these medications take time to work.”
Best Practices, continued from Page 27

Dr. Drew also gives patients the option of contacting her between visits if they can’t tolerate the medication. “I tell them if you can’t stand the side effects for two weeks, email me through the patient portal or call me. If they have a severe reaction, I will change the medication before their follow-up visit. In the past, patients would just stop their medication and return to the office feeling no better. They then would have to start all over with a new medication and new side effects.” For more stable patients, Dr. Drew sets a follow-up visit for four to six weeks out. At that time, she also gives patients another PHQ9 depression assessment to get an objective look at how they’re doing. “If the patient is doing well, we can wait three months,” she says. “If not, I will see the patient in a month.”

Challenges

There are challenges to keeping patients on antidepressant medications that go beyond side effects. “There’s the stigma of being depressed,” says Dr. Drew. “The patient may be afraid they’re going to be a different person with the medication. I tell them we want to fix the underlying problem so you can be yourself.” The most important thing for women is the effect of their depression on their families, says Dr. Drew. “Studies show anxious moms have anxious babies,” says Dr. Drew. “For patients who are reluctant to stay on medication, that’s made a huge difference to them. When we say, ‘Look what you’re doing for your family,’ mothers respond to that,” she adds.

For men, there’s more anxiety after a major illness. Dr. Drew talks to them about how depression affects their job performance. “If you’re better at your job, it makes you more secure,” she said.

It’s more difficult to treat those who don’t come in for depression, admits Dr. Drew. For the patient who comes in with multiple physical complaints but scores high on the PHQ9, I let them know right away that I think depression is contributing to their symptoms,” says Dr. Drew. “I do not wait until we have ruled out everything else, then blame it on depression. But I also don’t ignore their physical symptoms and let them know their concerns will be addressed if they do not resolve.”

A lot of patients with depression have comorbidities. “If you’re in pain constantly, you’re going to be depressed. People with COPD can’t breathe well enough to participate in the activities they enjoyed previously,” she says. “Divorce, job loss, aging — there are many contributing factors,” explains Dr. Drew. “So it’s important to individualize care. But it is also important to explain to patients that for whatever reason they have depression the medication can help them feel able to deal with life’s issues.”

“And always, I let patients know that once life has settled down and they have made significant lifestyle changes, that we will work on weaning them off their medications. But if those medications help them function well at work, relate better to their spouses and children and enjoy our beautiful state, then they should not feel bad about taking them long term.”
BCN members receive reminders about preventive care

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

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

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

We want to thank providers for working with members to ensure they have all their preventive screenings.
Pharmacy News

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 don’t have coverage for Tier 3 drugs.

Reminder: RC Claim Assist 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.

See the May-June issue (Page 36) for details.

Reminder: Members can get medications synchronized at the pharmacy

Blue Cross Blue Shield of Michigan and Blue Care Network launched our medication synchronization program with Express Scripts for all commercial (non-Medicare) lines of business in March.

This program allows your patients’ medications to be refilled on the same day. The member gets the convenience of fewer trips to the pharmacy and it may increase medication adherence.

See the full article in the March-April issue, Page 28.
What to know when coding for vascular disease

Vascular disease is any abnormal condition of the blood vessels and includes conditions that affect the circulatory system. There are many risk factors for vascular diseases, including aging, a family history of vascular or heart disease, diabetes, high cholesterol, hypertension, smoking and obesity.

Here are some important things to keep in mind when coding for vascular disease:

- Is the condition considered part of a patient’s past medical history that no longer requires any form of treatment?
- Does the patient have a chronic condition? State the acuity and note the current treatment.
- Is the current condition a manifestation of a chronic condition? (e.g., diabetic angiopathy)

**Peripheral vascular disease**

One disease of the vascular system is peripheral vascular disease, or PVD. Sometimes referred to as peripheral arterial disease or peripheral angiopathy, PVD is a circulatory condition resulting in reduced blood flow to the extremities, typically occurring in the legs. The American Heart Association defines PVD as diseases of blood vessels outside the heart and brain. It’s often a narrowing of vessels that carry blood to the legs, arms, stomach or kidneys.

The most common symptom of PVD is intermittent claudication, which is pain while walking that resolves after a few minutes of rest. The location of the pain depends on the site of the narrowed or clogged artery.

To code PVD to the highest specificity, look for these key components:

- Location of vein or artery affected
- Complications such as intermittent claudication, ulceration or pain at rest
- Laterality — left, right or bilateral
- The cause, if known
- Whether gangrene is present

If PVD is noted without further specificity, use ICD-10 code I73.9, PVD, unspecified. This code also includes intermittent claudication, peripheral angiopathy NOS and spasm of artery.

Documentation is extremely important when PVD is a manifestation associated with a specific condition. PVDs require a fourth — and sometimes a fifth — digit.

Examples below show coding with the required fifth digit:

- E11.51 Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
- E10.51 Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene

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

According to the AHA Coding Clinic (Fourth Quarter 2016), considered an official coding source by Centers for Medicare & Medicaid Services, new instructions have been released on the assumed cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves and circulatory system. These instructions are in accordance with the updates to the 2017, ICD-10-CM Official Guidelines for Coding and Reporting. Following is a look at the ICD-10-CM index format for certain conditions linked to Type 2 using the subterm “with”:

Diabetes, diabetic (mellitus)(sugar)
Type 2 E11.9
With
Amyotrophy E11.44
Chronic kidney disease E11.22
Circulatory complications E11.59
Peripheral angiopathy E11.51

If a provider has documented diabetes and peripheral angiopathy in a medical record, the conditions are assumed to be related even if the doctor doesn’t specifically document the relationship. However, if the doctor documents that the Type 2 diabetes mellitus isn’t the underlying cause of the peripheral angiopathy, the condition shouldn’t be coded as a diabetic complication. If the coder isn’t able to determine whether the Type 2 diabetes mellitus and peripheral angiopathy are related or the ICD-10-CM classification doesn’t provide coding instruction, it’s appropriate to query the doctor for clarification so that appropriate codes may be reported.

None of the information included herein 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:**
I have a question about a New 2017 CPT Code *99152. Should this be a Revenue Code 510 or 519. Will 519 be accepted on a facility claim?

**Answer:**
Blue Care Network does not accept facility claims with revenue codes from professional providers. When procedure code *99152 is submitted on a claim with revenue code 0510 or 0519 by any provider type — facility or professional — it will receive a rejection of BP3 to resubmit services on a CMS-1500 claim form.

**Question:**
Will Blue Care Network take a 510 Revenue Code on a UB claim?

**Answer:**
With few exceptions, BCN will usually ask the provider who submitted the code to resubmit the services on a CMS-1500 claim form. There may be exceptions. We would typically accept revenue code 0510, for example, if the facility provider is reporting codes from the surgical range.

**Question:**
Does Blue Cross Blue Shield Medicare Advantage pay for CPT II code 1111F?

**Answer:**
This communication is unable to provide an official response for the Blue Cross Medicare Advantage PPO. Please refer to the May 2016 Record article on the “New Medicare star ratings measure: Medication reconciliation post-discharge.”

As of now, both BCN and BCN Advantage accept procedure code 1111F for notification of medication reconciliation, but no reimbursement is made for this code. It’s classified in our system as non-reimbursable, meaning it provides support for another service. It will receive the explanation code BO3.

Please see Billing Q&A, continued on Page 34

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**Have a billing question?**

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

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Billing Q&A, continued from Page 33

**Question:**
I continue to receive rejections on J codes I submit. The rejections state “M123 Missing/incomplete/invalid name, strength, or dosage of the drug furnished.” I am using the information directly off the RC Claim Assist site, yet I still receive rejections. The specific J codes I receive rejections are J3301, J1100, and J7308.

**Answer:**
Sometimes the reporting on J codes with NDC amounts can be confusing, especially when the nomenclature in the code is different from what the unit is on the NDC. Not knowing exactly what’s being reported, we’ll take one of the codes and provide an example. Let’s use J3301 – Injection, triamcinolone acetonide, not otherwise specified, 10 mg.

The NDC for our claim is 0003-0293-05. It is for a 40 mg/mL, 1 mL vial. To make it simple, for this claim, the provider administered a 40 mg dose.

First, the units on the claim for the J3301 will be 4 as the code description is per 10 mg. That will give us the 40 mg.

Second, for the NDC, the following four components are required:

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<tr>
<th>Field name</th>
<th>Field description</th>
<th>ANSI (loop 2410)-Ref Desc</th>
<th>Required for J3301</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product ID qualifier</td>
<td>Enter “N4” in this field</td>
<td>LIN02</td>
<td>N4</td>
</tr>
<tr>
<td>National drug code</td>
<td>Enter 11 digit NDC specific to the drug</td>
<td>LIN 03</td>
<td>0003029305</td>
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<td>NDC units</td>
<td>Enter quantity/units per NDC</td>
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<td>1</td>
</tr>
<tr>
<td>NDC unit/measure</td>
<td>Enter NDC unit of measure (GR, ML or UN)</td>
<td>CTP05-1</td>
<td>ML</td>
</tr>
</tbody>
</table>

To report on a paper claim, include the following information on the line related to the NDC code:

- N4 + NDC code + 3 spaces + unit of measure + quantity
- For J3301, the NDC reporting would be: N40003029305 ML1

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Ambulance providers should bill actual mileage

As we explained in the May-June issue, BCN implemented a system update in June. To pay correctly, ambulance claims need to be handled differently based on whether the trip was under or over 100 miles.

- If the trip was below 100 miles, include actual mileage rounded up to the nearest tenth of a mile.
  
  Examples:
  - Trip mileage of 9.15 should be reported as 9.2 on the claim (actual mileage rounded to the tenth of a mile).
  - Trip mileage of 9.67 should be reported as 9.7.

- If the trip was below one mile include a zero before the decimal point and round to the nearest tenth of a mile.
  
  Examples:
  - Trip mileage of .9 should be reported as 0.9.
  - Trip mileage of .56 should be reported as 0.5.

- If the trip was 100 miles or more, round the mileage up to the nearest whole number. Don’t report tenths of a mile.
  
  Examples:
  - Trip mileage of 111.3 should be reported as 112.
  - Trip mileage of 117.8 should be reported as 118.

BCN improves coordination of benefits claim processing

We’re improving our service to you. Beginning at the end of July, Blue Care Network will process institutional coordination of benefits claims at the line level rather than at the claim level.

This means the remittance advices you view will reflect the accurate amount paid for each line item rather than showing our prorated payment based on the total of all line items on the claim.
Changes to CLIA reporting requirements

Blue Care Network contracts with Joint Venture Hospital Laboratories to provide all outpatient laboratory services. To facilitate patient care, we allow physicians who are certified under the Clinical Laboratory Improvement Amendments to submit claims for specific services performed in their offices.

Effective for claims processed on or after September 1, 2017, any providers reporting CLIA-waived tests in an office or outpatient setting will be required to include the following information on the claim:

- QW modifier on the laboratory test line
- CLIA certification number

We’re encouraging providers to begin reporting this information as soon as possible, but claims won’t be affected until September. This requirement is in line with Centers for Medicare & Medicaid Services guidelines. We’ll deny claims that are submitted with missing or inaccurate information.

BCN will begin rejecting paper claims on old CMS-1500 template in June

Beginning June 8, 2017, Blue Care Network will reject any paper professional claims received on the CMS-1500 (05) claim form. Blue Cross already rejects claims received on this old form. Any BCN professional paper claims must be on the CMS-1500 (02/12) claim form.

We posted a web-DENIS message on May 23 to warn BCN providers.

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:

- BCN AdvantageSM updates: Drug editing policies
- Treatment of Dupuytren’s contracture
- Endoscopic retrograde cholangiopancreatography
- Updates to ambulatory or 24 EEG monitoring
- Neurophysiology evoked potential studies to have diagnosis requirements
- Reporting a detailed fetal anatomical ultrasound with examination
- Foot and nail care updates
Use the appropriate electronic portal to submit authorization requests reviewed by eviCore

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

Here’s a summary of how to handle each type of authorization request:

<table>
<thead>
<tr>
<th>Type of request</th>
<th>Submit the initial request in this portal</th>
<th>What happens next…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, occupational and speech therapy by therapists</td>
<td>BCN’s e-referral system</td>
<td>Use the LMhealthcare portal to check the status of a request or to submit requests for additional services.</td>
</tr>
<tr>
<td>Physical medicine services by chiropractors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>eviCore website</td>
<td>Use the eviCore portal to check the status of a request or to submit a new request.</td>
</tr>
<tr>
<td>Intervventional pain management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-tech radiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have questions about these processes, you can always check the following:
- The eviCore-Managed Procedures page at ereferrals.bcbsm.com
- The Guidelines for services reviewed by eviCore healthcare for Medicare Plus Blue℠ PPO and Blue Care Network document, on the eviCore-Managed Procedures page at ereferrals.bcbsm.com
- The Outpatient PT/OT/ST page at ereferrals.bcbsm.com
- The Care Management chapter of the BCN Provider Manual, which you can access on the Provider Manual Chapters page at ereferrals.bcbsm.com. Look in these sections:
  - “BCN clinical review requirements”
  - “Managing PT, OT and ST / Managing physical medicine services by chiropractors”

These resources offer detailed explanations of the processes of requesting authorization for the various types of services that eviCore reviews for BCN. They are found in the BCN section at ereferrals.bcbsm.com.

Requests for ColoGuard test must be submitted to JVHL for review

Providers are required to contact JVHL, Blue Care Network’s laboratory partner, for ColoGuard® tests. See the full article on Page 6 for details.
Blue Care Network requires authorization for excisional breast biopsy

Blue Care Network continues to require authorization for excisional breast biopsy for members with Blue Care Network commercial (including self-funded groups) and BCN AdvantageSM products.

BCN provides coverage for excisional biopsy in certain situations in which there is a need for an open surgical procedure as opposed to a minimally invasive diagnostic procedure of needle core biopsy for suspected breast abnormalities.

As an alternative, BCN covers the minimally invasive diagnostic procedure of needle core biopsy for suspected breast abnormalities. Needle core biopsy doesn’t require clinical review.

Needle core biopsy is preferred over excisional biopsy for the diagnosis of breast cancer for the following reasons:

- Equals surgical biopsy in accuracy
- Eliminates the need for members with image-detected breast abnormalities to undergo an open surgical procedure
- Improves the cosmetic outcome for the member
- Increases opportunities for multidisciplinary treatment planning
- Lowers morbidity
- Costs less, overall, for diagnosis

Providers may submit electronic requests for clinical review for these procedures. Users will be prompted to complete an appropriateness questionnaire for clinical review consideration. If the criteria are met, the request will be automatically approved. If the criteria aren’t met, the request will require further clinical review. Health care providers may also contact BCN’s Care Management department at 1-800-392-2512 to request clinical review.

The authorization criteria and questionnaire have been updated and are available atereferrals.bcbsm.com. Click BCN and then click Clinical Review and Criteria Charts. Look under the “Authorization criteria and preview questionnaires” heading. The criteria for suspicious palpable findings was expanded upon to include negative imaging. A new criterion was added to address a significantly painful or tender mass that is persistent.
Providers can schedule phone appointments for eviCore clinical consultations on BCN radiology reviews

If you want to consult with an eviCore healthcare clinical representative on Blue Care Network radiology authorization requests, you can now schedule phone appointments online and not have to wait on hold. This applies only to radiology services reviewed by eviCore healthcare for BCN HMOSM commercial and BCN AdvantageSM members.

Here’s how to schedule an appointment for a phone consultation:

1. Visit the eviCore website.
2. Click Providers.
3. Scroll down and click Select Time and Date.
4. In the “Select Health Plan” field, select Blue Care Network.
5. In the “Select Solution” field, select Radiology.
6. In the “Contact Via” line, click either Email or Phone, depending on how you want eviCore to contact you to set up the appointment time.
7. In the “Case number” field, enter the case number.
8. In the “Request Appointment Date” field, enter the date you want the consultation to occur.
9. In the “First name,” “Last name,” “Email” and “Phone” fields, enter the contact information for the office representative who will set up the appointment.
10. In the “Select Duration Hours” field, enter the two-hour window of time during which a phone appointment can be scheduled with the eviCore physician.
11. In the “Message” field, indicate the name of the clinician in the office who wants to talk to the eviCore physician.
12. Click Submit.

You’ll receive a phone call or an email (or both, if you requested both in the “Message” field) that indicates the 15-minute time frame for your scheduled appointment.

Sometime during that 15 minutes, the eviCore physician will call the clinician whose name you entered in the “Message” field.

Examples of clinical consultations include:

- Questions that arise while you’re submitting an authorization request, such as what clinical information must be submitted
- Questions that arise when a request you’ve submitted is pended or denied

Before this scheduling option was made available, providers had to call eviCore and wait on hold until an eviCore physician was available.

Additional information

For additional information about reviews performed by eviCore health for BCN and BCN Advantage members, refer to the eviCore-Managed Procedures page in the BCN section at ereferrals.bcbsm.com.
Providers must attach radiation therapy worksheets to the case when submitting authorization requests to eviCore

For radiation therapy procedures reviewed by eviCore healthcare, providers must complete a worksheet with the pertinent clinical information and attach it to the case in eviCore’s online authorization system when submitting requests.

eviCore updates its radiation therapy worksheets from time to time. Here’s how you can access the most current worksheets:

1. Visit the eviCore website.
2. Click Radiation Therapy, on the Solutions tab.
3. Click Clinical Guidelines.
4. Scroll down and click View more physician worksheets.
5. Click to open the desired worksheet.

For many other procedures that eviCore reviews for BCN, worksheets are available to providers to use as guides in submitting their requests but providers are not required to submit them to eviCore with the case. For physical therapy, occupational therapy and speech therapy services and physical medicine procedures performed by chiropractors, worksheets aren’t available but providers may need to complete treatment plan forms and submit them to eviCore through the LMhealthcare.com provider portal.

As a reminder, BCN contracts with eviCore healthcare to review select non-emergency cardiology, interventional pain management, radiation therapy, radiology, physical therapy, occupational therapy, speech therapy and physical medicine (chiropractors) procedures when performed in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices. eviCore reviews these procedures for BCN HMO® (commercial) and BCN Advantage® members.

Additional information about the procedures eviCore reviews for BCN is available atereferrals.bcbsm.com. Click BCN and then click eviCore-Managed Procedures.

2017 InterQual criteria delayed until October 2017

Blue Cross Blue Shield of Michigan and Blue Care Network will delay implementing the 2017 InterQual® criteria until October 2017, due to upgrades being made to the e-referral system.

Until the upgrades are complete, we’ll continue to follow the 2016 InterQual criteria for all levels of care.

We’ll communicate about this later to let you know exactly when we’ll be implementing the 2017 criteria.
Prior authorization changes for outpatient facility or clinic-based sleep studies

Effective July 17, 2017, all requests to authorize outpatient facility and clinic-based sleep management studies for adult members 18 years of age and older will require the submission of evidence from the member’s medical record. This evidence must confirm signs and symptoms of obstructive sleep apnea. This applies to both BCN HMO℠ (commercial) and BCN Advantage℠ members.

This is in addition to the requirement to submit evidence of the specific condition the member has that would exclude or contraindicate a home sleep study, a requirement that has been in place since Oct. 3, 2016. Any documentation from the patient’s medical record that’s required can be attached to the request within the e-referral system through the Case Communication field. For instructions on how to attach documentation, refer to the article, How to attach clinical information to your authorization request in the e-referral system, in the November-December 2016 BCN Provider News, Page 44. These instructions are also in the e-referral User Guide, in the subsection titled “Create New (communication).”

As a reminder, home sleep studies don’t require clinical review. For home sleep study requests, you must submit an authorization request to facilitate claims payment but you aren’t required to complete a questionnaire for these services in the e-referral system.

Please also note that sleep studies cannot be billed on UB-04 claim forms. Facilities must have a separate provider agreement to be paid for home sleep studies.

The Sleep Management Program web page at eReferrals.bcbsm.com has been updated with these changes.
**INDEX: July–August 2017**

**BCN Advantage**
Chronic Care Improvement Program focuses on blood pressure control .................................. Page 11
Provider Distinction Awards delivered to provider offices ............................................................. Page 13
Notice of Medicare Non-Coverage is required for BCN Advantage members .......................... Page 14
Aspire Health to offer home visits for members with serious illness ..................................... Page 15
Blue Care Network’s Care Transition program helps BCN Advantage patients transition to home Page 16

**Behavioral Health**
BCN’s mental health and substance abuse treatment providers should use JVHL labs for their toxicology testing Page 24
Teen suicide: Factors that influence adolescent behavior and how they may be mitigated .......... Page 24
We’re updating qualification standards for freestanding substance abuse facility agreement .... Page 25
Quality corner: Primary Care Physician Contact .......................................................... Page 26

**Billing Bulletin**
Coding Corner: What to know when coding for vascular disease ........................................ Page 31
Billing Q&A .......................................................................................................................... Page 33
Have a billing question? .......................................................................................................... Page 33
Ambulance providers should bill actual mileage ................................................................. Page 35
Changes to CLIA reporting requirements ............................................................................. Page 36
BCN will begin rejecting paper claims on old CMS-1500 template in June ...................... Page 36
Clinical editing billing tips .................................................................................................. Page 36

**Network Operations**
Teen suicide: Factors that influence adolescent behavior and how they may be mitigated .......... Page 1
PARS now provides claims information .................................................................................. Page 1
Use these numbers for benefits and claims information beginning July 14 ...................... Page 1
Requests for ColoGuard test must be submitted to JVHL for review ................................ Page 5
We’ve made changes to Ambulance Provider Participation Agreement ............................. Page 7
BCN may request clinical documentation over the weekend .............................................. Page 7

Support charity by participating in physician survey ............................................................... Page 8
Providers can order tobacco cessation tools .......................................................................... Page 8
BCN Provider News redesign .................................................................................................. Page 9
Blue Care Network is closed July 3 and 4 ............................................................................. Page 10

**Patient Care**
Back-to-school tips for children with asthma, diabetes ............................................................. Page 17
Medical policy updates ............................................................................................................. Page 18
Case management program helps you care for patients ....................................................... Page 18
COPD diagnosis should include spirometry ......................................................................... Page 20
Criteria corner ......................................................................................................................... Page 21
Prenatal and postpartum care ................................................................................................ Page 22
August is National Immunization Awareness Month .............................................................. Page 23

**Pharmacy News**
Blue Cross Blue Shield of Michigan and Blue Care Network drug lists updated, available online Page 30
Reminder: RC Claim Assist is now available to Blue Care Network providers ...................... Page 30
Reminder: Members can get medications synchronized at the pharmacy ........................ Page 30

**Quality Counts**
Best Practices: Managing medication compliance helps patients with depression ................ Page 27
BCN members receive reminders about preventive care ...................................................... Page 29

**Referral Roundup**
Use the appropriate electronic portal to submit authorization requests reviewed by eviCore .... Page 37
Requests for ColoGuard test must be submitted to JVHL for review ................................ Page 37
Blue Care Network requires authorization for excisional breast biopsy ............................ Page 38
Providers can schedule phone appointments for eviCore clinical consultations on BCN radiology reviews .......................................................... Page 39
Providers must attach radiation therapy worksheets to the case when submitting authorization requests to eviCore .................................................. Page 40
2017 InterQual criteria delayed until October 2017 ........................................................... Page 40
Prior authorization changes for outpatient facility or clinic-based sleep studies .......... Page 41

**Feedback**

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