Physician assistants must re-enroll with Blue Cross, BCN starting October 2017

Physician assistants must re-enroll to be reimbursed for services within their scope of license for dates of service on or after Feb. 1, 2018. Beginning Oct. 1, 2017, physician assistants must:

- Re-enroll and be credentialed with Blue Cross Blue Shield of Michigan and Blue Care Network, including our Medicare Advantage programs
- Complete our attestation form, indicating that they have a legally required practice agreement with a physician, along with other required documents
- For participation with BCN, enroll as part of an existing contracted group or request participation via a new group practice
- Complete a CAQH ProView credentialing application within 14 calendar days of submitting enrollment requests

Current reimbursement arrangements will be terminated for dates of service after Jan. 31, 2018.

Please see PA, continued on Page 2

CMS begins transition to new fraud-protected Medicare card

The Centers for Medicare & Medicaid Services is taking steps to remove Social Security numbers from Medicare cards. This initiative will help CMS prevent fraud, fight identity theft and protect essential program funding, as well as the private health care and financial information of Medicare beneficiaries.

CMS will issue Medicare cards with a new unique, randomly assigned number called a Medicare Beneficiary Identifier to replace the existing Social Security-based Health Insurance Claim Number — both on the cards and in various CMS systems. CMS will start mailing new cards to people with Medicare benefits in April 2018. All Medicare cards will be replaced by April 2019.

CMS is committed to helping providers by giving them the tools they need. They want to make this process as easy as possible for you, your patients and your staff. Based on feedback from health care providers, practice managers and other stakeholders, CMS is developing capabilities where doctors and other providers will be able to look up the new MBI through a secure tool at the point of service.
Regarding dates of service on or after Feb. 1:
• PAs who have re-enrolled by Jan. 31 will be eligible for reimbursement for services within their scope of license either directly or via their affiliated group for all lines of business. Claims for PAs who have not re-enrolled will be denied.
• PAs may choose to continue to be affiliated with physician groups and bill under the groups. If so, PAs should ensure they indicate the groups’ information when they contract and re-enroll.
• PAs will continue to be reimbursed at 85 percent of the physician fee schedule. Current BCN authorization and referral requirements will continue to apply.

Why are Blue Cross and BCN making this change?
We’re making this change because the state of Michigan allows PAs to work within their full scope of practice without direct or general supervision by a participating physician. The state also requires that PAs initiate and maintain a practice agreement with participating physicians.

How to contract and re-enroll
Starting Oct. 1, PAs can find and use the agreements and enrollment forms on bcbsm.com.
Here’s where to find them starting Oct. 1.
• Log in to bcbsm.com as a provider.
• Click on Join Our Network.
• Click on Enrollment and Changes.
• Click on Provider Enrollment.
• Select Physicians and Professionals as your classification.
• Select Change an existing provider.
• Select Physician Assistant under Mid-level (health care) practitioners.
• Follow the prompts to the Physician Assistant Re-Enrollment Form and Physician Assistant Agreements.

Please note: The new documents won’t be posted until Oct. 1.
We’ll provide additional information in upcoming editions of The Record and BCN Provider News.
If you have questions, contact Provider Inquiry or your provider consultant.

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

BCN and Blue Cross will start incorporating CAQH VeriFide™ data into our existing processes this September for M.D., D.O., D.P.M. and D.M.D. practitioners who are due for recredentialing.

It is essential that you keep CAQH ProView application data current. That means you need to reattest to the data on an ongoing basis to ensure its accuracy.

Contributors
William Beecroft, M.D.; Belinda Bolton; Terri Brady; Richard Cook, Pharm. D; Laura Cornish, Pharm. D; Duane DiFranco, M.D.; Kelly Redmond-Anderson; Mary Ellison; Michelle Smith

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Medicare card, continued from Page 1

To make this change easier, there will be a 21-month transition period, beginning April 2018 through December 2019, when all providers will be able to use either the MBI or the HICN for billing purposes. Even though your systems will need to be able to accept the new MBI format by April 2018, you can continue to bill and file claims using a patient’s HICN during the transition period. We encourage you to work with your billing vendor to make sure that your system will be updated to reflect these changes as well.

Steps to help you get ready
Beginning in April 2018, Medicare patients will come to your office with new cards in hand. Here are five steps you can take today to help your office or facility get ready:

1. Go to the CMS provider website and sign up for the weekly MLN Connects® newsletter.
2. Attend CMS quarterly calls, also known as Open Door Forums, to get more information. They’ll let you know when calls are scheduled in the MLN Connects newsletter.
3. Verify your Medicare patients’ addresses. If the addresses you have on file are different than the Medicare address you get on electronic eligibility transactions, ask your patients to contact Social Security and update their Medicare records.
4. Work with CMS to help your Medicare patients adjust to their new Medicare card. When it’s available later this fall, you can display helpful information about the new Medicare cards.
5. Test your system changes and work with your billing staff to be sure your office is ready to use the new MBI format.

Help patients by ensuring your data is accurate

Blue Cross Blue Shield of Michigan and Blue Care Network members rely on our online provider directory for accurate, up-to-date provider information. Therefore, each quarter, we’re requesting that you review and confirm your demographic data with us. You can do this by going to the Atlas Systems PRIME-Hub website or submitting an audit verification of your data.

For information on how to use the Atlas Systems PRIME-Hub validation system, check out these FAQs.

To submit an audit verification:
• Mail: Provider Enrollment – Attestation 20500 Civic Center Dr. Southfield, MI 48076-4115 H200 –PDA
• Fax: 1-844-216-4941
• Email: providerdataintegrity@bcbsm.com

When you review and confirm, please pay close attention to:
• Your group or practice name. This should align with how you address patients when they contact your location and the name you do business as, or DBA.
• Your practice or group locations. Remove administrative locations and group practice locations that aren’t actively seeing patients.
• Practitioner locations. Only list locations where a specific practitioner provides direct appointments to our members.

If you have questions or need support with updating your data, visit bcbsm.com or call Provider Enrollment at 1-800-822 2761.
Blue Cross mobile app now includes approved referrals

Members can now view approved referrals and authorizations when they sign in to Member Secured Services at bcbsm.com. The updated Blue Cross mobile app also includes this new information.

Physicians can advise patients that they can view approved referrals and authorizations online. This application is not available in the West and Mid regions because providers don't need to submit referrals to Blue Care Network.

Blue Cross to help facilities confirm data for online directories

Facilities should review and confirm demographic data with Blue Cross Blue Shield of Michigan and Blue Care Network at least twice a year.

To help improve our online data, the Provider Enrollment and Data Management department will send you the information we have on file for your facility so you can confirm or make changes.

If you have questions or need help updating your information, call Provider Enrollment at 1-800-822-2761.

Correction: PARS will provide claims information

The article “PARS now provides claims information” in the July-August BCN Provider News contained incorrect information.

Hard copies of claims status information are available upon request for the Federal Employee Program®. Hard copies aren't available for Blue Care Network. Under Claims Inquiry, check status is only available for Medicare Plus BlueSM and BCN AdvantageSM policies. It's not available for BCN commercial policies.

Your provider consultant would like to visit you

We want to increase provider satisfaction by building positive relationships with you and by providing technical support to your practice.

Blue Cross Blue Shield of Michigan and Blue Care Network provider consultants provide information on billing as well as Blue Cross and Blue Care Network administrative policies and procedures. We'll help you work more efficiently with us and make sure you understand the many online resources we offer to make your jobs easier.

Request a meeting to learn about our online, self-service options. Find your consultant on our secure provider portal at bcbsm.com/providers.
Cultural sensitivity training available

Would you like to feel more confident and comfortable in culturally sensitive situations? Join William Beecroft, M.D., as he discusses how cultural differences can affect health care practices. This online program shares:

- Why cultural sensitivity is important
- Examples of culturally sensitive situations
- Government standards
- How to exhibit your knowledge and awareness of cultural sensitivity to the community
- Resources to learn more

The need for cultural sensitivity awareness and training is increasingly important, particularly since the U.S. Census Bureau projects that the non-Caucasian population will be more than 50 percent of the total population by 2044. Learn how to handle culturally sensitive situations by viewing this short training program from your office, home computer, smart phone or tablet.

Learn all about our online self-service tools

A new online learning tool is available for providers. The Provider Secured Services overview presentation walks you through our online self-service tools including:

- web-DENIS
- Provider Enrollment and Change
- Health e-Blue℠
- Electronic Funds Transfer

Check out our videos on effective patient communication

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

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

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

To watch the four videos, go to: brainshark.com/bcbsm/patientcommunication

You can view presentations from statewide professional forums

Presentations from our spring statewide professional forums are now available on web-DENIS. Visit the BCBSM Newsletters and Resources or BCN Provider Publications and Resources pages to view the slides.
Million Hearts “C” is for Cholesterol Management

Cholesterol management is an important focus of BCN Advantage’s Chronic Care Improvement program. The five-year program, started in 2012, is designed to prevent cardiovascular disease in BCN Advantage℠ members. The program highlights member self-management strategies and partnership with physicians.

The core of our program includes 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 1 million heart attacks and strokes in the United States by 2017.

Here are some facts about the prevalence of high cholesterol that you can share with your patients:

- Approximately 73.5 million American adults (31.7 percent) have high low-density lipoprotein, or “bad,” cholesterol.¹
- Fewer than one out of every three adults with high LDL cholesterol has the condition under control.²
- Less than half (48.1 percent) of adults with high LDL cholesterol get treatment to lower their levels.¹
- People with high total cholesterol have approximately twice the risk for heart disease as people with ideal levels.¹
- Nearly 31 million adult Americans have a total cholesterol level greater than 240 mg/dl¹

Please see Million Hearts, continued on Page 7
We recognize that our BCN Advantage doctors and their health care teams are the first line of defense in the battle against high cholesterol levels in our members. We’re committed to supporting you in your efforts to manage high cholesterol levels in your patients. Here are some tools and tips you can share with your patients:

You can encourage your BCN Advantage patients to log into their accounts at bcbsm.com to check out our wellness tools. Blue Care Network and Blue Cross Blue Shield of Michigan are working with WebMD® Health Services, an independent company, to provide online health and wellness services to members. On the Blue Cross® Health & Wellness online site powered by WebMD, members can take an interactive online health assessment, take part in digital health assistant coaching programs and access many helpful online resources, such as articles, videos and interactive quizzes.

The Million Hearts website also has many valuable resources to help educate, motivate and monitor your patients.

2017 Performance Recognition Program

Blue Cross and BCN’s Performance Recognition Program rewards Blue Care Network Commercial and Medicare Advantage providers for their role in helping Blue Cross and BCN achieve the objectives of the Healthcare Effectiveness Data and Information Set, or HEDIS®, and the Centers for Medicare & Medicaid Services star ratings programs.

The program rewards providers who encourage their patients to get preventive screenings and procedures as well as achieving patient outcomes such as cholesterol control. More information about this program is available in BCN 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 provider consultant. We appreciate your continued support of our physician incentive programs.

Additional resource for practitioners

Michigan Quality Improvement Consortium guidelines provide up-to-date evidence-based recommendations for lipid screening and management.

References


HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Risk assessment is key to managing osteoporosis

Physicians can help patients recognize the symptoms of osteoporosis and help them take steps to make lifestyle changes. Osteoporosis often goes undetected until a person falls and breaks a bone.

Take steps to make patients aware of risk factors:
• Confinement to bed
• Certain medical conditions and medications
• Family history of osteoporosis
• Low body weight
• Smoking or alcohol
• Vitamin D deficiency and low calcium diet
• Long term-steroid usage
• Lack of exercise

A fracture risk assessment, or FRAX, should include the following: Age, sex, weight, height, previous fracture, family history of hip fracture, current smoking, glucocorticoids, rheumatoid arthritis, vitamin D deficiency or low dietary calcium intake, inadequate physical activity, loss of height (1.5 inches), family history of osteoporosis, Depo-Provera use, aromatase inhibitor therapy, androgen inhibitor therapy and Lupron therapy.

Lifestyle changes may need to include diet and exercise. Low calcium levels or intake appears to be associated with low bone mass, rapid bone loss and high fracture rates. A good source for obtaining calcium through diet is low-fat dairy products including milk, yogurt, cheese and ice cream; dark green, leafy vegetables such as broccoli, collard greens, bok choy and spinach; sardines and salmon; tofu; almonds; and foods fortified with calcium such as orange juice, cereals and bread.

Women older than 50 should consume 1,200 milligrams of calcium daily and men between the ages of 51 and 70 should consume 1,000 milligrams daily but increase that dose to 1,200 once 70 and older.

As one ages, the need for vitamin D increases. It’s recommended that people 51 through 70 consume at least 600 international units of vitamin D daily, and after the age of 70 the consumption needs to increase to 800 international units per day. A few good sources for obtaining vitamin D in the diet are certain kinds of fish, herring, salmon, and tuna, and low-fat milk fortified with vitamin D.

Regular physical activity has long been identified as having a positive affect on health, and exercise plays a key role in preserving bone density in older adults.

Adults should engage in at least 30 minutes of moderate physical activity most days of the week. Although exercise is a positive way to help prevent osteoporosis, any exercise that presents a risk of falling, or is high-impact, and could cause fractures in older adults, should be avoided.

It is important for the provider to know the patient’s family history because heredity may be a factor in developing osteoporosis.

References:
Management and Prevention of Osteoporosis (MQIC guideline)
Physicians should recommend physical activity to older patients

One in three older adults fall every year and these falls threaten the lives, independence and health of these adults. Twenty to 30 percent of those adults who suffer moderate to severe injuries after experiencing a fall will find it harder to get around, or live independently. Falls also increase the risk of an early death.

One out of every five falls causes a serious injury such as a broken bone or head injury. The most common cause of traumatic brain injury is a fall.

People who fall but don’t experience an injury may develop a fear of falling which may cause many to limit their activities. This can lead to reduced mobility and loss of physical fitness which increasing their actual risk of falling.

One of the most important things providers can recommend to their older patients is physical activity. There are four types of exercise that encompasses all the benefits of physical activity: Endurance, strength, balance and flexibility. It’s important to remind patients to start out slowly and build up to more activity. Exercising shouldn’t cause pain or cause someone to become tired. Many local fitness centers, hospitals, churches, religious groups, senior/civic centers, parks, recreation associations, YMCAs, YWCAs or even shopping malls have exercise, wellness or walking programs.

See the attached PDF for a list of tips you can give to your older patients.

Please see Physical activity, continued on Page 10
Prescribe an exercise program to build strength and improve balance

The facts are decisive, but convincing older patients to adopt an exercise program can be challenging.

The SilverSneakers® fitness program by Tivity Health™ makes it easier to turn a medical recommendation into a reality. With the general advice to “eat right and exercise,” you can direct your patients to a comprehensive program that provides encouragement, direction and support every step of the way.

SilverSneakers is available at no additional cost to BCN Advantage℠ and Medicare Plus Blue℠ PPO members. Please encourage your patients to contact their health plan to verify their SilverSneakers eligibility. To learn more, visit silversneakers.com.

For more information contact:
National Institute on Aging Information Center
1-800-222-2225 (toll-free)
1-800-222-4225 (TTY/toll-free)
nia.nih.gov
nia.nih.gov/Go4Life

References:
http://www.cdc.gov/physicalactivity/basics/older_adults/index.htm
http://www.cdc.gov/HomeandRecreationalSafety/index.html
https://www.niams.nih.gov/Health_Info/Bone/Osteoporosis/Fracture/prevent_falls_ff.asp
http://www.cdc.gov/features/activity-older-adults/index.html

Physical activity, continued from Page 9

The following list includes some groups you can recommend to older patients looking for information about physical activity:

- American College of Sports Medicine
  1-317-637-9200
  acsm.org

- Centers for Disease Control and Prevention
  1-800-232-4636 (toll-free)
  1-888-232-6348 (TTY/toll free)
  cdc.gov

- National Library of Medicine
  Medline Plus
  Exercise for Seniors
  Exercise and Physical Fitness
  medlineplus.gov

- President’s Council on Fitness, Sports and Nutrition
  1-240-276-9567
  fitness.gov
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 below for the full list of recipients.

The office of Dr. John Loewen, M.D., Sagola

From left: Linda St. Arnauld (Blue Cross Blue Shield of Michigan), Beth Walstrom and Dr. John Loewen

FMC, Iron Mountain

From left: Daniel McMahon, M.D., Ellen VanLaanen, D.O., Linda St. Arnauld (Blue Cross Blue Shield of Michigan), Nicole Linder, M.D. and Stephen Leonard, M.D.

CMS publishes new physician specialty codes

The Centers for Medicare & Medicaid Services has published a notice to inform providers to bill new physician specialty codes for Advanced Heart Failure and Transplant Cardiology (C7), Medical Toxicology (C8), and Hematopoietic Cell Transplantation and Cellular Therapy (C9). The new codes are effective on Oct. 1, 2017.

See the CMS website for details.
UAW Retiree Medical Benefits Trust coverage changing for Medicare members in 2018

Effective Jan. 1, 2018, the UAW Retiree Medical Benefits Trust ("the Trust") will be transitioning coverage for its Medicare primary members in Michigan from the Blue Cross Blue Shield Traditional Care Network plan to the Medicare Plus Blue℠ Group PPO plan. This means that unless members choose to stay in their current Traditional Care Network, they’ll have new coverage starting in January.

Members who currently have BCN Advantage℠ will remain in their plan. New Trust members aging into Medicare still have the option of selecting BCN Advantage.

As always, it’s important that you ask your patients about recent changes in insurance carriers, benefits, and request a copy of their new ID cards when they come for services. You should also check member benefits and eligibility on web-DENIS.

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

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

See details in the March-April issue.
Dementia can present diagnosis and treatment challenges

By Denice Logan, D.O.

As the population age continues to increase, so does the prevalence of Alzheimer’s and dementia.

Dementia is a category of degenerative brain disorders affecting the memory, thinking and behavior. The definitive diagnosis can be made only post mortem, with a brain biopsy. It’s important to make an early diagnosis because it may help educate affected patients and family members about what to expect. Also, families can plan advance directives that involve the patient.

Worldwide, there are probably more than 30 million people suffering from Alzheimer’s. Alzheimer’s dementia accounts for two-thirds of the diagnosis of dementia. Lewy Body dementia, is less than 20 percent, while vascular dementia is 20 percent or greater.

The varying degree of progression can be seen with Alzheimer’s but the Lewy Body dementia is more predictable with its symptoms. An example of a person with a definitive diagnosis of Lewy Body dementia was Robin Williams. Post mortem diagnosis was confirmed in 2014; his diagnosis was made in 2007, initially, from his early symptoms. Unfortunately, no matter what kind of dementia is present, progression occurs.

It is not uncommon to identify a comorbid diagnosis dementia in Down syndrome, as the majority of Down syndrome patients will develop dementia. Parkinson’s disease can also have a comorbid diagnosis of dementia. Vascular dementia is usually thought of as related to cerebro-arterial disease, like what can be seen with a stroke. Other forms of vascular dementia can also be seen with a cerebral hypoxic encephalopathy, after a sudden cardiac death event, which some patients survive. The risk of developing Alzheimer’s or vascular dementia appears to be increased by many other conditions that damage the heart and blood vessels. These include heart disease, diabetes, stroke, high blood pressure and high cholesterol. Therefore, we should include cigarette smoking, as it also contributes to atherosclerosis.

Often, members may not acknowledge they are experiencing a memory problem because they may consider it normal. The family members, or caregivers may notice changes in a patient. The primary care physician may include a geriatrician, neurologist or psychiatrist and Alzheimer resources early in the process. The work-up, history and physical exam and other tests to rule out other causes for the symptoms is needed to establish a diagnosis. The mini mental state exam, or MMSE, and the mini-cog test should be included during the initial assessment.

Rethinking Dementia, a West Michigan dementia think tank, is considering work on a directory of resources to include an algorithm to follow to assist in this diagnosis. This hasn’t been completed yet.
From the medical director, continued from Page 13

This diagnostic process and the subsequent therapeutic treatment is typically covered for patients with Blue Cross Blue Shield of Michigan plans similar to the coverage for diagnosis of presenting symptoms of other diseases. There are some tests such as imaging studies that may require a preauthorization from eviCore healthcare. Tests that are determined to be medically unnecessary are not covered. Of course, providers have an appeal process available to them. Sometimes, a denial for services may due to a limited amount of information being provided by the physician, or information that fails to support an approval of the preauthorization request. Depending on the type of insurance plan, there may be more requirements such as restricted choice of providers, or more restrictive preauthorizations.

Blue Cross has value partnership programs such as our Physician Group Incentive Program, or PGIP, and the Patient Centered Medical Home model. These programs emphasize the need to focus on population management and chronic care management. BCN also offers chronic care management programs. This helps a practice to identify patients early who may be at risk for dementia such as Alzheimer’s disease. The goal is to improve care and lower the cost for dementia patients.

See the scale for Medicare and Medicaid costs on the Alzheimer’s Association website. Remember Medicare doesn’t pay for custodial care for dementia. As the dementia becomes severe, custodial care may be necessary. Medicaid or the Part B Medicare Advantage program may provide assistance. This may include nursing home custodial care. Families who provide this financial coverage can easily spend up to $90,000 per year in out-of-pocket costs, according to the Alzheimer’s Association website. This does not include the effect and costs on the caregivers.

Therefore, it’s important to be familiar with the member’s benefit coverage when making referrals so you can recommend affordable options.

There’s a wealth of information available on the Alzheimer’s Association website. One helpful tool is 10 Early Signs and Symptoms of Alzheimer’s.
2017 InterQual criteria take effect October 2017

Blue Care Network’s utilization management and behavioral health staffs use McKesson Corporation’s InterQual® criteria when reviewing requests for Blue Care Network and BCN Advantage™ members.

InterQual criteria have been a nationally recognized industry standard for more than 20 years. BCN may use other criteria resources for appropriate levels of care, including BCN medical policies, the member’s specific benefit certificate and clinical review by the BCN medical directors.

McKesson Corporation’s CareEnhance™ solutions include InterQual clinical decision support tools. McKesson is a leading provider of supply, information and care management products and services designed to manage costs and improve health care quality.

Follow MQIC blood lead testing guidelines

Michigan Quality Improvement Consortium guidelines recommend blood lead level testing at ages 9 months and 18 months. The guidelines can be found at the Michigan Quality Improvement Consortium website.

The Michigan Department of Community Health has a Lead Poisoning Prevention Program. Michigan’s Childhood Lead Poisoning Prevention Program provides education and outreach regarding lead hazards and the effects of lead poisoning. Prevention strategies are included in a state work plan for preventing childhood lead poisoning. It also offers information on the number of children with elevated blood lead levels and the percentage of children tested. The program includes training on in-office lead level testing, and a questionnaire on lead exposure.

For more information on this program, visit the Michigan Department of Health and Human Services website.

Medical policy updates

Blue Care Network’s medical policy updates are posted on web-DENIS. Go to BCN Provider Publications and Resources and click on Medical Policy Manual. Recent updates to the medical policies include:

Noncovered services
- Secretory type II phospholipase A2 (sPLA2-IIA) testing to predict susceptibility to coronary artery disease
- Surgical deactivation of headache trigger sites
- Balloon dilation of the Eustachian tube

Covered service
- Vestibular function testing
InterQual, continued from Page 15

BCN will begin using the following criteria in October:

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<thead>
<tr>
<th>Criteria/Version</th>
<th>Application</th>
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<tbody>
<tr>
<td>InterQual® Acute – Adult and Pediatrics</td>
<td>• Inpatient admissions&lt;br&gt;• Continued stay discharge readiness</td>
</tr>
<tr>
<td>InterQual® Level of Care – Subacute and Skilled Nursing Facility</td>
<td>• Subacute and skilled nursing facility admissions</td>
</tr>
<tr>
<td>InterQual® Rehabilitation – Adult and Pediatrics</td>
<td>• Inpatient admissions&lt;br&gt;• Continued stay and discharge readiness</td>
</tr>
<tr>
<td>InterQual® Level of Care – Long Term Acute Care</td>
<td>• Long-term acute care facility admissions</td>
</tr>
<tr>
<td>InterQual® Level of Care – Home Care</td>
<td>• Home care requests</td>
</tr>
<tr>
<td>InterQual® Imaging</td>
<td>• Imaging studies and X-rays</td>
</tr>
<tr>
<td>InterQual® Procedures – Adult and Pediatrics</td>
<td>• Surgery and invasive procedures</td>
</tr>
<tr>
<td>Medicare Coverage Guidelines (Applies to BCN Advantage only)</td>
<td>• Services that require clinical review for medical necessity and benefit determinations</td>
</tr>
<tr>
<td>Blue Cross/BCN medical policies</td>
<td>• Services that require clinical review for medical necessity</td>
</tr>
<tr>
<td>BCN-developed imaging criteria</td>
<td>• Imaging studies and X-rays</td>
</tr>
<tr>
<td>BCN-developed Local Rules</td>
<td>• Exceptions to the application of InterQual criteria that reflect BCN’s accepted practice standards</td>
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<thead>
<tr>
<th>Behavioral Health Criteria/Version</th>
<th>Application</th>
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<tr>
<td>BCN Behavioral Health Utilization Management Clinical Criteria</td>
<td>Behavioral health services that require clinical review for medical necessity for:&lt;br&gt;• Autism&lt;br&gt;• Neurofeedback&lt;br&gt;• Residential mental health&lt;br&gt;• Transcranial magnetic stimulation</td>
</tr>
<tr>
<td>InterQual® Behavioral Health Criteria – Adult</td>
<td>• Inpatient, partial hospital, intensive outpatient and outpatient admissions&lt;br&gt;• Continued stay, discharge readiness</td>
</tr>
<tr>
<td>InterQual® Behavioral Health Criteria – Substance Abuse Disorders and Dual Diagnosis</td>
<td>• Inpatient, partial hospital, intensive outpatient and outpatient admissions&lt;br&gt;• Continued stay, discharge readiness</td>
</tr>
<tr>
<td>InterQual® Behavioral Health Criteria – Geriatric</td>
<td>• Inpatient, partial hospital, intensive outpatient and outpatient admissions&lt;br&gt;• Continued stay, discharge readiness</td>
</tr>
<tr>
<td>InterQual® Behavioral Health Criteria – Adolescent</td>
<td>• Inpatient, partial hospital, intensive outpatient and outpatient admissions&lt;br&gt;• Continued stay, discharge readiness</td>
</tr>
<tr>
<td>InterQual® Behavioral Health Criteria – Child</td>
<td>• Inpatient, partial hospital, intensive outpatient and outpatient admissions&lt;br&gt;• Continued stay, discharge readiness</td>
</tr>
<tr>
<td>InterQual® Behavioral Health Criteria – Procedures</td>
<td>• Electroconvulsive therapy; acute, short-term, continuation and maintenance&lt;br&gt;• Neuropsychological testing&lt;br&gt;• Psychological testing</td>
</tr>
</tbody>
</table>
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:**
Under General Medical – Intermediate – IV Medication Administration
There are providers who utilize the criterion of receiving IV drips such as nitroglycerin or an antihypertensive to meet inpatient criteria for patients with diagnosis of chest pain or hypertensive emergency. When is this criterion appropriate to use for a patient who may have chest pain or are in a hypertensive emergency?

**Response:**
When there are specific criteria for a condition, it isn’t appropriate to apply General Medical criteria.

This is addressed in the 2016 review process: “InterQual® Acute Level of Care Criteria include condition-specific, general, and extended stay subsets. If a patient’s primary condition or diagnosis requiring hospitalization matches one of the following condition-specific subsets, then refer to the appropriate subset.”

If the patient is experiencing chest pain, apply the ACS subset only. It would not be appropriate to apply General Medical criteria in the case of cardiac chest pain.

Hypertensive emergency may be found in the General Medical subset, Critical level of care, under the Cardiovascular heading. However, if the patient requires a lower level of care, in this case, it may be appropriate to apply the IV medication administration criteria at the Intermediate level of care.

Note: It’s important to note that with the 2017 InterQual release, Hypertension will have its own subset. So, when applying the 2017 criteria, the reviewer would apply the Hypertension subset, and the General Medical subset will no longer be appropriate.

**Question:**
Under Infection: GI/GU/GYN – Clostridium difficile colitis: Do we need a confirmed lab result that shows C. difficile or can presenting symptomology and the ordering of applicable interventions be enough to meet the criteria? The criteria do not specifically state actual or suspected.

**Response:**
The diagnosis of C. diff is mainly a clinical one. No lab result or culture is required to apply the criteria. It would be appropriate to apply the Infection: GI/GU/GYN subset criteria for C. diff if the admitting diagnosis is C. diff.
Helping members manage their asthma

The prevalence of asthma increases every year in the United States. The number of adults who currently have asthma is 17.7 million, according to the Centers for Disease Control and Prevention. And approximately 6.3 million children under 18 have asthma.

Blue Care Network’s Asthma Management program provides members with the tools to make informed health choices. Program members learn about their condition, how it affects their lives and how to manage symptoms. The program is available for BCN members age 2 and older and is consistent with the Michigan Quality Improvement Consortium guidelines for the Management of Asthma in both children and adults.

The chronic condition management program offers information that explains the importance of working with the health care team as well as the primary care physician. We send members materials about what tests they need and information about how to recognize and control triggers.

We also offer the following:

- Information on medications and how to self-administer medications
- Education about how to use a peak flow meter
- Education about maintaining an exercise program as an asthmatic patient

Children who have asthma receive age appropriate information on how to manage the disease while at school or away from parents’ supervision.

We offer management action plans to both children and adults. The plans can be used by the patient and physician together to control the disease process and prevent hospitalizations.

Enrollment in the Asthma Case Management program is offered to those with severe symptoms. We develop an individualized plan of care and monitor outcomes in conjunction with the member’s physician.

The Chronic Condition Asthma program is a part of Blue Care Network’s Blue Cross® Health & Wellness benefit. Encourage members to use this program when appropriate. Current referral requirements apply. Registered nurses staff the chronic condition management team and are available Monday through Friday, from 8:30 a.m. to 5 p.m. Call them at 1-800-392-4247, or 1-800-257-9980 for TTY users.
Intimate partner screening is part of MQIC preventive service guidelines

Intimate partner violence screening is part of the Michigan Quality Improvement Consortium Adult Preventive Services (ages 18-49) Guideline. Look for it at the MQIC website.

If you think one of your patients is a victim of domestic violence, encourage the patient to talk to someone he or she trusts or encourage them to call the National Domestic Violence Hotline, available 24 hours a day, every day. Online chat is available every day from 8 a.m. to 3 a.m. Eastern time at 1-800-799-7233 (SAFE).


Intimate partner screening is part of MQIC preventive service guidelines

Domestic violence, also referred to as intimate partner violence, is a repetitive pattern of behaviors used to maintain power and control over an intimate partner. These are behaviors that physically harm, arouse fear, prevent a partner from doing what they wish or force them to behave in ways they don’t want. Abuse includes the use of physical and sexual violence, threats and intimidation, emotional abuse and economic deprivation. Many of these different forms of abuse can be going on at any one time.

Domestic violence is an epidemic that can affect individuals in every community, regardless of age, economic status, sexual orientation, gender, race, religion or nationality. It can result in physical injury, psychological trauma and even death.

Domestic violence often intensifies gradually over time so it isn’t always easy to determine in the early stages of a relationship if a person is abusive. Often the abusive behaviors are dismissed or downplayed in the beginning of a relationship. It’s important to note that domestic violence doesn’t always manifest as physical abuse. Emotional and psychological abuse can often be just as damaging to the victim as physical abuse.

Many times, domestic abuse intensifies when the victim attempts to escape the abuser, terminate the relationship or seek help as the abuser feels a loss of control over the victim.

Anyone can be a victim of domestic violence. Victims of domestic violence come from all age groups and genders, all backgrounds and communities, all education and economic levels, all ethnicities and cultures, all religions and lifestyles.

The same can be said of abusers – there is not typical abuser. It’s important to note that the majority of abusers are only violent with their current or past intimate partners. One study found that 90 percent of abusers don’t have criminal records, and are generally law-abiding outside of the home.

Remind patients about breast cancer screening

October is National Breast Cancer Awareness Month.

According to the U.S. Department of Health and Human Services, breast cancer is the second most common cancer in women. About one in eight women born today in the United States will get breast cancer at some point in their lives.¹

The good news is that many women can survive breast cancer if it’s found and treated early. Please remind your patients about the importance of routine breast cancer screening.

Blue Care Network follows these screening guidelines:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Ages 18 - 49</th>
<th>Ages 50 - 74</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography</td>
<td>Discuss with your doctor</td>
<td>Biennial screening</td>
</tr>
</tbody>
</table>

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

Prepare for flu season

Influenza is a serious disease that affects people differently but can lead to hospitalization and sometimes death. Every flu season is different and during the flu season about 90 percent of deaths occur in people over 65 years old. Flu season can begin as early as October and last as late as May.

Below are the Centers for Disease Control and Prevention’s vaccine recommendations.

The Food and Drug Administration’s Vaccines and Related Biologics Advisory committee endorsed the World Health Organization’s recommended vaccine for use in the U.S. during the 2017-2018 flu season. The recommendation was that a trivalent vaccine be used for 2017-2018, and contain the following:

• A/Michigan/45/2015 (H1N1) pdm09-like virus
• A/Hong Kong/4801/2014 (H3N2)-like virus
• B/Brisbane/60/2008-like virus (B/Victoria lineage)
  
• It was recommended that quadrivalent vaccines containing two influenza B viruses contain the above three viruses and a B/Phuket/3073/2013-like virus (B/Yamagata lineage).
  
• The vaccine viruses recommended for inclusion in the 2017-2018 Northern Hemisphere influenza vaccines are the same vaccine viruses that were chosen in 2017 Southern Hemisphere seasonal flu vaccines.

• Blue Cross Blue Shield of Michigan and Blue Care Network provide coverage for all eligible members of influenza vaccines as recommended by the CDC and the Advisory Committee on Immunization Practices. Again, as in 2016-17, the ACIP and CDC are not recommending the use of the live attenuated influenza vaccine, nasal formulation (LAIV, FluMist®). Blue Cross and BCN will not be providing routine coverage for this vaccine.
  
• More information is available on the FDA VRBPAC website.

Who should get vaccinated

The Advisory Committee on Immunization Practices recommends that everyone from 6 months of age and older get vaccinated every year. Everyone is at risk for contracting the flu, but there are others at an even greater risk who could develop serious complications. Those at such high risk include:

• Children 6 months through 4 years of age
• Adults 50 years of age and older
• People with chronic pulmonary (asthma even if well controlled), cardiovascular (except hypertension), renal, hepatic, neurologic, hematologic or metabolic disorders including diabetes
• Immunosuppressed individuals including those whose immunosuppression is caused by medications or human immunodeficiency viruses
• Pregnant women or those women who may become pregnant during the influenza season
• Children 6 months through 18 years of age who are on long-term aspirin therapy
• Those living in nursing homes or other long-term extended care facilities
• American Indians/Alaska natives
• People with a body-mass index of 40 or greater
• Health care personnel
• Household contacts and out-of-home caregivers of children less than 6 months of age and adults 50 years and older
• Household contacts and out-of-home caregivers of people with medical conditions that places them in a high-risk category for complications from influenza

Infants are very susceptible and vulnerable to complications from the flu and therefore it’s very important to protect them by vaccinating the people around them against the flu. This includes parents, grandparents, siblings, babysitters, daycare workers, caregivers and health care personnel.

References:
http://www.mqic.org/
https://www.cdc.gov/vaccines/index.html
Help patients understand pneumonia vaccine recommendations

Protection against pneumococcal disease can be accomplished by administering two different pneumococcal vaccines, depending on age and underlying conditions.

One agent is the pneumococcal conjugate vaccine, called PCV 13 or Prevnar 13. PCV 13 protects against 13 types of pneumococcal bacteria. These 13 types of strains can cause the most severe infections in children and almost half of infections in adults.

The Centers for Disease Control and Prevention’s recommendation for PCV 13 is to routinely give to children at 2, 4, 6, and 12-15 months of age. The CDC also recommends administration of PCV 13 to children and adults 2 to 64 years of age with certain health conditions. It is indicated also for all of those 65 years of age and older, no matter what the underlying conditions might be, unless there is a contraindication to the vaccine.

People who have had a severe allergic reaction to any of the components of PCV13, a life-threatening allergic reaction to a dose of PCV13, or an earlier pneumococcal vaccine called PCV7, or to any vaccine containing diphtheria toxoid (for example, DTaP), should not get vaccinated with PCV13.

The other vaccine is known as pneumococcal polysaccharide vaccine, commonly abbreviated PPSV23, and it contains 12 of the serotypes included in PCV13, plus 11 additional serotypes.

The CDC’s recommendations for those who should receive a pneumococcal vaccine are:

- Adults 65 years old or older, PPSV23 at least one year after PCV13 for immunocompetent patients
- Anyone 2-64 years of age with certain long-term health problems such as diabetes: PPSV23
- Anyone 2-64 years of age with immunocompromising conditions: PCV13 followed by PPSV23 at least eight weeks later
- Adults 19-64 years of age who smoke cigarettes or have asthma or COPD, PPSV23

The recommended guidelines from the Michigan Quality Improvement Consortium state the following:

- Pneumococcal vaccine: Administer before age 65 if risk factors are present.
- Consult Advisory Committee on Immunization Practices website.
- Age 65 or older: Give PCV13 first and PPSV23 at least one year later.
- If patient has already received the PPSV23, give PCV13 at least one year later.

Risks and side effects

There are no side effects or only minor side effects from the pneumococcal vaccine. There may be some pain or redness at the site of the injection. Serious effects are rare and are due to an allergic reaction to a part of the vaccine. PPSV23 is an inactivated bacteria vaccine and therefore an infection cannot occur from the administration of this vaccine. If an adverse event occurs after the administration of any vaccine, it should be reported to the Vaccine Adverse Events Reporting System, or VAERS. Report it online, by facsimile or mail. For more information, call 1-800-822-7967 or go online at vaers.hhs.gov.

Assistance programs are available to cover vaccine expenses for those who are uninsured. Since health care reform, all insurance plans are required to cover vaccines as recommended by the CDC.
Preventive services guidelines updated for 2017

The Michigan Quality Improvement Consortium updated the adult preventive guidelines for ages 18 and older for 2017. Blue Care Network follows the MQIC guidelines that support several Healthcare Effectiveness Data and Information Set® measures. These HEDIS® measures are used by the National Committee for Quality Assurance® and the Centers for Medicare & Medicaid Services to determine quality health care practices. The guidelines are available on the Michigan Quality Improvement Consortium website.

The following preventive care guidelines were updated in 2017:
- Adult Preventive Services Ages 18-49
- Adult Preventive Services Age ≥ 50

The updated recommendations for ages 18-49 include:

**Immunizations:**
- If risk factors are present, consult Advisory Committee on Immunization Practices website.

The updated recommendations for age ≥ 50 include:

**Immunizations:**
- Pneumococcal before age 65: If risk factors present, consult Advisory Committee on Immunization Practices website.
- Pneumococcal age 65 and older: Give PCV13 first and PPSV23 at least one year later. If the patient already received PPSV23, give PCV13 at least one year later.

These guidelines are based on several sources with levels of evidence provided for the most significant recommendations. The grade definitions used for these guidelines are defined by the United States Preventive Services Task Force.

Other MQIC guidelines updated in 2017 include:
- Advance Care Planning
- Management of Acute Low Back Pain in Adults
- Management of Uncomplicated Acute Bronchitis in Adults
- Primary Care Diagnosis and Management of Adults with Depression
- Management and Prevention of Osteoporosis
- Prevention of Pregnancy in Adolescents 12-17 Years

We value our partnership with practitioners in promoting quality health care. These guidelines were developed as a resource to assist practitioners and aren’t intended to be a substitute for medical judgment. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

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

Watch for our annual physician satisfaction survey

Our annual physician satisfaction survey will be available online in October. We'll give you the link to the survey in the next issue. It will be available atereferrals.bcbsm.com.

Your responses to the annual survey help us gauge your satisfaction with Blue Care Network’s clinical review process and complex case management programs so we can make improvements.
Help male patients make informed decisions about prostate cancer screening

The Michigan Quality Improvement Consortium Guidelines recommends against prostate-specific antigen based screening for prostate cancer. It’s recommended that men make an informed decision with their health care providers about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks and potential benefits of the screening. Men shouldn’t be screened unless they have received this information.

The discussion about screening should take place at:

- Age 50 for men who are at average risk of prostate cancer and are expected to live at least 10 more years
- Age 45 for men at high risk of developing prostate cancer; this includes African Americans and men who have a first degree relative (father, brother or son) diagnosed with prostate cancer at an early age (younger than age 65)
- Age 40 for men at even higher risk (those with more than one first degree relative who have prostate cancer at an early age)

As new information about the benefits and risks of testing becomes available, the discussion about the pros and cons of testing should be repeated. It’s also important to consider changes in the patient’s health, values and preferences. Overall health status, and not age alone, is important when making decisions about screening.

Sources:


Physician advice can help reduce SIDS

Your contribution to reducing the risk of sudden infant death syndrome by sharing safe infant sleep messages is crucial. Research shows that advice from health care providers affects parent and caregiver choices about infant sleep position and infant sleep environment.

While great progress has been made in reducing the SIDS rate by 50 percent since 1992, there is still much to do. In the United States, African-American and American Indian/Alaska native infants are at a higher risk for SIDS than Caucasian or Hispanic infants.

Meanwhile, the rates of other sleep related causes of infant death such as accidental suffocation have increased. Michigan Quality Improvement Consortium guidelines recommend that the risk for accidental deaths in infants as well as SIDS-related deaths be included in conversations with parents.

For information about the Safe to Sleep® campaign visit the National Institutes for Health.

BCN members receive reminders about preventive care

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

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

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

We want to thank providers for working with members to ensure they have all their preventive screenings.
Well-child visits present opportunities for physicians

A well-child visit is the perfect opportunity to monitor the physical, emotional and psychological well-being as a child grows and develops. From birth through early childhood a child will have more frequent well-child visits offering excellent opportunities for physicians to communicate information on normal growth and development as well as education on immunizations, safety, exercise and nutrition with the parents.

Providers should record the child’s weight, height, and head circumference on a growth chart and keep information in the child’s medical record. Well-child visits also include opportunities to provide body mass index screenings and discussions about many topics: nutrition, sleep, safety, physical activity, violence and abuse/bullying, sexually transmitted infection prevention, suicide threats, alcohol and drug abuse, behavioral/emotional problems, anxiety, stress reduction, coping skills, immunizations, skin cancer prevention, tobacco use and secondhand smoke exposure, poison prevention, burn prevention, and injury prevention. Family relationships, school, and access to community services can also be discussed and documented at these visits.

Find recommended routine preventive services for infants, children and adolescents at the Michigan Quality Improvement Consortium website.

Developmental screening

A well-child visit is an opportunity to monitor a child’s mental, social and emotional well-being. Developmental screening can be obtained through a short test that can tell if a child is learning basic skills when he or she should or if there are any delays. The American Academy of Pediatrics recommends that children should be screened for developmental delays and disabilities during regular well-child visits at the following intervals: 9 months, 18 months and 30 months. Additional screenings may be recommended for children at risk for developmental problems due to preterm birth or low birth weight.

Preventive health care schedule for infants

Physicians can recommend that parents schedule visits before their child is born to discuss common issues such as feeding, circumcision and immunizations.

After birth, the first visit for breast fed babies should be two to three days after coming home or two to four days for all babies released from a hospital before they are two days old. After that, it’s recommended that visits occur at the following ages:

- By 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 2 years
- 2½ years
- 3 years
- Each year after until the age of 21

References:
www.mqic.org
http://www.cdc.gov/ncbddd/childdevelopment/screening.html
Evidence-based treatment for major depression in adults

We know more now of what works and what doesn’t in the treatment of major depression. Even with that improved understanding, patients still fail to reach remission of their symptoms and they frequently have relapses. The use of medications, psychotherapy, exercise, diet, mindfulness exercises and spiritual resources has improved outcomes.

Remission of the disease is the desired outcome. Unfortunately, the treatments we currently have are less than optimal. Non-remission and partial remission are all too common. A study, Sequenced Treatment Alternatives to Relieve Depression — STAR*D (published in the American Journal of Psychiatry, 2006), found patients achieve 44 percent full remission and 35 percent partial remission with optimal care.

The current recommendation of the American Psychiatric Association is to carefully diagnose, aggressively implement treatments, monitor progress using objective measures, frequently reevaluate progress and change of interventions based on the measurements and current algorithms to improve outcomes.

Diagnosis is crucial when treating major depression. Many medical problems can present with comorbid depressive symptoms. Diabetes, heart disease, chronic pain, endocrine disorders and sleep apnea are only a few of the many medical problems that share similar symptoms with major depression. Unless the underlying issue is treated, the depression symptoms won’t fully respond to medications or psychotherapy interventions.

A careful medical evaluation is a first step. Many times, physicians take a strategy of a presumptive diagnosis and start a trial of medications but then get stuck when the symptoms don’t respond, leading to questions of what to do next. The Diagnostic and Statistical Manual (DSM-5) includes other symptoms of major depression that weren’t included previously, such as bereavement. Reviewing the more inclusive diagnostic criteria can help discover the less obvious forms of depression.

Please see Depression, continued on Page 27
The mnemonic “SIG E CAPS” has always been a good screening tool for the initial diagnosis of depression. The acronym stands for:

- **S** = suicidal ideation
- **I** = lack of interest or initiative
- **G** = excessive guilt
- **E** = lack of energy
- **C** = change in cognition
- **A** = sad affect or apathy/appetite change
- **P** = psychomotor agitation or retardation
- **S** = somatization/sleep disturbance

This brief review may prompt further objective measure of the symptoms. Use of the PHQ-2 or 9, which is incorporated into many electronic medical record systems, gives a clear objective measure of the severity of depression symptoms and is repeatable to measure progress in response to the treatment interventions that have been initiated. Other measures, such as the Zung Depression Rating Scale or the Beck Depression Inventory, are also well established tools for this purpose.

STAR-D was a multicenter study done several years ago to determine the most efficient treatment for major depression. The result of this well-done trial has been the basis of evidence-based algorithms. The first of these was the Texas Implementation Medication Algorithm. This has generally been the accepted progression of medications standard and interventions to attain the most effective outcomes in the treatment of depressive disorders. Michigan adopted this and has a protocol, now named the Michigan Implementation Medication Algorithm. It is virtually identical to the Texas version.

The basic premise is to complete a thorough diagnostic evaluation using an objective measure. Once the presumptive diagnosis is made, the provider initiates an antidepressant medication of a selective serotonin reuptake inhibitor, selective serotonin and norepinephrine reuptake inhibitor or an “atypical” (bupropion, mirtazepine) class medication. The provider then titrates the medication to full Food and Drug Administration-approved dose or highest tolerated dose for a full four weeks. For the best likelihood of optimal outcome, initiating a course of cognitive behavioral psychotherapy at the outset of treatment is indicated. There is a generally held view that cognitive behavioral psychotherapy is as good as medications for the initial intervention but that use of medications and psychotherapy has the best overall outcome.

At the four-week to six-week interval, it’s important that the provider re-administer the same objective scale along with clinical interview during this follow-up visit. If there’s no improvement; switch to another class of medication or add psychotherapy. Another re-evaluation should take place at the four to six-week interval again. If there is still no improvement, then the medical provider should switch to another class of medications.

Another re-evaluation should take place at the four- to six-week interval again. If there is still no improvement and the primary care physician is managing the treatment, a request for a psychiatric consultation for diagnostic confirmation and possible use of augmentation agents is recommended. These might include such medications as lithium, thyroid hormone (t3) or a psychostimulant. Each of these has literature to support their use but should be initiated by a specialist or at least in consultation with one. Continuing to re-evaluate with objective scales may help identify progress that would be missed using only subjective evaluations even by the most experienced provider.

There are additional steps in the algorithm that the specialist can progress to as indicated. Combinations of medications and somatic treatments, such as electroconvulsive therapy, transcranial magnetic stimulation, vagal nerve stimulation, deep brain stimulation (investigational) each can be done in an objectively measured progression. Since full remission of symptoms is the goal, it’s very important to keep working toward

Please see Depression, continued on Page 28
Depression, continued from Page 27

that goal until it is achieved. Educating the patient about the importance of staying on medications, diet, exercise (30 to 45 minutes five times weekly of aerobic exercise) and psychotherapy, along with the use of spiritual resources and mindfulness is a very important part of the relationship that providers have with their patients. The following graph shows the courses of illness that can occur with the optimal one being total remission.

Phases of Depression and its Rx

Blue Care Network encourages using step progression in the treatment of depression and the adherence to using objective clinical measures to guide treatments. We know there is no quick fix to this disease, but with adherence to standard clinical practice, there are generally moderately good outcomes that can make a world of difference in our members’ lives.

Coordination of care with the primary care physician, psychiatrist, therapist, and encouragement of exercise, diet and mindfulness including spiritual resources all work together better than any one or two resources will on its own.

References
   Available at: https://www.michigan.gov/mdch/0,4612,7-132-2941_4868_38495_38496_38506-0,00.html

Blue Care Network offers depression resources for providers and patients. A provider tip sheet, office poster and member brochure are available on web-DENIS. Go to BCN Provider Publications and Resources and click on Behavioral Health. The information is under General Resources.
BCN’s Depression Management program offers resources for members

Blue Care Network’s Depression Management program provides members diagnosed with depression with education and self-management strategies to deal with this potentially disabling condition. The program was developed in conjunction with the Michigan Quality Improvement Consortium guideline for *Management of Adults with Major Depression*.

The goals of the program include:

- Educating members about the basic pathophysiology of depression and current treatment modalities with emphasis on acute and continuation phases of treatment
- Providing members with self-management techniques with an emphasis on medication compliance
- Promoting decreased workplace absenteeism
- Decreasing inappropriate inpatient admissions and emergency room visits
- Addressing comorbid medical conditions
- Helping practitioners track and monitor services for members with depression

The Depression Management program is available to all commercial HMO members 18 years and older and BCN Advantage members.

We identify members through:

- Claims for outpatient, inpatient and emergency room visits for depression
- Pharmacy claims for antidepressants
- Referrals from physicians
- Data collected from members’ completions of health assessments
- Referrals from BCN’s utilization and case management departments
- Member self-referral

We automatically enroll members in the program, unless they choose to opt out by contacting BCN.

Enrolled members are stratified into two levels. Level one members receive a program booklet and introductory letter, a depression self-management booklet, medication refill reminder letters if necessary, ongoing telephone support from a chronic condition management registered nurse and web-based chronic condition management information and tools at *bcbsm.com*.

We place members in level two if they’ve been admitted to the hospital with a primary diagnosis of major depression. Level two members receive all interventions previously mentioned as well as the opportunity to enroll in a behavioral health case management program provided by BCN’s Behavioral Health department. The behavioral health case manager makes sure that a follow-up visit is scheduled within seven days of discharge and monitors appointment compliance. We also call noncompliant members to provide support and education. BCN provides additional support to members with readmissions, including a member-specific plan of care.

We offer physicians support through patient specific case management reports, clinical guidelines, articles and program assistance from a behavioral health chronic condition management specialist.

To learn more about BCN’s Depression Management program or to refer a member, contact a behavioral health chronic condition case management specialist at 1-800-482-5982 or 1-800-257-9980 for TTY users, from 8 am to 5 pm., Monday through Friday.
Behavioral health physician review phone number has changed

Effective Aug. 21, 2017, the phone number for the Blue Care Network Behavioral Health Physician Review Line has changed to 1-877-293-2788. This is the number for physician-to-physician reviews of determinations related to medical necessity.

The previous Physician Review Line number, 734-332-2567, is no longer working.

Here’s a summary of how to reach a BCN medical director to discuss a behavioral health determination for a BCN member:

• During business hours (8 a.m. to 5 p.m., Monday through Friday), call 1-877-293-2788 (the new Physician Review Line number).

• After business hours (for emergent cases only), call 1-800-482-5982. (This is the current number and it is not changing.)

The numbers for calling BCN Behavioral Health during business hours for other purposes are not changing, either. Those are:

• 1-800-482-5982 for BCN HMOSM (commercial) members

• 1-800-431-1059 for BCN AdvantageSM members

Also effective Aug. 21, the mailing address for BCN Behavioral Health has changed to:

Blue Care Network
Behavioral Health
Mail Code H100
26899 Northwestern Highway
Southfield, MI 48034

Motivational interviewing:
Improving treatment adherence in patients with psychosis

Blue Care Network sponsored a webinar about motivational interviewing to help improve compliance in patients with psychosis. We’re making the slide presentation available to providers through the PDF link below.

Motivational interviewing is a method that seeks to strengthen an individual’s motivation for a specific goal by eliciting and exploring the person’s own argument for change.

If you have questions about motivational interviewing, send an email to Dr. Kristyn Stewart, a medical director at BCN: KStewart@bcbsm.com.

Telepsychiatry uplift ending Nov. 1

Beginning Nov. 1, a fee uplift will no longer be available when behavioral health providers submit telepsychiatry codes with modifier GT, which indicates the service was done by interactive audio and video telecommunications systems, also referred to as telemedicine. The uplift was provided initially for the purpose of compensating for originating site fees. Since originating sites can bill for this service directly, the uplift will be removed, effective Nov. 1.

For information about telepsychiatry visits, see the article in the Nov.-Dec 2016 issue.
Overcoming barriers to statin therapy

The Centers of Medicare & Medicaid Services introduced a new Star measure endorsing statin therapy as best practice in treating patients with diabetes. Based on the American College of Cardiology and the American Heart Association guidelines, many patients without hyperlipidemia can benefit from being on a statin, especially those with diabetes age 40-75\(^1,2\). Statins prevent both first myocardial infarctions and recurrent MIs and prevent cardiovascular death. Absolute reductions are greatest in people at highest risk (for example, those with known cardiovascular disease or very high LDL cholesterol levels)\(^1,2\). Nevertheless, the benefits of statin therapy are convincing in people with diabetes at moderate or even low risk for cardiovascular disease.

**Star measure**

<table>
<thead>
<tr>
<th>Statin Use in Persons with Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requirements:</strong></td>
</tr>
<tr>
<td>• All patients with diabetes*</td>
</tr>
<tr>
<td>• Ages 40 to 75</td>
</tr>
<tr>
<td><strong>Statin therapy regardless of LDL lipid levels</strong></td>
</tr>
</tbody>
</table>

*Based on two medication fills of a diabetes agent. Excludes end-stage renal disease and hospice.

**Barriers exist**

We know many patients may be reluctant to start or continue statin therapy when prescribed. A study by Harrison and colleagues identified the top five reasons patients didn’t want to pick up their cholesterol medication: general concerns about the medication, decided to try lifestyle modifications, fear of side effects, didn’t think the medication was needed and didn’t believe their condition was life threatening\(^3\).

An internal survey of Blue Cross Blue Shield of Michigan providers identified medication adverse effects, specifically myalgia, as the top reason members refused or stopped statin therapy. The table on page 32 includes some helpful tips to overcoming common statin barriers and misconceptions regarding statin therapy in patients with diabetes.

Please see Statin therapy, continued on Page 32
### Helpful Tip

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Solution</th>
</tr>
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</table>
| Myalgia                 | • Try a lower or less frequent dose, such as every other day simvastatin or once weekly rosuvastatin.4,5,6,7  
                          | • Try a different statin that is more hydrophilic, such as pravastatin or fluvastatin.8 These may be less likely to cause myalgia.  
                          | • Try a brief period of discontinuation, then re-challenge with the same statin if it isn’t contraindicated after symptoms resolve.8 |
| Elevated liver enzymes | It’s reasonable to re-initiate the same statin at a lower dose or try a different statin once liver function returns to normal.9 This can safely be done alongside routine liver function test monitoring. |
| Patient has Type 1 diabetes | The ADA guidelines state that the recommended prescribing criteria for statins should be considered for both Type 1 and Type 2 diabetes.1 |
| Patient has LDL < 100 mg/dl | Statins are recommended in all patients with diabetes ages 40-75 regardless of their LDL level.1 LDL levels should still be monitored, since an elevated LDL is a risk factor for CVD and monitoring can help determine the best dose for the patient.  
                          | • LDL < 100 mg/dl – Moderate-intensity statin  
                          | • LDL ≥ 100 mg/dl – High-intensity statin  
                          | If patient has LDL ≥ 50 mg/dl and ACS, ADA guidelines recommend the use of moderate-intensity statin plus ezetimibe.1 |
| “Risk Calculator” esti- mates a low 10-year atherosclerotic CVD risk | This tool has limited use in patients with diabetes since all patients age 40-75 with diabetes should be considered for a statin.1 |
| Drug interaction with concomitant medication | Simvastatin, lovastatin and atorvastatin are susceptible to the most drug interactions.8 If initiating a medication that interacts, consider switching to a different statin with less potential for drug interactions such as pravastatin, rosuvastatin or fluvastatin.10 |

### References

MQIC guidelines focus on reducing antibiotic use

Antimicrobial resistance remains one of the most important public health concerns, according to the Centers for Disease Control and Prevention and the Michigan Antibiotic Resistance Reduction Coalition. Healthcare Effectiveness Data and Information Set® has measures that focus on reducing antibiotic use:

- Appropriate testing for children with pharyngitis
- Appropriate treatment for children with upper respiratory infection
- Avoidance of antibiotic treatment in adults with acute bronchitis

Members with acute upper respiratory tract infections account for many visits to the physician’s office yearly and although most of these infections are viral, many are being treated with antibiotics.

We have clinical practice guidelines for antibiotic utilization for upper respiratory infections that are available from the Michigan Quality Improvement Consortium website. The guidelines are based on several sources with levels of evidence provided for the most significant recommendations. The Acute Pharyngitis in Children 3-18 guideline was updated in January 2017. The Management of Uncomplicated Acute Bronchitis in Adults guideline was updated in May 2016.

**Acute Pharyngitis in Children 3-18 Years Old MQIC Guideline** includes:

- Possible etiologies for pharyngitis and tonsillitis
- Recommended assessments and treatments
- Recommendations if there is clinical failure
- Rheumatic fever considerations

**Management of Uncomplicated Acute Bronchitis in Adults MQIC Guideline** includes:

- Recommended assessments and treatments
- Clinical information and testing for diagnosis
- Treatment section recommends avoiding antibiotics
- Education and counseling to patient/family

The guidelines were developed as a resource to assist practitioners and aren’t intended to be a substitute for medical judgment. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Resources for educating patients about antibiotics

It’s challenging to work with a patient and family who are requesting an antibiotic when it’s not appropriate.

Below are some websites to assist you in educating your patients about the proper use of antibiotics:

- **CDC website.** Enter “Get Smart Home” in the search box. Click on the category titled Get Smart About Antibiotics | Home | Know When They Work | CDC for recommended interventions that reduce inappropriate outpatient prescribing of antibiotics.

- **The MARR website** has a program called PEARLS where you will find recommended actions to use for patients that request antibiotic therapy that isn’t needed. Enter “PEARLS Strategy” in the search box. Click on the category PEARLS Strategy which provides communication strategies for discussing viral illness with patients.

- **Choosing Wisely** has materials available explaining when it’s appropriate to use antibiotics.

Consumer Health Choices has The 5 Questions to ask your doctor before you take antibiotics flyer that you can give to your patients and posters you can use in your office.
Prevent unnecessary delays: Include key information in opioid requests

Blue Cross Blue Shield of Michigan and Blue Care Network are working with the medical community to address opioid abuse through utilization management. To help us deliver effective therapy to your patients, while ensuring safe and appropriate use, we’re asking providers to include key information with opioid requests.

To prevent delays in processing claims for opioid prescriptions, submit all opioid requests with the following information:

- Recent chart notes
- Diagnosis
- Documentation of trial and failure of alternatives
- Treatment plan

Chart notes are useful to verify dosing regimens and patient usage. Hospital chart notes are essential to review opioids prescribed during transitions of care. If a patient continues therapy that was initiated in a hospital setting, hospital chart notes are required. This is especially important for cancer patients on opioid therapy or chemotherapy. Claims will be denied for both if chart notes are not included.

A diagnosis helps the insurer differentiate between opioids prescribed for pain and opioids prescribed for substance abuse disorder.

Documentation of trial and failure of alternatives and a treatment plan ensure that the most up-to-date opioid prescribing guidelines are followed.

The opioid epidemic is a public health crisis that must be addressed through a collaborative effort at multiple levels of the health care system. Prior authorization programs reduce prescriptions for high-risk doses and decrease rates of opioid overdose.1,3 With your help, we can continue to share in the responsibility to curb prescription opioid misuse and connect more of our patients to safe and effective treatment.

For more information on the BCN utilization management criteria for opioids, visit the Prior Authorization and Step Therapy Guidelines page at bcbsm.com.

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Statistics about prescription drug misuse

More than 27 million people used illicit drugs or misused prescription drugs in 2015, according to the U.S. surgeon general.4 Among those who met diagnostic criteria for substance use disorder, 12.5 million people reported misuse of prescription opioid pain relievers.8

In Michigan, there were 1,275 opioid overdoses in 2015 which accounted for 67 percent of all drug overdose deaths. Opioid overdose deaths exceeded gun and traffic fatalities.4 Opioid abuse continues to increase despite prevention efforts such as state-run prescription drug monitoring programs and evidence-based prescribing guidelines.

References

Two drugs will have higher copays effective Sept. 1

The following drugs will become nonpreferred (Tier 3) drugs on our Blue Cross Blue Shield of Michigan and Blue Care Network commercial (non-Medicare) prescription drug plan drug lists, effective Sept. 1.

- Cipro® HC
- Pancreaze®

Instead of the Cipro HC listed above, you can help your patients save money by prescribing one of these lower-cost alternatives:

<table>
<thead>
<tr>
<th>Lower-cost alternatives</th>
<th>Tier</th>
<th>Copayment level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neomycin/Polymixin B/ Hydrocortisone (Cortisporin Otic)</td>
<td>1</td>
<td>Generic</td>
</tr>
<tr>
<td>Otovel®</td>
<td>2</td>
<td>Preferred brand</td>
</tr>
<tr>
<td>CiproDex®</td>
<td>2</td>
<td>Preferred brand</td>
</tr>
</tbody>
</table>

Instead of Pancreaze, you can help your patients save money by prescribing one of these lower-cost alternatives:

<table>
<thead>
<tr>
<th>Lower-cost alternatives</th>
<th>Tier</th>
<th>Copayment level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creon®</td>
<td>2</td>
<td>Preferred</td>
</tr>
<tr>
<td>Zenpep®</td>
<td>2</td>
<td>Preferred</td>
</tr>
</tbody>
</table>

We’ve notified our affected prescription drug plan members of this change to encourage them to speak with you about switching to a lower-cost drug. If they decide to continue filling their current prescription on or after Sept. 1, they’ll be charged a higher copayment.

Overcoming barriers to statin therapy

The Centers of Medicare & Medicaid Services introduced a new Star measure endorsing statin therapy as best practice in treating patients with diabetes. Based on the American College of Cardiology and the American Heart Association guidelines, many patients without hyperlipidemia can benefit from being on a statin, especially those with diabetes age 40-75. Statins prevent both first myocardial infarctions and recurrent MIs and prevent cardiovascular death.

For more, see the complete article on Page 31.
Prevent denials on weight loss, diabetes and testosterone drug prior authorizations using key lab values

Blue Cross Blue Shield of Michigan and Blue Care Network understand that submitting prior authorization forms takes time and we want to help improve the process.

As we work towards a more efficient prior authorization process, we identified that the three medication classes below are often missing key lab values and patient-specific data that are required for coverage. Submitting prior authorization requests with complete patient information expedites processing and reduces additional outreach to your practice.

Medications that are most commonly denied due to missing patient data on drug request forms include weight loss drugs, GLP-1 agonists and testosterone.

Please remember to submit the following required lab values or measurements:

<table>
<thead>
<tr>
<th>Drug category</th>
<th>Required lab values or measurements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss</td>
<td>BMI (body mass index)</td>
</tr>
<tr>
<td>GLP-1 agonists – diabetes</td>
<td>Current HbA1c (hemoglobin A1c) from past three months</td>
</tr>
<tr>
<td>Testosterone</td>
<td>Two morning testosterone levels in the past year included in the lab report</td>
</tr>
<tr>
<td></td>
<td>Also required: At least two documented signs or symptoms of testosterone deficiency</td>
</tr>
</tbody>
</table>

Note: The table above does not include all requirements for drug coverage. For a complete list of criteria, see Prior Authorization/Step Therapy Program guidelines on bcbsm.com.

We update drug lists monthly; we’ll no longer publish drug list quick guides

Effective immediately, Blue Cross Blue Shield of Michigan and Blue Care Network Pharmacy Services has discontinued publishing:
- The Custom Quick Guide
- The Custom Select Quick Guide

Instead, the Custom Drug List and the Custom Select Drug List are updated monthly to provide our customers with timely information. These drug lists are searchable and contain the most up-to-date information.

We regularly update our drug lists. For the most recent updates, go to bcbsm.com/rxinfo.
Blue Care Network no longer covers Evzio, effective Sept. 1

To provide appropriate therapy and affordable prescription drug benefits, Blue Care Network commercial (non-Medicare) plans will no longer cover Evzio® injection, effective Sept. 1, 2017.

Naloxone, the active ingredient in Evzio, is used to reverse the effects of an opioid overdose until emergency medical care can be given. BCN will continue to provide coverage for more cost-effective alternative naloxone products that provide the same treatment.

The following table includes some information about Evzio and the covered alternatives below.

| Available Naloxone Products |
|-----------------------------|-----------------|-----------------|-----------------|
| Drug                        | Strength and formulation | Average cost*  | Cost to the member as of Sept. 1, 2017 |
| Evzio                       | 0.4mg/0.4mL and 2mg/0.4mL injection | $4900          | Full cost (not covered) |
| Narcan®                     | 4mg nasal spray    | $150            | Preferred brand copay |
| Naloxone                    | 0.4mg/mL and 1mg/mL injection (vial and syringe) | $50            | Generic copay |

*Cost for drug based on the average wholesale price

If you’ve been prescribing Evzio, please discuss the covered alternatives with your patients.

We have a new phone number to reach Pharmacy Clinical Help Desk

Providers who need to contact the Pharmacy Clinical Help Desk about drugs covered under the medical benefit should call 1-800-437-3803, effective July 5, 2017. This applies to members covered through BCN HMO℠ (commercial), BCN Advantage℠ and Blue Cross Medicare Plus Blue℠ PPO products.

Providers who have been using other numbers to contact the Pharmacy Clinical Help Desk for drugs covered under the medical benefit should begin using the 1-800-437-3803 number. All other numbers to the Pharmacy Clinical Help Desk were discontinued.
**Billing Q&A**

**Question:**
I read an article in BCN Provider News about Cologuard® that references BCN’s medical policy, but I couldn’t find it on web-DENIS.

**Answer:**
The medical policy containing information on Cologuard® is titled, “Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening.”

Brand names are rarely used in the titles of our medical policies. When looking up BCN medical policies on web-DENIS, it is best to look for the main topic contained in the policy and either search for a key word or a procedure code. If you can’t find it, Provider Inquiry can help you.

Note: There is also an updated article in this issue regarding changes in authorization requirements related to Cologuard. See Page 40.

**Question:**
We have a podiatry office that has completed a prior authorization and would like to use Hyalomatrix code Q4117 along with CPT code *15275. When we received our insurance benefit verification, it stated it was covered in this location (code Q4117). When the service took place in an outpatient setting, Medicare covered this product as well. How can the provider appeal this denial?

**Answer:**
The HCPCS code, Q4117, is noted in our medical policy, Skin and Tissue Substitutes, as an allowed skin substitute as it is FDA approved. While there are no restrictions for this service in an office or outpatient location, your individual provider contract may affect the reimbursement provided for this code, as well as other services reported on the claim. For example, sometimes in an office setting the individual claim lines are reimbursed as individual claim lines. In an outpatient setting, though, the supplies and ancillary services may roll up under the major service, such as a surgical procedure.

It is important to review your remittance advice, and if you have any questions to check with Provider Inquiry.

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.

*CPT codes, descriptions and two-digit modifiers only are copyright 2016 American Medical Association. All rights reserved.*
Billing Q&A, continued from Page 38

**Question:**
Sometimes we see a patient for therapy at some point in the day, but then will receive a call and need to bring the patient back in for crisis intervention. When we bill the CPT codes for the initial therapy and the crisis intervention, *90837 and 90839* respectively, we can't get paid for both services.

**Answer:**
CPT code *90837* is not separately reimbursable when reported with CPT code *90839* for therapy sessions performed on the same date of service. An individual psychotherapy session is considered mutually exclusive to a psychotherapy session for crisis. When multiple services are performed on the same day, the more comprehensive code should be reported to document the scope and level of services provided.

When reporting the psychotherapy crisis management code, it is important to remember the code should be used for the first 30 to 74 minutes of therapy. If additional time is needed, an add-on code is available, *90840* for each additional 30 minutes.

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

Reminder: Ambulance providers should bill for mileage at the line level

We ran an article in the last issue letting ambulance providers know that Blue Care Network implemented a system update.

This is a reminder that providers should bill mileage at the line level (loop 2400 CR106 for EDI claims). We have been receiving claims for mileage at the claim level.

CMS publishes new physician specialty codes

The Centers for Medicare & Medicaid Services has published a notice to inform providers to bill new physician specialty codes for Advanced Heart Failure and Transplant Cardiology (C7), Medical Toxicology (C8), and Hematopoietic Cell Transplantation and Cellular Therapy (C9). The new codes are effective on Oct. 1, 2017. See the CMS website for details.

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:
- Medicare annual wellness visit guidelines
- Epoetin alfa and darbepoetin alfa
Blue Care Network updates authorization requirements for Cologuard

Blue Care Network has updated its authorization requirements for the fecal DNA analysis, known as Cologuard®. Effective retroactive to March 1, 2017, a preauthorization will not be required for this colorectal cancer screening test.

There are criteria that have been established for the screening test that must still be met for the test to be covered. Please make sure the following are met when referring the member for Cologuard colorectal cancer screening testing:

• Member must:
  - Be between the ages of 50 and 75*
  - Be at average risk for colon cancer
  - Be asymptomatic (no signs or symptoms of colorectal disease, including but not limited to lower gastrointestinal pain, blood in the stools, positive fecal occult blood test or fecal immunochemical test)
  - Have not had a Cologuard test in the previous three years

• Patients should not provide a sample if they have diarrhea or blood in their urine or stool (such as bleeding hemorrhoids, bleeding cuts or wounds on their hands, rectal bleeding or menstruation).

• The Cologuard test is not indicated in the following (not all inclusive):
  - Symptomatic individuals
  - Personal history of adenomatous polyps
  - Personal history of colorectal cancer
  - History of inflammatory bowel disease
  - Family history of colorectal cancer or adenomatous polyps in a parent or other first degree relative, particularly when the age of the cancer onset is 45 years or less
  - Familial adenomatous polyposis
  - Lynch syndrome
  - Personal history of chronic ulcerative colitis
  - Personal history of Crohn’s disease
  - Personal diagnosis of a relevant cancer syndrome passed on from your family, such as hereditary non-polyposis colorectal cancer syndrome, Peutz-Jeghers Syndrome, MYH-Associated Polyposis, Gardner’s syndrome, Turcot’s (or Crail’s) syndrome, Cowden’s syndrome, juvenile polyposis, Cronkhite-Canada syndrome, neurofibromatosis, or familial hyperplastic polyposis

Please see Cologuard, continued on Page 41
Cologuard, continued from Page 40

Cologuard may produce false positive or false negative results. Every Cologuard result must be reviewed by the attending physician so that appropriate diagnostic studies may be arranged.

JVHL, our laboratory vendor, will not coordinate testing or supply kits. The ordering physician should send a requisition to Exact Sciences. Exact Sciences will mail the kit to the patient. The order form is on the Cologuard website.

Effective screening

Screening for colorectal cancer is a key measure in preventive health. As part of the Affordable Care Act, there is no cost-sharing for most members for these tests when done for cancer screening.

It is important, though, to take the time to discuss the benefits of each type of screening test with members. If the member has a positive result to any of the screening tests, any subsequent tests become diagnostic at that point and could result in cost-sharing, depending on the member’s benefit certificate.

Screening tests for colorectal cancer and the recommended frequency include:

- Stool based testing
  - Guaiac fecal occult blood testing (yearly)
  - Immunochemical fecal occult blood testing (yearly)
  - Fecal DNA analysis (every three years)
- Direct visualization testing
  - Colonoscopy (every 10 years)
  - Flexible sigmoidoscopy (every five years)

The recommended frequencies noted are for patients with normal risk factors. For members found to be at higher risk, the frequency of the direct visualization tests may be changed. Additionally, patients at higher risk due to family or personal history are not appropriate for the stool based-testing. Those factors should be considered when discussing options for colorectal cancer screening with a member.

*The US Preventive Services Task Force recommends colon and rectal screening for patients aged 50-75. Screening in patients above the age of 75 years should be an individualized decision made in consultation with an attending physician or other qualified health professional.

Reminder: Some home health care services require prior authorization

Blue Care Network requires prior authorization for home health care services in these instances:

- When services are administered by a noncontracted home health care provider
- When services are requested for retirees covered under the UAW Retiree Medical Benefit Trust (group number 00278806)
Reminder: Submit only the pertinent medical records for BCN initial inpatient admission requests

To reduce the time it takes us to respond to authorization requests for initial acute care inpatient admissions, Blue Care Network is asking that hospitals limit the clinical information they send.

Please send only the pertinent parts of the medical record. This applies to both Blue Care Network HMOSM (commercial) and BCN AdvantageSM members.

Some hospitals send the member’s entire clinical record when the request is submitted. This increases the time we spend responding to the request.

**The form is optional now**

The parts of the record you should send are outlined on the *Request for Review of Initial Inpatient Admission* form. We recommend that you use the form as a guide.

Submitting the form itself is optional now. (It was required just recently, but we’ve changed that.)

Hospitals that continue to submit the entire clinical record will ultimately be required to submit the form.

**Where to find the form**

The form is located at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Click BCN and then click Clinical Review & Criteria Charts. Look under the heading Referral/clinical review information.

In June 2017, we posted a news item at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) and a web-DENIS message alerting providers to this change.
Change in authorization requirements for sleep management studies was effective July 17, 2017

Effective with dates of service on or after July 17, 2017, all requests to authorize outpatient facility and clinic-based sleep management studies for adult members age 18 and older 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 HMOSM (commercial) and BCN AdvantageSM 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 is 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. These instructions are also in the e-referral User Guide, in the subsection titled "Create New (communication)."

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

Communications about the change in sleep study requirements were posted online in May 2017, as a web-DENIS message and a news item in the BCN section at ereferrals.bcbsm.com.
Remember to obtain BCN authorization for certain elective outpatient services

We want to remind providers to obtain required authorizations for elective outpatient services that require it. Typical services that require authorization include outpatient surgery and gastrointestinal procedures.

To determine whether authorization is required for a specific service, refer to the documents posted on the Clinical Review & Criteria Charts page at ereferrals.bcbsm.com. Also, review BCN’s Referral & Clinical Review Program document.

Facilities: Remember to obtain BCN authorization for drugs covered under the medical benefit

We want to remind facilities to obtain required authorization for drugs covered under the medical benefit when it is required. In addition, some drugs are required to be administered at specific locations.

Providers should refer to the information about these requirements available on BCN’s Medical Benefit-Pharmacy page at ereferrals.bcbsm.com. There, you’ll find lists of the requirements for various drugs, for both BCN HMO™ (commercial) and BCN Advantage™ members.
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