What clinical practices can do to minimize drug diversion

Physicians have a unique opportunity to prevent and report drug diversion. The Centers for Medicare & Medicaid Services publishes a booklet to help physicians prevent and report the diversion of prescription drugs.

The booklet, “A Prescriber’s Role in Preventing the Diversion of Prescription Drugs,” offers the following tips:

• Exercise caution with patients who use or request combination or “layered” drugs for enhanced effects (for example: anti-psychotics with opioids or benzodiazepines).

• Document thoroughly when prescribing narcotics or choosing not to prescribe.

• Protect access to prescription pads.

• Keep a DEA or license number confidential unless disclosure is required by state law.

Please see Drug diversion, continued on Page 2

Blue Cross
Blue Shield of Michigan and Blue Care Network launch opioid task force to tackle growing crisis

By Duane J. DiFranco, M.D.

With overdose deaths in Michigan tripling in just the last five years and more than 1,000 people treated in emergency departments daily for not using prescription opioids as directed, it’s alarming — but not surprising — that opioid abuse and deaths in the United States have reached the level of a natural disaster.

In August, the White House Commission on Combating Drug Addiction and the Opioid Crisis urged the president to declare the opioid crisis a national emergency.

Please see Medical Director, continued on Page 3

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- Write prescriptions clearly to minimize the potential for forgery.
- Move to electronic prescribing so that paper prescriptions are not required.
- Adhere to strict refill policies and educate office staff.
- Ask patients to bring in the unused portion of narcotics if they are ineffective.
- Use State Prescription Drug Monitoring Programs, where available, to monitor patient prescribing before refilling or adding new medications.
- Refer patients with extensive pain management or prescription controlled medication needs to specialized practices.
- Communicate with pharmacists or other providers, as well as pharmacy benefit managers, and collaborate with them when suspicious behaviors are observed.
- Collaborate with pharmacy benefit managers and managed care plans to determine the medical necessity of prescriptions for controlled substances.

Source: CMS “A Prescriber’s Role in Preventing the Diversion of Prescription Drugs.”
Opioid abuse is a public health crisis that is growing at a terrifying pace. As Michigan’s largest health insurer with a strong social mission, Blue Cross Blue Shield of Michigan has a responsibility to address it. In addition to significant efforts already underway, Blue Cross and Blue Care Network have created an internal task force to coordinate and advance efforts to help make a difference.

The task force includes representatives from across the company to ensure a comprehensive and coordinated approach to tackling the issue.

We’ve been active in battling the opioid epidemic for several years now. Our comprehensive efforts have included robust pharmacy management programs, enhanced access to high-quality treatment, public advocacy at the state and national levels and dedicated social mission and communications campaigns.

Clinical programs have produced encouraging results. For example, Blue Cross’ ePrescribing rate has tripled in the last year and a half. Over the last six years, use of the “Triple Threat” drug combination has decreased 76 percent. Opiate pill volume has fallen by more than 250,000 pills, a 30 percent decrease. Fentanyl use has dropped by 60 percent.

The task force will expand on these existing efforts to help members, and hopefully all Michiganders, deal with the growing opioid issue.

**Task force objectives**

The task force is addressing the opioid problem from multiple angles, identifying current and future efforts to make a difference. It is also examining opportunities with providers and members; enhancing access to high-quality treatment; fighting fraud and abuse; working to improve state and federal laws; providing support for innovative community coalitions that are addressing the crisis; and championing a communications effort to educate the public, the media and our members.

The goal at Blue Cross and BCN is to establish a comprehensive plan that helps prevent opioid abuse and continues collaboration with providers, enabling them to better identify patients with opioid use disorders, and more effectively treat them.

In the meantime, providers can do their part to help combat the opioid epidemic by reviewing the literature (we’ve included some relevant articles in this issue), considering dedicated continuing medical education related to opiate prescribing and by focusing their continuous improvement efforts on this important aspect of clinical care delivery.
Blue Care Network offers two new Healthy Blue Living HMO options

In January 2018, Blue Care Network will be offering two new options — Healthy Blue Living HMO BasicSM and BCN Wellness Rewards TrackingSM — to help employers reward good health habits in their employees.

Currently, Healthy Blue LivingSM HMO puts a spotlight on healthy lifestyles and encourages members to take charge of their health. As a result, they have a better understanding of their current health status and receive lower out-of-pocket costs for the whole benefit year when they complete plan requirements.

Like the Healthy Blue Living HMO product, Healthy Blue Living Basic members will be required to visit their primary care physician within 90 days of enrollment or renewal, complete and submit the BCN Qualification Form and an online health assessment. Both products focus on primary prevention and the effective management of health measures including tobacco, body weight, mental health (depression), blood pressure, cholesterol and blood sugar. Healthy Blue Living Basic also offers enhanced and standard levels based on the member meeting plan requirements and deadlines. Unlike Healthy Blue Living HMO, Healthy Blue Living Basic subscribers will not be required to complete a cotinine test to check for tobacco use.

The new BCN Wellness Rewards Tracking is an add-on program for employers who want to introduce the idea of rewarding wellness to their employees. It is available for employer groups with BCN HMO products except for Healthy Blue Living and Healthy Blue Living Basic and may be offered to either the subscriber only, or both the subscriber and covered spouse. The program comes with a fixed administrative fee. In the Wellness Rewards Tracking program, members must complete the BCN Qualification Form and health assessment within 90 days and members will not be required to complete a cotinine test to check for tobacco use. Employers can choose the incentives for members who complete the requirements (for example, lower premium contributions, a day off from work or a gift card).

For more information, please see the comparison chart in the PDF or on the BCN Publications and Resources web-DENIS page under BCN Products. Click on Healthy Blue LivingSM.
Alpha-numeric prefixes will appear on member ID cards next year

As you’re probably aware, most Blue Cross Blue Shield ID cards display a three-character alpha prefix in the first three positions of the ID number. However, with the ongoing development of new products and networks, the need for new prefixes for member ID cards is growing. To accommodate this need, alpha-numeric prefixes may be issued as early as April 15, 2018.

Numeric values may be assigned in any of the three positions of the prefix, but the prefix will never consist of numbers only. Existing prefixes on member ID cards will remain active and aren’t affected by this change.

In the future, you’ll not only see the three-character alpha-only prefixes but also prefixes with a mix of letters and numbers. As a result, all health care providers and billers must ensure that their systems are able to accept both alpha and numeric characters in the prefix field prior to April 15, 2018.

You should continue to submit member ID numbers, including prefixes, to conduct everyday transactions, as required by Blue Cross.

**Remember:** Unless you’re a dental provider or pharmacy, failure to include the prefix on your claim submission could result in misrouted claims and claim denials. Also, keep in mind that ID cards are for identification purposes only; they don’t guarantee eligibility or payment of your claim. Always check eligibility and benefits at each benefit either through web-DENIS or by calling our [Provider Automated Response System](#).

If you have any questions or concerns, call Provider Inquiry or talk with your provider consultant.

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Reminder: Our updated process for making group changes starts Jan. 1, 2018

On Jan. 1, 2018, we’re removing the [Group Change Form](#) from [bcbsm.com/producers](#). Authorized individuals will need to make any necessary group changes by using the Provider Enrollment and Change Self-Service online application.

If you aren’t currently registered for online enrollment and change processing, here’s the process:

1. Go to [bcbsm.com/producers](#).
2. Hover your mouse over Join Our Network, and click on Enrollment and Changes.
3. Click on self-service FAQ.
4. Click on How do I sign up?

For more information, see the article in the [May-June issue](#).
New digital tools help members navigate their plans

Over the years, doctors have urged us to educate members about their Blue Cross Blue Shield of Michigan plans. They say that having to explain plan details takes time away from their core business: treating patients.

That’s one reason we’ve created a wide range of digital tools to help patients navigate their plans. These tools are available when they log in to their account at bcbsm.com and through our new Blue Cross mobile app.* These resources allow them to:

- Track claims and EOBs.
- Verify coverage.
- Check for approvals on their prior authorizations and referrals. (See article in the Sept-Oct. issue of BCN Provider News.)
- Share important information with you (for example, they can email or text their member ID card directly to you).
- Research the cost of services and procedures to find the most affordable options.
- Find in-network care when they need it.
- Select a primary care physician (required for BCN and Blue Cross® Physician Choice PPO members).
- Use Blue Cross® Health & Wellness programs to track their health risks and discover ways to live healthier. (To learn more about these programs, see the article in the May-June issue of Hospital and Physician Update.)

Our digital tools are especially helpful when a patient has billing questions or needs to know:

- Enrollee ID number
- Customer service phone number
- List of current prescriptions
- Copayment amounts for office, urgent care or emergency room visits

Help us spread the word

To help spread the word about our new app, we’ve created a mobile app kit that health care providers can use. It includes postcards for members, a stand to hold the postcards and a poster. If you haven’t received your kit, contact your provider consultant.

*For iOS 9.0.0. or Android 4.4.2 or better.
Blue Care Network offices will be closed Nov. 23 and 24 for Thanksgiving, and Dec. 22, 25 and 26 for the Christmas holidays.

When BCN offices are closed, call the BCN After-hours Care Manager Hot Line at 1-800-851-3904 and listen to the prompts for help with:

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

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

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

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

As a reminder, when an admission occurs through the emergency room, we ask that you contact the primary care physician to discuss the member’s medical condition and coordinate care before admitting the member.

We’ve made changes to our **Find a Doctor** search

We’ve made changes to the **Find a Doctor** search, available through the patient’s member account on our mobile app and at [bcbsm.com](http://bcbsm.com).

Changes effective in September make it easier for Blue Cross and BCN members to find care. Members can:

- Search for in-network health care providers with a new customized category search
- Select the type of search they want to perform
- Search by category in a drop-down menu

Within the “Select a category” field, members can search:

- Doctors by name or specialty
- Places by name and type
- Costs for procedures
- Medical care groups (BCN only)

**Why does this matter?**

Use **Find a Doctor** with your patients to provide more focused and relevant results, helping your patients come to more informed decisions about choices for care. You can help patients find providers in your referral base and lower-cost alternatives.

Ask your patients to pull up their Blue Cross app and talk through scenarios together.
Reminder: Re-enrollment with Blue Cross and BCN for physician assistants starts October 2017

Beginning Oct. 1, 2017, physician assistants must re-enroll with Blue Cross Blue Shield of Michigan and Blue Care Network, including our Medicare Advantage programs. Physician assistant re-enrollments will be processed with an effective date of Feb. 1, 2018.

Please refer to the following documents for complete information:

- August 2017 Record article
- September-October 2017 BCN Provider News article
- Frequently asked questions, located on web-DENIS
  1. Log in to web-DENIS.
  2. Click BCN Provider Publications and Resources.
  3. Click on Learning opportunities under Other Resources
  4. Find FAQ for Physician Assistant Re-enrollment for Reimbursement.

Also please note:

- All PAs are encouraged to re-enroll as early as possible beginning Oct. 1, 2017, to ensure claims don’t reject inappropriately for dates of service on or after Feb. 1, 2018.
- Upon re-enrollment, be sure your CAQH data is current and consistent with the information you provide on the re-enrollment form.
- Current reimbursement arrangements will be terminated for dates of service after Jan. 31, 2018.

How to contract and re-enroll

Physician assistants can find and use the Blue Cross and BCN practitioner agreements and enrollment forms on bcbsm.com/providers.

About reimbursement for dates of service on or after Feb. 1, 2018

- PAs who have re-enrolled by Jan. 31, 2018, will be eligible for reimbursement for services within their scope of license either directly or under a group for all lines of business.
- PAs who haven’t re-enrolled will have their claims denied.

If you have any questions, contact Provider Inquiry or your provider consultant.
Here are some tips for navigating PARS

Here are some tips and reminders for calling the Provider Automated Response System, known as PARS:

- You can’t bypass PARS for claims or eligibility and benefits, even if you need to speak with a representative; calls will be transferred from PARS to the appropriate call center for assistance.

- Follow the prompts carefully when interacting with the interactive voice response system and listen for the prompts offering a transfer to a representative (played at the end of the options menus, where applicable). This applies to both claims and benefits and eligibility. Pressing “0” at any point on PARS or saying “representative” won’t get you to a representative faster.

- You can enter numeric information on PARS with your touchtone keypad. Spelling of the member’s first name isn’t numeric and must be spoken. This applies to both claims and benefits and eligibility.

- PARS has changed. You’ll first be asked if you’re calling for claims or benefits and eligibility. If you don’t answer this question, the call will be handled as a benefits and eligibility call.

- For claims, PARS will ask two questions to determine whether BlueCard is involved. Providers in Michigan who delivered services to a non-Michigan member won’t be able to use the IVR for claims status and, if these questions are not answered correctly, you may not be connected with a representative.

  Question 1: Are you calling on behalf of a Michigan member?
  Answer: Say “yes” if it’s a Michigan policy; say “no” if the member doesn’t have Blue Cross Blue Shield of Michigan or Blue Care Network.

  Question 2: Were the services rendered in Michigan?
  Answer: Say “yes” if you’re a Michigan provider; say “no” if the services weren’t provided in Michigan.

  » For Michigan providers who saw non-Michigan members, the answers would be “no” and then “yes.” There will be an option to transfer to a representative.

- Claims status on PARS
  - Claims status should only be selected if you’re inquiring on the initial outcome of your claim. It shouldn’t be selected if you know the initial outcome of your claim but wish to discuss further.

  - PARS will ask, “Are you calling in for a status on your claim?”
    - If you’ve already submitted a claim, but you haven’t received a reply on web-DENIS or through your remittance/voucher, you should answer “yes.”
    - If you’ve submitted a claim and you already obtained the initial outcome via web-DENIS or through your remittance/voucher, but you would like additional assistance, you should say “no.”

  - After listening to claims status, PARS will ask: “Do you want to repeat that, hear the next claim, get details, get a hard copy, benefits and eligibility, or more options?”
    - If you say “Get details,” you’ll be asked to provide the procedure or revenue code for the claim lines you’re checking. PARS will provide the claims information at line-level and will then ask: “Do you want to repeat the information, check other claims, get benefits or speak to a representative?”
    - If you say “more options,” PARS will ask: “Would you like to inquire on another date of service, inquire on another member, inquire on another contract, request a hard copy or speak with a representative.”
• Non-claims status inquiries on PARS
  - If you said “no” to claims status, PARS will ask if you’ve received a voucher for the claim you billed.
    » If you’ve already verified claims information on web-DENIS or through your remittance/voucher, and you need additional assistance, you should answer “yes”
  - PARS will ask what you would like to discuss about your claim: Payment other than anticipated, rejection/denial, accounts receivable/payable, follow up on a previous inquiry, etc... Regardless of your selection, PARS will be able to transfer the call to a representative. However, at this point, PARS will say,
    » “If you are calling on a status of your claims, say status.”
    » If you are calling for eligibility and benefits, say eligibility and benefits.
    » Or, if you would like to speak to a representative, say representative.”

This allows you to check other information through PARS before being transferred. Please listen to the end of this option menu to hear the offer to transfer to a representative.

• Claims inquiry options on PARS
  - If you said “no” to claims status and “no” to receiving a voucher, PARS will ask if you’re calling about something else.
    » If you say “something else,” PARS will treat the call as though it’s for claims status and will ask for the member/claims information.
    » PARS will provide the claims information, if a claim is found.
    » After claims status is provided, PARS will offer the following options: “Do you want to repeat that, hear the next claim, get details, get a hard copy, benefits and eligibility or more options?”
      □ If you say “more options,” PARS will offer the following: “Would you like to inquire on another date of service, inquire on another member, inquire on another contract, request a hard copy, or speak with a representative?”

Your previous feedback on the new PARS Claims Status IVR helped us make these improvements.
BCN Advantage Prestige members with coronary artery disease to get no-cost prescriptions in pilot program

We’re piloting a program that lets BCN Advantage℠ HMO-POS Prestige members get specific drugs with no copayment if they have a diagnosis of coronary artery disease.

Prestige members with coronary artery disease will receive:

- A specially designed care management program
- Health improvement information that includes advice on managing their condition
- No costs for the following classes of medications for the entire benefit year
  - Antiplatelet drugs
  - Statins
  - Angiotensin Converting Enzyme inhibitors and Angiotensin II Receptor Blockers
  - Beta-blockers

Evidence shows that patients who properly follow their doctor’s medication regimen have fewer future cardiac events, less need for surgical procedures and better health results.

Your qualifying patients will receive information directly from BCN Advantage.

This pilot is part the Medicare Advantage Value-Based Insurance Design program, which lets Medicare try new ways to improve Medicare Advantage plans.
BCN Advantage offers one new product for 2018, discontinues another

Starting Jan. 1, 2018, some of your patients may be covered by another new BCN Advantage product, BCN Advantage HMO HealthyValue. For plan identification, the member’s ID card will show the BCN Advantage HMO HealthyValue product name on the front of the card at the top.

This new product is an offshoot of the BCN Advantage HMO HealthySaver product introduced last year. HealthySaver combines the Mercy Health provider network in four west Michigan counties with the Together Health and Ascension Health networks in southeast Michigan and Kalamazoo county for a coverage total of 15 counties. This product’s success spurred talks to create a $0 premium plan supported by higher deductibles and copays.

BCN Advantage HMO HealthyValue
The BCN Advantage HMO HealthyValue product is available to Medicare-eligible residents of the following counties: Arenac, Genesee, Iosco, Kalamazoo, Kent, Livingston, Macomb, Muskegon, Oakland, Oceana, Ottawa, Saginaw, St. Clair, Washtenaw and Wayne.

- The monthly premium is $0.
- The medical deductible is $300.
- The out-of-pocket maximum is $4,700.
- Office visit copays are $10 for a primary care physician and $50 for a specialist.
- The hospital stay copayment is $285 for days one through seven and is $0 for days eight through 90.
- There is a Part D prescription benefit with a $250 deductible; however, the deductible does not apply to Tier 1 or Tier 2 drugs.
- Prescription copays are as little as $2 for preferred generics at a preferred pharmacy. See sidebar article on Page 13.

BCN Advantage HMO-POS Core discontinued
A new product last year, BCN Advantage HMO-POS Core was available in all 69 counties served by the BCN Advantage HMO-POS network. It was similar to a PPO. Members paid a 20 percent coinsurance for most services rather than a specified dollar amount copayment that is the standard structure of BCN Advantage plans.

Blue Cross Blue Shield Medicare Advantage PPO offered a similar Core plan in 2017. Due to very low enrollment, both have been discontinued for 2018.

Regardless of the plan, you should always look up the member’s name or enrollee ID in web-DENIS to verify the member’s eligibility and coverage details.

If the member’s coverage has changed since the last visit, you’ll be aware of the details of the member’s new coverage.
BCN Advantage holds premiums and benefits steady for 2018

The big news for the 2018 plan year is that BCN AdvantageSM did not raise premiums for our existing products; in fact most dropped a bit. We also tried to hold the line on member cost share as well, with only minor increases for 2018. Plus, we added a new HMO plan, BCN AdvantageSM HMO HealthyValue, and terminated BCN AdvantageSM HMO-POS Core. See related article on Page 12.

Benefit changes are minimal for 2018. Here’s a summary:

For all plans:
- Expanded the list of service categories that may be subject to prior authorization
- Aligned emergency room copay with the Centers for Medicare & Medicaid Services mandate by increasing the emergency room copay from $75 to $80
- Increased Initial Coverage Limit, or ICL, from $3,700 to $3,750
- Increased TROOP, or true out-of-pocket limit, from $4,950 to $5,000
- Decreased coverage gap for prescription drugs from 51 percent to 44 percent (generics) and 40 percent to 35 percent (brands)

For specific plans:
- Basic only: Lowered Part D deductible by $5
- Elements only: Increased inpatient skilled nursing facility copay from $150 to $164.50 for days 21 through 100; $0 copay remains for days 1 through 6
- Classic only: Increased inpatient acute and inpatient mental health copays for days 1 through 6 from $170 to $175; increased copays for physical, occupational and speech therapy, cardiac and pulmonary rehabilitation, and renal dialysis from $20 to $30
- The hearing aid benefit was doubled from $500 ($250 per ear) to $1,000 ($500 per ear) for members who purchase our Optional Supplemental Dental, Vision and Hearing plan

Plans available in 2018
The BCN Advantage plans available in 2018 are:
- BCN AdvantageSM HMO-POS Elements
- BCN AdvantageSM HMO-POS Basic
- BCN AdvantageSM HMO-POS Classic
- BCN AdvantageSM HMO-POS Prestige
- BCN AdvantageSM HMO MyChoice Wellness
- BCN AdvantageSM HMO ConnectedCare
- BCN AdvantageSM HMO HealthySaver
- BCN AdvantageSM HMO HealthyValue – NEW

BCN Advantage to use Express Scripts pharmacy network
BCN Advantage will use the Express Scripts pharmacy network in 2018. There will be cost-sharing changes for all BCN Advantage plans that have a Part D pharmacy benefit. The Express Scripts system bases copays on its structure of standard and preferred pharmacies. Members who use preferred pharmacies will pay significantly less for prescription drugs, with copays as little as $1.

Other changes to note in the Part D drug benefit include:
- Lowered Part D deductible for Basic by $5
- Increased Initial Coverage Limit (ICL) from $3,700 to $3,750 on all plans
- Increased TROOP from $4,950 to $5,000 on all plans
- Decreased coverage gap from 51 percent to 44 percent (generics) and from 40 percent to 35 percent (brands)
CMS now covers supervised exercise in some patients with cardiovascular disease

The Centers for Medicare & Medicaid Services will now cover up to 36 sessions of supervised exercise therapy over a 12-week period for patients with symptomatic peripheral artery disease who experience intermittent claudication.

Research shows that supervised exercise therapy sessions can ease leg pain and discomfort and improve mobility in patients with cardiovascular disease, according to the CMS decision memo.

BCN Advantage℠ doesn’t cover this benefit. Providers need to bill original Medicare for this service. Peripheral artery disease affects 12 to 20 percent of Americans age 60 and older.

Medicare Part D prescribers are required to enroll in Medicare or opt out

Physicians and other eligible professionals who write prescriptions for Part D drugs must be enrolled in Medicare or have a valid opt-out affidavit on file for their prescriptions to be covered under Part D.

See Page 39.
Providers can’t bill Qualified Medicare Beneficiaries for deductibles or coinsurance

Federal law prohibits all Medicare providers from billing Qualified Medicare Beneficiaries, also known as QMBs, for Medicare deductibles, coinsurance or copayments.

All Medicare and Medicaid payments a provider receives for furnishing services to a qualified Medicare beneficiary are considered payment in full.

These billing rules apply to BCN Advantage dual-eligible members (those who have BCN Advantage as their primary coverage and a Medicaid product as their secondary coverage.) The Centers for Medicare & Medicaid Services language in BCN provider contracts under the “Member Hold Harmless” provision also state the provider may not hold members liable for Medicare Parts A and B cost sharing that are the legal obligation of the health plan or the state.

Providers are subject to sanctions if they bill a QMB for amounts above the sum total of all BCN Advantage and Medicaid payments (even when Medicaid pays nothing).

Per MLN Matters article revised August 23, 2017, “Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB),” CMS recommends providers take the following steps to ensure compliance with QMB billing:

1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.

2. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid.

3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the states in which you operate. Different processes may apply to Original Medicare and MA services for individuals enrolled in the QMB program. For Original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center to automatically receive Medicare-adjudicated claims.

For more information and payment explanations used on remittance advices, refer to the BCN Advantage Provider Manual under “BCN Advantage claims processing.”
Reminder: Use updated forms for BCN Advantage members being discharged from a hospital inpatient stay

Providers must use the updated Important Message from Medicare form and the Detailed Notice of Discharge form for BCN AdvantageSM members being discharged from an inpatient hospital stay. This was effective Aug. 28.

The forms, recently revised by the Centers for Medicare & Medicaid Services, are available at these locations:

- On the CMS website.
- On the eReferrals.bcbsm.com website. Click BCN and then click Forms. Look in the BCN Advantage section of the page under the subheading “Hospitals, for inpatients.” These forms have the BCN Advantage logo and contact information for KEPRO, the Quality Improvement Organization for Michigan.

You can use either the CMS forms or the forms specific to BCN Advantage.

The forms are used to inform BCN Advantage members hospitalized at an inpatient facility that they have special appeal rights if they are dissatisfied with their discharge plan or believe that the coverage of their hospital stay is ending too soon.

Providers can find additional information about each form in the BCN Advantage chapter of the BCN Provider Manual. Look in the section titled “QIO immediate review of hospital discharges.”

BCN Advantage Members receive out-of-pocket cost cards

Improving our members’ experiences continues to be a focus at Blue Care Network. To help ensure that they understand their cost-sharing responsibilities and have no surprises when they seek health care services, we’re mailing out-of-pocket cost cards in January to our BCN Advantage members.

The card features helpful information, including:

- A customized tear-out card with a member’s out-of-pocket costs for certain covered medical services
- Definitions of common health care terms related to costs
- Breakdown of copayment and coinsurance amounts during the initial coverage phase for prescription drugs for Tiers 1 through 5
- Preferred and standard pharmacy cost share information on 31-day supply and 32-to-90 day supply prescriptions
Reminder: UAW Retiree Medical Benefits Trust coverage changing for Medicare members in 2018

Effective Jan. 1, 2018, the UAW Retiree Medical Benefits Trust will transition coverage for its Medicare primary members to the Medicare Plus Blue Group PPO plan from the Blue Cross Blue Shield Traditional Care Network plan. This means that members who don’t choose to stay in their current Traditional Care Network will have new coverage starting in January.

Members who currently have BCN Advantage™ will remain in their plan. New URMBT 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 and benefits, and request a copy of their new member ID card when they come for services. You can also check member benefits and eligibility on web-DENIS.

Provider Distinction Awards delivered to provider offices

Here’s a sampling of a photos from provider offices that received Provider Distinction Awards from BCN Advantage.

Click on the PDF at the right for the full list of recipients.

Green Bay Oncology

Jules Blank, M.D., and Darcy Getzloff, certified nurse practitioner

Epic Primary Care Detroit
Prescribing opioids for chronic pain: Provider resources

Blue Care Network and Blue Cross Blue Shield of Michigan are involved in initiatives to address the opioid crisis, including participating in provider education efforts.

Through this newsletter, we’ll continue to provide you with resources about prescribing opioids and how to discuss risks with patients.

There are many resources available from The Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services.

One such resource is the CDC’s Guideline for Prescribing Opioids for Chronic Pain, intended to help improve the communication between providers and patients about the risks and benefits of opioid therapy and reduce opioid disorder and overdose.

The CDC also has training videos: Applying CDC’s Guideline for Prescribing Opioids

The CDC has published a pocket guide to help physicians determine whether prescribing lower dosages of opioids can help patients.
Diabetes patients require certain tests

Blue Care Network is commemorating American Diabetes Month in November by reminding physicians about the assessment and treatment of their diabetic patients.

The Michigan Quality Improvement Consortium guidelines recommend periodic medical assessments, laboratory tests and education to guide effective self management in patients with Type 1 and Type 2 diabetes mellitus.

The following tests are recommended:

- Hemoglobin A1C (two to four times annually based on individual therapeutic goal)
- Urine microalbumin measurement (annually)
- Serum creatinine and calculated glomerular filtration rate (annually)
- Fasting lipid profile (annually)
- Dilated eye exam by ophthalmologist or optometrist or digiscope evaluation (annually, or every two years in absence of retinopathy)
- TSH and LFTs

For more information about treating diabetic patients, refer to the MQIC guidelines.

The level of HbA1c may be reduced with lifestyle choices of diet, weight loss and physical activity. Members that continue to be challenged with HbA1c levels greater than 9 percent may benefit from working with a BCN nurse case manager.

Our Chronic Condition Management program provides tools to help make informed health choices and manage their conditions. To refer members, call Chronic Condition Management at 1-800-392-4247; TTY 1-800-257-9980. Specialists are available from 8:30 a.m. to 5 p.m., Monday through Friday.

For more information about treating diabetic patients, see article on diabetic nephropathy on Page 30.
Criteria corner

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

These questions pertain to Adult Asthma Criteria 2016 Acute setting.

**Question:**
How do you count a continuous treatment – for example, a continuous nebulizer treatment given for 10 minutes? Does it count as one dose or do we have to determine how many doses were given in the continuous treatment?

**Answer:**
When multiple doses of a short-acting beta agonist are given in one long or continuous nebulizer treatment, criteria should be applied for the number of doses given, rather than for one treatment.

**Question:**
Do the three short-acting beta-agonist treatments given initially to meet the symptom/finding criteria count toward the required 6x/24hr treatments under interventions?

**Answer:**
Yes, they may be used to apply criteria, as long as they were given within that episode day.
CMS offers resources to help providers improve care for patients with disabilities

In celebration of the 26th anniversary of the Americans with Disabilities Act, the Centers for Medicare & Medicaid Services Office of Minority Health and the Medicare-Medicaid Coordination Office would like you to explore new and existing resources to help you provide person-centered care for individuals with disabilities.

One such tool, the Disability-Competent Care Self-Assessment Tool is designed to help health plans and health systems evaluate their current ability to meet the needs of adults with functional limitations. Health plans and health systems can improve their disability competency by using this tool to identify strategic opportunities for improvement.

The model encourages participant direction in choices regarding health, wellness, and life in the community. A variety of experts have provided guidance within the tool for plans and providers to better serve individuals with complex care needs.

CMS also offers the following resources to help you care for patients with disabilities. Links are embedded in the titles.

- Increasing the Physical Accessibility of Health Care Facilities
- Does Disability Affect Receipt of Preventive Care Services among Older Medicare Beneficiaries?
- Medicare Fee-For-Service Beneficiaries with Disabilities, by End Stage Renal Disease Status, 2014
- The Disability Competent Care Model
- Competent Care Self-Paced Training Assessment Review Tool
Educate patients about the dangers of smoking

The American Cancer Society marks the Great American Smokeout on the third Thursday of November each year to encourage smokers to quit.

By quitting even for one day, smokers and smokeless tobacco users take an important step toward a healthier life, one that can reduce cancer risk. Oral or smokeless tobacco products also cause cancer and can lead to nicotine addiction. The use of any smokeless tobacco product isn’t considered a safe substitute for quitting.

Tobacco use is the most preventable cause of death in the U.S., yet approximately 40 million Americans or one in every five adults still smokes cigarettes. According to the American Cancer Society, cigarette smoking rates have dropped (from 42 percent in 1965 to 17 percent in 2014). However, cigar, pipe, and hookah are very much on the rise.

The dangers of secondhand smoke

According to the Surgeon General’s Report, there have been more than 20 million smoking-related deaths in the United States since 1964; 2.5 million of those deaths were among nonsmokers who died from exposure to secondhand smoke. Secondhand smoke exposure is also known to cause strokes in nonsmokers.

Secondhand smoke is a mixture of two forms of smoke that come from burning tobacco:

- Side stream smoke: Smoke from the lighted end of a cigarette, pipe, cigar or tobacco burning in a hookah.
- Mainstream smoke: The smoke exhaled by a smoker

While it is generally known that mainstream smoke can be detrimental, side stream smoke is also very toxic. Side stream smoke has higher concentrations of carcinogens and is more toxic than mainstream smoke. It has smaller particles than mainstream smoke. These smaller particles make their way into the lungs and the body’s cells more easily. When nonsmokers are exposed to secondhand smoke, it’s called involuntary, or passive, smoking.

Nonsmokers who breathe in secondhand smoke take in nicotine and toxic chemicals by the same route smokers do. Quitting smoking alleviates exposure to secondhand smoke that is harmful to others.

Blue Care Network has partnered with WebMD to provide a telephone-based tobacco cessation and lifestyle coaching program.

We encourage physicians to counsel all patients who smoke or use smokeless tobacco to quit at each visit until they are successful.

We also provide tools you can use in your office. Use the form in the PDF below to order notepads and office posters.
Screen kids early to avoid cardiovascular disease

Atherosclerosis begins in childhood and progresses slowly into adulthood, leading to coronary heart disease. Children are also at risk for developing hypertension, metabolic syndrome and Type 2 diabetes.

The American Academy of Pediatrics recommends that all children be screened for high cholesterol at least once between the ages of 9 and 11 and again between 17 and 21.*

Michigan Quality Improvement Consortium guidelines recommend screening for children older than 2 who are at increased risk for genetic forms of hypercholesterolemia. The best method for testing is a fasting lipid profile. If the child has values within the normal range, testing should be repeated in three to five years.

Children 8 years old and older with abnormal cholesterol readings may be considered for cholesterol-reducing medications. Younger children with abnormal readings should focus on weight reduction, healthy eating habits and an active exercise program.

For younger patients who are overweight or obese and have a high triglyceride concentration or low HDL concentration, weight management is the primary treatment.

During the office visit, the primary care physician should address the following risk factors with the child and his or her family:

- Family history of heart disease
- Family history of obesity
- Family history of high blood pressure
- Family history of diabetes
- Child’s height and weight and body mass index
- Blood pressure measurement at age 3, then yearly if normal
- Lipid screening if indicated
- Review of child’s diet and daily physical activity
- Tobacco use by parents and the child beginning at age 12, including second hand smoke exposure; counseling for smoking cessation

Our Care Management team provides parents and caregivers of overweight children with information about hypertension, nutrition and other factors related to cardiovascular disease. Call the Care Management nurse line at 1-800-392-4247.

*Guidelines sponsored by the National Heart, Lung and Blood Institute

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

- Fetal magnetocardiography
- PCR panel testing for gram-negative bacillus antimicrobial resistance genes
- Polymetabolite urine testing for adenomatous polyps
- Retinal polarization scan (Retinal birefringence scanning)

Covered service

- Aqueous shunts and stents for glaucoma
- Corneal collagen cross-linking
BCN continues to follow AAP palivizumab guidelines

Blue Care Network follows guidelines from the American Academy of Pediatrics for the use of Synagis®, also known as palivizumab. Palivizumab, approved in 1998, has reduced respiratory syncytial virus hospitalizations. AAP consistently updates its Synagis guidance for prevention of respiratory syncytial virus. The guidance was developed to implement palivizumab in the most cost-effective way.

Palivizumab is a monoclonal antibody given monthly to prevent RSV during the RSV season in pre-term or high-risk infants. RSV season in Michigan generally starts around December 1 and continues for four to five months.

High-risk infants were previously defined as infants with bronchopulmonary dysplasia, those born at or before 35 weeks gestation and children with hemodynamically significant congenital heart disease. In addition, it was indicated for children undergoing cardiopulmonary bypass.

Due to the advancement in neonatal care since 1998, there has been a steady decline in RSV hospitalization both with and without prophylaxis. This has changed the need for palivizumab. Because high-risk infants are no longer at such a risk, AAP has stated criteria to identify those high-risk infants: Palivizumab is recommended for infants born before 29 weeks, 0 days gestation, who are younger than 12 months at the start of RSV season.

Palivizumab is no longer recommended for infants born at 29 weeks, 0 days gestation or later, but may be indicated for:
- Infants younger than 12 months with hemodynamically significant congenital heart disease
- Infants younger than 12 months with chronic lung disease — defined as birth at before 32 weeks, 0 days, and less than 21 percent oxygen for at least 28 days after birth
- Infants younger than 24 months who are profoundly immunocompromised during the RSV season, children who required at least 28 days of oxygen supplementation after birth and those who require medical intervention (oxygen, chronic corticosteroids, diuretic therapy)
- Children younger than 12 months with pulmonary abnormalities or neuromuscular disease that impairs the ability to clear secretions from upper airways

The AAP also emphasizes that the risk of RSV disease is higher in Alaskan Native American patients, and use has been broadened in these individuals as well as other selective American Indian populations.

The guidance states a maximum of five monthly doses may be given to infants in the first year of life. This differs from the previous recommendations, where certain infants required fewer doses. Although those born within the season may require fewer doses, palivizumab is no longer recommended for infants in their second year of life as it was in certain populations in the past. It is no longer recommended for prevention of health care-associated RSV disease and should be discontinued in any child who has a breakthrough RSV hospitalization.

A publication and commentary published in Pediatrics in the August 2016 issue demonstrated additional support for the current recommendations. As of August 1, 2017, no additional changes have been noted to the AAP guidance.

RSV seasonal trends and surveillance data are available at the Centers for Disease Control and Prevention.

- Please note that BCN requires prior authorization for the coverage of Synagis (palivizumab) in accordance with the AAP guidance.
- For a full list of drugs in the prior authorization program and how to request an authorization, go to ereferrals.bcbsm.com and click Drugs Covered Under the Medical Benefit on the Clinical Review and Criteria Charts page. You can also call the BCN Specialty Pharmacy Help Desk at 1-800-437-3803, 8 a.m. to 4:30 p.m., Monday through Friday, to initiate a prior authorization request.

References:
Help prevent Type 2 diabetes in children

While Type 2 diabetes is usually diagnosed in adults, it’s increasingly diagnosed in children and adolescents, particularly in American Indians, African-Americans and Hispanics and Latinos, according to the Centers for Disease Control and Prevention.

Obesity is a major risk factor for Type 2 diabetes in children. Type 2 diabetes mellitus can remain asymptomatic for a long time. According to the National Institutes of Health, obesity in children may be attributed to the following modifiable habits:

• High-calorie food choices
• Lack of physical activity
• Parental obesity
• Irregular eating habits that include skipping meals and overeating
• Parents with poor nutritional habits and sedentary lifestyles

The Michigan Quality Improvement Consortium guidelines recommend that physicians assess children at each periodic health exam. These key components should be addressed:

• Education of parents with children under 2 years old about obesity risk and prevention
• Assessment of body mass, risk factors for overweight and excessive weight gain relative to linear growth in children age 2 or older
• Education to promote healthy weight in children age 2 years or older with a body mass index less than the 85th percentile for age

For children 2 years or older, guidelines recommend that the general assessment include:

• Performing a history (including focused family history) and physical exam
• Measuring and recording weight and height on CDC BMI-for-age growth chart
• Assessing risk factors, including pattern of weight change (watch for increases of three to four BMI units/year.)
• Assessing dietary patterns (for example, frequency of fast-food meals, skipping breakfast, frequency of fruit and vegetable intake, portion sizes)
• Physical activity level

For additional information about prevention and identification of childhood overweight and obesity refer to the updated MQIC guidelines.

Overweight or obese children may benefit from weight loss supervision from their health care practitioners. Studies in adults have indicated that if an individual can reduce his or her body weight by 5 to 7 percent and maintain at least moderate activity for 30 minutes most days of the week, he or she can reduce the risk of diabetes.

Physicians should provide counseling about nutrition, weight control and physical activity to young people and their families, as well as an individualized plan of care. Some children may also need treatment for hypertension and hyperlipidemia, including follow-up every three months. Pharmacologic therapy for weight loss isn’t recommended for children until more safety and efficacy data is available.
Help patients get enough Vitamin D

In previous issues of the BCN Provider News we’ve discussed Choosing Wisely®, an initiative that promotes conversations between physicians and patients about medical tests and procedures that may be unnecessary or potentially harmful. In this issue, we discuss the Choosing Wisely campaign on vitamin D testing.

Low vitamin D increases the risk of broken bones. It may also contribute to other health problems. That’s why doctors often order a blood test to measure vitamin D. However, many people don’t need the test. Even though many people have low levels of vitamin D, few have seriously low levels. If your patient is at risk for other diseases, such as diabetes and heart disease, a vitamin D test isn’t usually helpful. It’s important to advise your patients to make lifestyle changes — to stop smoking, to aim for a healthy weight and to be physically active.

Encourage your patients to get vitamin D from sun and their diet. A quick 10-minute walk during the middle of the day in the summer can give a body all the vitamin D it needs for the day. The body even stores some of the extra vitamin D to help during the darker winter months. People with darker complexions might need to spend up to an hour in the sun to get the same amount of vitamin D.

Also, encourage your patients to eat foods rich in vitamin D. Some foods rich in vitamin D include:

- Meat, poultry and fatty fish such as salmon, mackerel, sardines and fresh herring
- Tofu, orange juice and dairy products fortified with vitamin D
- Shrimp

Encourage your patients to eat breakfast. Two eggs, a glass of orange juice, and a bowl of cereal and milk can add up to about 300 IU of vitamin D — half of the daily requirement.

Be sure to discuss supplements with your patients when appropriate. The daily recommended dose of vitamin D for adults under the age of 70 is 600 international units. For adults over the age of 70, the daily dose is 800 IU.

When should you order a vitamin D test?
Here are some conditions that might warrant a vitamin D test:

- Your patient has osteoporosis
- Your patient has a disease that damages the body’s ability to use vitamin D. These are usually serious and ongoing diseases of the digestive system, such as inflammatory bowel disease, celiac disease, kidney disease, liver disease and pancreatitis.

For more information on vitamin D testing, visit Choosing Wisely.
Behavioral health documentation guidelines now available

By Dr. William Beecroft, BCN Medical Director

Contracted behavioral health providers must follow the recently published guidelines when documenting behavioral health services provided to members. These guidelines apply to services for BCN HMO℠ (commercial), BCN Advantage℠, Blue Cross PPO (commercial) and Blue Cross Medicare Plus Blue℠ members. They were developed for all products to make it easier for providers to locate and follow.

Where to locate the guidelines

You’ll find the guidelines at refereals.bcbsm.com. Click either BCN or Blue Cross, as appropriate. Then click Behavioral Health.

The guidelines are published in two documents:

- Behavioral health medical record documentation requirements for applied behavior analysis services
- Behavioral health medical record documentation requirements and privacy regulations — for services other than applied behavior analysis

The guidelines contain the requirements for documenting specific treatments. For ABA, this includes line therapy, supervision, parental training or socialization groups, and re-evaluation. For non-ABA treatment, this includes the initial evaluation and subsequent individual, group and family therapy.

Why the guidelines were developed

Over the past few years, Blue Cross Blue Shield of Michigan and Blue Care Network have added new types of providers who have enhanced our networks’ capabilities for care. Some providers have never worked with insurance carriers and haven’t previously had to document their services clearly and specifically enough to match the services billed.

In addition, we have had complaints from members that the services billed did not match the services they thought they were receiving. We’ve also been subject to additional reporting requirements from federal and local government agencies and our accrediting organizations. These require more detailed documentation of services provided.

With these issues in mind, we developed documentation guidelines to align with those published by the Centers for Medicare & Medicaid services, with local and federal regulatory agencies, with accrediting agencies and with good documentation practices. We feel this will help providers document their care in ways that meet both medical and legal requirements.

Please see Documentation, continued on Page 28
Additional information

In each guidelines document, you’ll see requirements for both medical and nonmedical treatment providers. Medical providers (physicians, nurse practitioners and physician assistants) must follow the CMS documentation guidelines in the Medical Learning Network guide ICN 006764 (August 2016).

For nonmedical providers, we’ve outlined detailed documentation requirements for the most common types of interventions that would be used.

When you document these interventions, there’s no need to document anything that did not occur. On the other hand, you should document any interventions you provided in addition to those we listed. That way, you’ll have a way to remember these interventions and these notes will complete the member’s record.

Also, standard care involves using screening tools to document the progress of your patient. Documenting the use of those tools can be helpful in measuring the progress of your patient or in identifying measurably poor progress and the subsequent need to review the treatment interventions provided.

Many electronic medical records already have most or all of these items within their database, although it may take some time to learn where they are to make the process go more quickly.

We encourage you to familiarize yourself with the new documentation requirements and start to use them immediately. Over the next few weeks, provider manuals will be updated with hyperlinks to the guideline documents.

Remember, the general rule of thumb is: “If it’s not documented, it didn’t occur.”

As always, we appreciate the good care you provide our members.

Blue Care Network now pays for collaborative care codes for all lines of business

Blue Care Network allows payment of collaborative care codes G0502, G0503, G0504 and G0507 for primary care practices that have developed practice alignment with the Compass or Impact model of collaborative care. This was effective Oct. 1, 2017.

The model utilizes an embedded psychiatrist within the treatment team that can help the primary care providers provide comprehensive care to patients. The psychiatrist can be onsite or participate via video conference to provide consultation to the medical team. The collaborative care codes are paid to the primary care practice who must have a separate established contract to pay their psychiatric consultant. The psychiatrist cannot bill additionally for a consultation or evaluation code for the patient unless he or she is evaluating the member face to face.

Ample evidence shows that this practice style enhances care and improves outcomes of members with mental health needs. Most improvement is seen with members who have three or more chronic illnesses. In fact, we know that patients with cardiovascular disease, COPD, diabetes, connective tissue disorders, along with fibromyalgia and many others experience significant depression as a comorbid issue. Therefore, treating depression and other mental health issues using evidence-based interventions and consultation with an in-house or consulting psychiatrist can have excellent outcomes.

Please see Collaborative care, continued on Page 29
Collaborative care, continued from Page 28

Primary care practices who wish to bill these codes will need to be able to validate that they meet the criteria outlined below. BCN reserves the right to review records and claims to confirm the practice is following these practice guidelines.

1. The practice has a contract with a psychiatrist that is credentialed with Blue Care Network of Michigan and has completed the certification course through the American Psychiatric Association (APA) for Collaborative Care (CoCare).

2. The primary care physician who is leading the CoCare team has taken the certification course through the APA in collaborative care practices.

3. Care Managers have received training in the CoCare model either in an educational institution or through CME programming.

4. The practice has a practice consultant that is specialized in the Collaborative Care model to assist in the transition to this style of patient care or has attended enough CME activities that they feel comfortable making this transition themselves.

5. The practice utilizes an electronic or equivalent paper medical record that includes the ability to track patients engaged in this model of care.

6. The practice uses evidence-based scales at least quarterly to screen and track progress and to decrease barriers to care.

7. The practice has established team meetings, at least biweekly, to clinically collaborate on selected patients receiving this service.

8. The practice keeps adequate documentation to report care management activity and episodes of coordination of care between care manager, PCP, psychiatrist and interventions relayed to the patient.

9. The practice is willing to participate in periodic data reporting based on utilization and objective screening measures.

For further information, the American Psychiatric Association has special didactic programs for primary care physicians to learn more about collaborative care. The foundation for this practice style has been outlined in several studies, but the best known are the Diamond Program, the Impact Model and the Compass Model. An article on collaborative care services can also be found on the CMS website.

Continue to submit documents for the Behavioral Health Incentive Program

Continue to submit your self-reported documents for 2017. If you’re not yet submitting but would like to start, or want to find out more about the program, the booklet and other documents on web-DENIS can answer many of your questions.

Follow the steps below to find the booklet, forms, and instruction guides:
- Log in to web-DENIS
- Go to BCN Provider Publications and Resources
- Click on Behavioral Health under Resources
- Scroll down to Behavioral Health Incentive Program

We encourage all providers to review the instructions on web-DENIS regarding electronic submissions. It’s quicker to submit electronically and our incentive payments for electronic submissions are higher than for manual submissions.

Be on the lookout for BHIP 2018 documents and forms, which will be posted on web-DENIS in January.
**Best Practices**

Monitoring for nephropathy is an important diabetes care measure

Treating diabetic patients means constant monitoring and education to manage their conditions.

For one HEDIS measure in particular — monitoring for nephropathy — Barbara Gurden, M.D., makes it a priority at her Laingsburg practice to test diabetic patients at every visit. She also schedules follow-up visits every three to six months, depending on whether the patient’s diabetes is under control or whether the patient has co-morbidities.

To make sure every diabetic patient is tested for nephropathy, Dr. Gurden works with her quality team and ensures that patients make their follow-up appointments before they leave the office.

“If a patient fails to make the appointment, the receptionist lets me know and we send the patient a message to reschedule,” says Dr. Gurden.

“We also work with our quality team to review lists of patients who have either missed an appointment or missed the nephropathy measure. We’re constantly going through lists of our diabetic patients. You need to be consistent.”

She also credits her medical assistant with making sure all diabetics get their microalbumin tests. The assistant has been working for her 14 of her 20 years in practice.

It’s important to constantly watch both GFR and microalbumin to detect nephropathy, says Dr. Gurden. “I’ll refer to a nephrologist if I start seeing the patient’s GFR levels dropping. I had a patient this year whose GFR decreased quite a bit so I referred her to a specialist. She had a kidney tumor and ended up having surgery. She’s now doing well. We do a lot of coordination with nephrologists because patients will sometimes listen more to a specialist. You need to have a team or pros. It’s too hard to do it by yourself.”

Patient education is also integral to helping patients stay on top of their diabetes and manage their condition. “At the diabetic visit, we also discuss blood pressure, eye exams and why it’s important to check their feet. It’s not just one thing we look at.”

Part of educating patients about the risks associated with diabetes means helping them understand that they need to keep their blood pressure under control, as well as their sugar. “We also tell them to be careful with nonsteroidal anti-inflammatory drugs, or NSAIDs, which can cause a lot of kidney damage,” says Dr. Gurden. The office also advises patients about adequate hydration and nutrition.

For all diabetic patients, Dr. Gurden makes sure patients are compliant with medication.

“We watch prescription refills and receive notifications from the pharmacy. “If someone is non-compliant, we call those patients and our staff will review their medications.”

“I also let patients know I’m diabetic,” says Dr. Gurden. “It helps them to know that I have to experience everything they experience.”

Dr. Gurden says there are challenges associated with treating diabetic patients, and those diagnosed with nephropathy.

Please see Best Practices, continued on Page 31
**Best Practices, continued from Page 30**

“For some diabetic patients, a diagnosis of nephropathy becomes a wake-up call for them. They’re getting into chronic morbidity issues associated with diabetes.”

For others, it’s difficult to make lifestyle changes, she says. “One of my patients is morbidly obese, and it doesn’t matter what I say to her or what specialists I send her to. We’ve worked with two endocrinologists and she’s not been able to control her diabetes for a number of years. It’s heartbreaking. I’ve referred her to a nephrologist in the hopes of preventing further damage.”

Dr. Gurden continues to work with the patient to count carbohydrates and discuss diet. “It doesn’t help to get mad,” she says. “You have to keep talking to patients to help change their habits.”

**MQIC guidelines updated**

The following MQIC guidelines and alerts have been reviewed and updated. They’re available on the MQIC website.

- MQIC 2017 Lipid Screening and Management guideline
- MQIC 2017 Medical Management of Adults with Hypertension guideline
- Hypertension guideline update alert
- MQIC 2017 Medical Management of Adults with Osteoarthritis guideline
- Osteoarthritis guideline update alert
- MQIC 2017 Screening, Diagnosis and Referral for Substance Use Disorders guideline
- Substance Abuse Disorder guideline update alert

**Monitoring for Nephropathy**

For HEDIS® 2018 there are several ways providers can make patients compliant for this diabetes sub-measure **Monitoring for Nephropathy**. They are the following:

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there documentation of end stage renal disease,</td>
<td>STOP!</td>
</tr>
<tr>
<td>chronic or acute renal failure, renal insufficiency, diabetic nephropathy,</td>
<td>Patient is compliant</td>
</tr>
<tr>
<td>dialysis or renal transplant or visit to a nephrologist in member’s medical record?</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>STOP!</td>
</tr>
<tr>
<td>Was a urine test for albumin or protein (even a spot urine test counts)</td>
<td>Patient is compliant</td>
</tr>
<tr>
<td>performed during the measurement year (2017)?</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>STOP!</td>
</tr>
<tr>
<td>Is there documentation of evidence that member was on ACE inhibitor/ARB therapy during the measurement year?</td>
<td>Patient is compliant</td>
</tr>
</tbody>
</table>

If you would like more information about HEDIS®, please contact Blue Cross Quality & Population Health department at HEDIS, message line at 1-855-228-8543.

HEDIS® is a registered trademark of the National Committee for Quality Assurance. Reference: HEDIS 2018 Volume 2 Technical Specifications for Health Plans, NCQA
HEDIS 2017 results

The Healthcare Effectiveness Data and Information Set, or HEDIS®, the most widely used set of performance measures in the managed care industry, has been submitted to the National Committee for Quality Assurance accreditation process.

HEDIS is part of an integrated system to establish accountability in managed care organizations. It was originally designed to address private employers’ needs as purchasers of health care and has been adopted for use by public purchasers, regulators and consumers and used by the Centers for Medicare & Medicaid Services for their star ratings.

Areas of improvement were noted in the following measures:

Commercial
- Adult BMI
- Antidepressant medication management – Acute and continuation phase
- Appropriate testing for children with pharyngitis
- Avoidance of antibiotic treatment for adults with acute bronchitis
- Cervical cancer screening
- Chlamydia screening in women
- Childhood immunizations – Combo 2
- Comprehensive diabetic care – HbA1c control <8.0%
- Comprehensive diabetic care – HbA1c poorly controlled >9.0% (inverted rate)
- Comprehensive diabetic care – Blood pressure <140/90
- Comprehensive diabetic care – Medical attention for nephropathy
- Control of high blood pressure
- Follow-up care for children prescribed ADHD medication – Initiation, continuation and maintenance phases
- Persistence of beta-blocker treatment after a heart attack
- Pharmacotherapy management of COPD – Systemic corticosteroid
- Postpartum care
- Use of spirometry testing in the assessment and diagnosis of COPD
- Weight assessment and counseling for nutrition and physical activity – BMI percentage, nutrition counseling and physical counseling
- Well-child visits in the first 15 months of life – Six or more visits
- Well-child visits in the third, fourth, fifth and sixth years of life

Marketplace/QHP
- Annual monitoring for patients on persistent medications
- Antidepressant medication management – Effective acute phase treatment
- Appropriate testing and treatment for children with pharyngitis
- Cervical cancer screening
- Childhood immunizations – Combo 3
- Comprehensive diabetic care – Eye examinations
- Controlling high blood pressure
- Follow-up care for children prescribed ADHD medication – Continuation and maintenance phase
- Medication Management for People with Asthma (75 percent of treatment period)
- Prenatal care
- Postpartum care
- Use of imaging studies for low back pain (Inverted rate)
- Weight assessment and counseling for nutrition and physical activity – BMI percentage, nutrition counseling and physical counseling
- Well-child visits in the first 15 months of life – Six or more visits
- Well-child visits in the third, fourth, fifth and sixth years of life

Please see HEDIS, continued on Page 33
HEDIS, continued from Page 32

Medicare
• Adult BMI
• Annual monitoring for patients on persistent medications
• Comprehensive diabetic care – Eye exam
• Comprehensive diabetic care – Medical attention for nephropathy
• Engagement of alcohol and other dependence treatment – Engagement
• Engagement of alcohol and other dependence treatment – Initiation
• Hospitalizations for potentially preventable complications (lower is better)
• Medication reconciliation post-discharge
• Osteoporosis management in women who had a fracture
• Pharmacotherapy management of COPD – Systemic corticosteroid
• Use of spirometry testing in the assessment and diagnosis of COPD

We would like to thank our affiliated practitioners for providing quality care to our members and allowing BCN staff to conduct medical record reviews.

Primary care providers can still find opportunities to provide aggressive intervention in the management and care of our members with diabetes, controlling high blood pressure and ordering procedures for breast, cervical and colorectal cancer screening.

BCN is actively involved in activities throughout the year that positively impact our HEDIS® rates, including:
• Physician Performance Recognition Program which is tied to some of the HEDIS® measures
• Health e-BlueSM
• Member interactive reminder telephone calls and cards
• Member and physician education
• Member health fairs
• Disease management programs
• Care management follow-up telephone calls and letters
• Member incentive programs
• HEDIS/CAPHS summit meeting
• MedXM at home services (BMDs)

We look forward to working with you to promote continued improvement in all areas of patient care and services.

For more information about HEDIS, contact the BCN Population Health and Analytics Department at 1-855-228-8543.
Making progress on excessive antibiotic prescriptions

The rate at which antibiotic prescriptions were filled dropped 9 percent from 2010 through 2016, according to a study by the Blue Cross Blue Shield Association — an indication that public health campaigns aimed at curbing excessive antibiotic use are making headway.

“I’m pleased to hear that the recent BCBSA health report shows that collaborative efforts by the Centers for Disease Control and Prevention, Blue Cross Blue Shield of Michigan’s Value Partnerships initiative, the Michigan Antibiotic Resistance Reduction Coalition and others are paying off in decreasing inappropriate antibiotic use in Michigan and across the nation,” says Dr. George Kipa, deputy chief medical officer at Blue Cross.

For years, U.S. health care professionals and policy makers have been concerned about the overuse of antibiotics, which is known to cause antibiotic-resistant — or “superbug” — bacteria. This is especially true of broad-spectrum antibiotics (think Z-Pak), which are used to treat a wide range of bacteria and have created antibiotic-resistant bacteria strains that are immune to common medications.

The report, which included 173 million patient claims for filled antibiotic prescriptions from more than 31 million commercially insured Americans under age 65, produced a number of key findings. For example, it seems that pediatricians are leading the charge when it comes to curtailing antibiotic use. Prescriptions filled for children declined 16 percent, and those for infants fell even more, with a drop of 22 percent.

What else did we learn?

Fill rates also dropped the most for broad-spectrum antibiotics — 13 percent — compared with the other types of antibiotics studied that are less likely to create antibiotic-resistant bacteria. These include intermediate-spectrum and narrow-spectrum antibiotics, although both experienced modest fill rate declines.

On the other hand, the antibiotic fill rates for reserved spectrum antibiotics, which are used for bacteria that have developed resistance to other antibiotics, increased by 30 percent. This could reflect higher rates of infection from bacteria with resistance to broader-spectrum antibiotics, or possibly a shift from inpatient to outpatient use of reserved antibiotics in recent years.

Another finding: There is a lot of regional variation in antibiotic prescription fill rates, with the highest-prescribing states (Mississippi, Alabama and Arkansas) filling nearly three times as many prescriptions per person as the lowest-prescribing states (Hawaii, Oregon and Montana).

See the full report.
Proper coding to improve HEDIS scores for antibiotic use

Antibiotic resistance is a growing problem, and misuse of antibiotics is the main culprit. More than 90 percent of the time, the cause of acute bronchitis is viral, yet many patients are being prescribed antibiotics.

Although antibiotics are inappropriate for viral infections there are times patients may have a compromising co-morbid condition or a competing bacterial diagnosis, making an antibiotic appropriate and necessary.

If you prescribe an antibiotic, include the diagnosis code for the bacterial infection or co-morbid condition.

HEDIS® antibiotic measurement data is captured through diagnosis codes and prescription claims, and therefore it’s important to use correct exclusion codes where necessary. A subset of Blue Cross providers who prescribed an antibiotic for acute bronchitis or upper respiratory infection were contacted for follow-up. Outreach revealed patients commonly had a co-morbid condition to justify the antibiotic but diagnosis codes weren’t documented.

The table on the right highlights HEDIS antibiotic measures and common examples of competing and co-morbid diagnoses. For additional information, please see Blue Cross Blue Shield of Michigan’s Clinical Quality Corner for provider tip sheets regarding these measures and others.

To find the tip sheets:
- Log in to Provider Secured Services on bcbsm.com
- Go to BCBSM Newsletters and Resources.
- Click on Clinical Quality Corner under Operations and Training
- Select the tip sheets you want to view.

<table>
<thead>
<tr>
<th>HEDIS® measure</th>
<th>Appropriate treatment for children with upper respiratory infection</th>
<th>Avoidance of antibiotic treatment in adults with acute bronchitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusions: common competing and co-morbid diagnoses</td>
<td>Competing diagnosis:</td>
<td>Competing diagnosis:</td>
</tr>
<tr>
<td></td>
<td>• Otitis media</td>
<td>• Otitis media</td>
</tr>
<tr>
<td></td>
<td>• Pneumonia</td>
<td>• Pneumonia</td>
</tr>
<tr>
<td></td>
<td>• Acute/chronic sinusitis</td>
<td>• Acute/chronic sinusitis</td>
</tr>
<tr>
<td></td>
<td>• Cellulitis</td>
<td>• Cellulitis</td>
</tr>
<tr>
<td></td>
<td>• Acute cystitis/UTI</td>
<td>• Acute cystitis/UTI</td>
</tr>
<tr>
<td></td>
<td>• Gastroenteritis</td>
<td>• Gastroenteritis</td>
</tr>
<tr>
<td></td>
<td>Co-morbid conditions:</td>
<td>Co-morbid conditions:</td>
</tr>
<tr>
<td></td>
<td>• COPD/emphysema</td>
<td>• COPD/emphysema</td>
</tr>
<tr>
<td></td>
<td>• Chronic bronchitis</td>
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<tr>
<td></td>
<td>• Cystic fibrosis</td>
<td>• Cystic fibrosis</td>
</tr>
<tr>
<td></td>
<td>• HIV</td>
<td>• HIV</td>
</tr>
<tr>
<td></td>
<td>• Malignant neoplasm</td>
<td>• Malignant neoplasm</td>
</tr>
</tbody>
</table>

Want to know more about how you’re performing on antibiotics and other HEDIS® measures?
Go to Health e-BlueSM and check out the quality summary report to learn more.
For questions regarding this article, contact BCNRXQualityPrograms@bcbsm.com.

References

HEDIS® is a registered trademark of the National Committee for Quality Assurance.
Help your patient stay adherent with a 90-day supply

Patients who receive a 90-day supply of a medication have a 20 percent greater adherence rate compared with patients receiving a 30-day supply. Similar findings were identified among our Medicare members receiving statins, anti-diabetic agents and renin-angiotensin system antagonists for star quality measures. Eighty-five percent of members receiving a 90-day supply were adherent compared to only 65 percent of members receiving a 30-day supply.

We encourage providers to write 90-day supply prescriptions for all chronic maintenance medications, where appropriate. We’re even partnering with community pharmacies to talk to patients and their providers about transitioning to 90-day supplies. Members who switch to a 90-day supply save time by making fewer trips to the pharmacy and, depending on their drug plan, may save money.

Meijer pharmacy now offers free 90-day supplies of metformin and atorvastatin. Many of our members have already taken advantage of this offer.


Another tip to improve adherence

Encourage your patients to talk with their pharmacist about enrollment in an automatic refill program, if available at their pharmacy.

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Blue Cross and BCN will not cover select high-cost prescription drugs that have comparable alternatives

To address the high cost of drugs and provide the best value for our members, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans do not cover select high-cost, FDA-approved drugs for which more cost-effective therapeutic alternatives are available.

Vanatol® LQ, used to treat headaches, has been targeted for exclusion, effective Nov. 1, 2017.

The following table includes the average cost for one dose of the targeted drug and associated therapeutic alternatives:

<table>
<thead>
<tr>
<th>Drug not covered beginning Nov. 1, 2017</th>
<th>Cost per dose</th>
<th>Cost to member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vanatol® LQ</td>
<td>$45</td>
<td>Full cost (not covered)</td>
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<tr>
<td>Generic alternatives</td>
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<tr>
<td>Esgic</td>
<td>&lt;$1</td>
<td>Generic copayment</td>
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<tr>
<td>Fioricet</td>
<td>&lt;$1</td>
<td>Generic copayment</td>
</tr>
<tr>
<td>Fiorinal</td>
<td>&lt;$1</td>
<td>Generic copayment</td>
</tr>
<tr>
<td>Phrenilin</td>
<td>&lt;$1</td>
<td>Generic copayment</td>
</tr>
</tbody>
</table>

As part of this ongoing initiative, Blue Cross and BCN will continue to identify select high-cost drugs and will stop covering them when there are more cost-effective alternatives available for our commercial members.
Blue Cross Blue Shield of Michigan and Blue Care Network to cover generic low to moderate-dose statins at zero cost share

Blue Cross and BCN will cover low-to moderate-dose generic statin drugs at zero cost share when they’re prescribed for members who are 40 to 75 years old, effective Dec. 1, 2017.

We’re doing this because the U.S. Preventive Services Task Force recommends that adults without a history of cardiovascular disease use a low-to moderate-dose statin to prevent cardiovascular disease events and mortality when they meet the following criteria:

- They are 40 to 75 years-old
- They have one or more cardiovascular disease risk factors (for example, dyslipidemia, diabetes, hypertension or smoking)
- They have a calculated 10-year risk of a cardiovascular disease event of 10 percent or greater

This change applies to Blue Cross and BCN commercial (non-Medicare) members and does not apply to grandfathered, retiree or religious-accommodated groups.

These low-to moderate-dose generic statin drugs include:

- Atorvastatin (Lipitor®) - Less than or equal to 20mg
- Fluvastatin (Lescol®/XL®) - Less than or equal to 80mg
- Lovastatin (Mevacor®) - Less than or equal to 40mg
- Pravastatin (Pravachol®) - Less than or equal to 80mg
- Rosuvastatin (Crestor®) - Less than or equal to 10mg
- Simvastatin (Zocor®) - Less than or equal to 40mg

We’ll cover the generic statins at zero cost share only if members meet plan requirements and have a prescription. Members outside the 40-to-75 age range will continue to receive generic statins at their applicable cost-share.

Note: Quantity limits apply. Refer to the Blue Care Network Quantity Limits document on our website. Work with your patients to request approval if a patient’s use exceeds our quantity limits.
Reminder: 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.

See full article in the Sept.-Oct. issue.

Blue Cross forms task force to address opioid abuse

Blue Cross Blue Shield of Michigan and Blue Care Network have formed a task force to address the opioid problem from multiple angles, identifying current and future efforts to make a difference. It is also examining opportunities with providers and members; enhancing access to high-quality treatment; fighting fraud and abuse; working to improve state and federal laws; providing support for innovative community coalitions that are addressing the crisis; and championing a communications effort to educate the public, the media and our members.

See the following articles in this issue for more information and what providers can do:

- Medical director column ................................................................. Page 1
- What clinical practices can do to minimize drug diversion ...................... Page 1
- Prescribing opioids for chronic pain .................................................. Page 18
Medicare Part D prescribers are required to enroll in Medicare or opt out

The Centers for Medicare and Medicaid Services requires physicians and other eligible professionals who write prescriptions for Part D drugs to be enrolled in Medicare or have a valid opt-out affidavit on file for their prescriptions to be covered under Part D.

Recently CMS has announced that it will delay enforcement of the requirements in 42 CFR § 423.120(c)(6) until Jan. 1, 2019. Beginning Jan. 1, 2019, Medicare Part D prescription drug benefit plans may not cover drugs prescribed by providers who are not enrolled in (or validly opted out of) Medicare, except in very limited circumstances. Unless you enroll (or validly opt out), Medicare Part D plans will be required to notify your Medicare patients that you aren’t able to prescribe covered Part D drugs. Part D plans will only cover up to one three-month provisional supply of a drug, if prescribed by a provider who hasn’t enrolled in or validly opted out of Medicare.

If you opt out, you can’t receive reimbursement from traditional Medicare or a Medicare Advantage plan, either directly or indirectly (except for emergency and urgent care services).

We strongly encourage you to enroll as soon as possible to allow CMS time to process your application before the implementation date.

In addition, for Part D claims to adjudicate appropriately, eligible prescribers must ensure their taxonomy information is accurate in the CMS National Plan and Provider Enumeration System National Provider Identifier registry. You can search the registry to verify the taxonomy code associated with your NPI. The taxonomy code is an element that Express Scripts® uses to determine whether a claim may be paid based on eligibility to prescribe.

For the latest information about these requirements, please visit Part D Enrollment Information at CMS.
“Once morbid obesity is diagnosed and coded as such, it’s important that the diagnosis be coded correctly during each visit. To provide the best quality of care for these patients, accurate and consistent coding plays a key role in helping identify appropriate disease and care management programs for morbidly obese patients.”

— Dr. Raymond Hobbs, Blue Cross medical consultant

With obesity on the rise, it’s crucial that doctors recognize the negative effect that obesity and accompanying complications can have on their patients’ health.

“Overweight,” “obesity” and “morbid obesity” are distinct diagnoses that should be properly documented.

The Centers for Medicare & Medicaid Services includes morbid obesity (ICD-10-CM code E66.01) and its associated body mass index values (40 and above: ICD-10-CM code range Z68.41-Z68.45) in its ICD-10 Hierarchical Condition Categories for calendar year 2017. This categorization affects how providers document the condition.

Coding issues occur when the condition isn’t noted in the medical record. For example, even when height and weight measurements alone might indicate that the patient is morbidly obese, the provider must document the BMI of 40 or more — as well as co-morbid conditions such as diabetes and hypertension — in the notes.

Can a BMI value of 40 with co-morbid conditions and no mention of morbid obesity in the medical record be used to code for morbid obesity? The answer is no. Documentation of “morbid obesity” must be noted in the medical record to assign code E66.01. It’s important to note that BMI is a secondary code assignment; a primary diagnosis of overweight, obesity or morbid obesity must be in the documentation to submit the BMI code.

In addition, health care providers might not document morbid obesity in its early stages as they evaluate the patient over time and recommend interventions that could help reverse the trend. These may include education about how the condition can affect overall health, exercise and diet counseling.

Here are some morbid obesity coding tips:

- A coder can only code what is documented in the medical record.
- The diagnosis must be documented to its highest specificity. The BMI or complications alone can’t determine the specificity and ICD-10 code selection.
- It’s crucial to document the medical condition even after a patient has had weight loss surgery.
- Documentation is the key to coding morbid obesity.
- When the diagnosis of “overweight” or “obesity” is documented in the medical record and it’s noted the patient has a BMI of 40 or above — along with co-morbid conditions affecting the patient’s overall health — the coder can only code the condition of overweight or obesity with the Z code for the BMI of 40 or above.

None of the information included in this article is intended to be legal advice and, as such, it remains the provider’s responsibility to ensure that all coding and documentation are done in accordance with all applicable state and federal laws and regulations.
Billing Bulletin

Question:
After a patient delivers, I may see her more than once during the postpartum period. Typically, it’s for routine follow-up. Can I report the code for postpartum care for each of these visits?

Answer:
While Blue Care Network accepts the component codes for care during the antepartum period, the postpartum care can be reported with the postpartum only code (*59430), or with the procedure codes that include delivery and postpartum care (*59410, *59515, *59610, *59614 or *59622). In any instance, these codes are reported only once.

For more information on the guidelines, including timeframes for reporting post-partum visits to ensure HEDIS compliance, please refer to the BCN Provider Manual. Look for billing instructions in the Claims (Billing) chapter.

Question:
I received a denial for an evaluation and management code *99214 for diagnosis of otitis media. The denial stated: “Our clinical editing rules define this service as inappropriate for the intensity of the E/M care expected for the diagnosis.” Where can I find more information regarding this edit?

Answer:
The denial or edit you received is related to our clinical editing program. On the claim denial where you received the description, there would also be an EX or explanation code, possibly N68. Our BCN Provider Manual contains a section on our clinical editing program. Although it doesn’t go into detail on every edit, it provides you with information on the program and how to appeal if you disagree with an edit.

Regarding the edit you describe, the system will look at the diagnosis on the claim and the level of the evaluation and management code reported. If the diagnosis reported would not appear to support the level, an edit will occur. If the provider disagrees, he or she can submit an appeal with the medical record documentation. We will then review it according to coding guidelines and provide a determination.

The information about the appeal process, along with the appeal form, is also in the BCN Provider Manual.

Question:
Why won’t BCN cover a pelvic and transvaginal ultrasound on the same day?

Answer:
A transvaginal ultrasound is a diagnostic test, providing a look at the female reproductive organs. Other than during pregnancy, we wouldn’t expect a pelvic ultrasound to be performed during the same session. When done during the same session, both procedures are typically evaluating the patient for the same condition. This represents a redundancy in services, and the pelvic ultrasound is subject to an edit (non-payment).

In extenuating circumstances, you may appeal and submit medical records to support the medical need for both procedures. Such indications may include the inability to visualize all the structures or a finding of some pathology extending outside of the pelvis. This needs to be clearly documented in the medical record.

Please see Billing Q&A, continued on Page 42
Billing Q&A, continued from Page 41

**Question:**
We have claims with rejections on code *96377 (Neulasta on-body injector) with modifier 59 due to other services given on the same day in our office. Is this a payable code?

**Answer:**
CPT code *96377 is considered a reimbursable service. Not knowing what services are being provided or reported on the same date of service, it’s possible you’re receiving a clinical edit, indicating that the service is incidental to another service being reported on the same date.

If this is the case and you are receiving such an edit, for example, N91 or QN1, and you feel the service is distinct from the other services being provided, you should submit a clinical editing appeal. We monitor appeals received, as well as determinations, to evaluate if changes need to be made to our editing.

**Question:**
My question is in regards to a transesophageal echocardiogram performed along with moderate sedation (CPT code *93312-26 with moderate sedation code *99152.) What would be the correct billing date of service for both? The TEE report is performed and the report is electronically signed two days later. Is this a procedure that would be billed the date the actual service was performed along with the sedation code or billed out using the date the report was electronically signed? How would you bill the moderate sedation? Would *99152 be billed using the actual date performed, as a stand-alone code?

**Answer:**
The actual date the service was performed would be the appropriate date to report for both services.

---

**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.*
Clarification: Reporting J codes with NDC amounts

In the July-Aug. issue, we answered a question in the Billing Q&A column about J codes with NDC amounts. In an accompanying table, in the “Field description” column, it indicated, “Enter 11 digit NDC specific to the drug” and under the column “Required for J3301” it shows only the 10 digits. The 10-digit format is repeated on the third line down from the table. For J3301, the NDC reporting would be: N40003029305 ML1.” Apparently, this caused some confusion.

We attempted to provide a shortened version of information that’s available on the BCN Provider Publications and Resources website.

For the most accurate and current information on our guidelines for the reporting of National Drug Codes, please do the following:

1. Log in to Provider Secured Services.
2. Click BCN Provider Publications and Resources.
3. Click Billing/Claims in the left navigation bar.
4. Scroll down to the Professional Claims — Billing Instructions heading.
5. Click to open the National Drug Code reporting billing instructions under that heading.

This resource provides information on finding the NDC and the unit of measure, as well as the process for submitting both electronic and paper claims.

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:

- Reporting the JW modifier
- SCODI and fundus photography
- Status B codes
- Pap smear billing
- Reporting counseling for contraceptive care and services
Tell us what you think about BCN Care Management services – You could win a prize!

Blue Care Network wants to know how satisfied you are with BCN Care Management services and how we can improve to better meet your needs.

Your feedback is important to us. Please complete the 2017 BCN Care Management Survey and encourage your office colleagues to do so as well, including physicians, nurses and referral coordinators. Your input will help us evaluate our efforts and determine other improvements we can make to enhance our Care Management processes.

You can access the survey through Dec. 31, 2017.

As a token of our appreciation, those who respond and provide their contact information following the survey will be entered in a drawing to win one of two $250 gift certificates.* All survey responses must be submitted no later than December 31, 2017, to be eligible for the random drawing.

If you have any questions, please contact your provider consultant.

*Two winners will be selected in a random drawing at the end of the survey from among all eligible entries. The winner will receive a $250 gift certificate. No participation is necessary. The drawing will take place approximately one month following the closure of the survey. The winner will be notified by telephone or email following the drawing.

This drawing is open to all contracted BCN providers. If you do not wish to participate in the survey but wish to be included in the drawing, you may enter by emailing BCNPhysicianSurvey@bcbsm.com with your entry request. Please include your name, phone number, office name and address. All requests must be emailed no later than December 31, 2017.
Effective Jan. 1, 2018, some authorization requirements will change for services for BCN HMOSM (commercial) and BCN AdvantageSM members. Here’s a summary of the changes.

Providers will need to request authorization and complete a questionnaire for both BCN HMO and BCN Advantage members for the services listed below, for dates of service on or after Jan. 1, 2018:

- Cranial neurostimulator pulse generator (deep brain stimulation), insertion or replacement
- Endoscopy, upper gastrointestinal, for gastroesophageal reflux disease
- Endovascular intervention, peripheral artery
- Gastric stimulation
  Note: The questionnaire will be required only for BCN Advantage members.
- Hammertoe surgery
  Note: This applies only to procedure codes *28160 and *28285 when used with these diagnosis codes: M12.271-M12.279, M20.40, M20.42, M20.5x1-M20.62, M24.571-M24.576, M24.671, M24.676, M65.871-M65.879, M67.00-M67.02, M77.50-M77.52, M77.9, Q66.7, Q74.2, S92.521x-S92.529x and S93.121x-S93.129x.
- Implantation of neurostimulator for intrathecal or epidural drug infusions
- Joint replacement (revision), total — hip or knee
  Note: The requirement for authorization and questionnaire related to the revision procedure is in addition to the authorization and questionnaire already required for the initial replacement procedure.
- Nasal sinus endoscopy (sinusotomy or ethmoidectomy)
- Noncoronary vascular stents
- Sacral nerve stimulation
- Vascular embolization or occlusion (TACE, RFA or UAE)

The affected services are represented by the following procedure codes:

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<thead>
<tr>
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<td>*43180</td>
<td>*43254</td>
<td>*61885-61886</td>
<td>*64561</td>
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</tr>
</tbody>
</table>

In addition, for the following services, authorization is currently required but a questionnaire will also be required sometime in 2018:

- Blepharoplasty and repair of brow ptosis
- Hyperbaric oxygen therapy

When the questionnaire is available in the e-referral system for these two services, we’ll communicate that in a web-DENIS message and a news item at ereferrals.bcbsm.com.

Updated information about authorization requirements for BCN HMO and BCN Advantage members will be available in December 2017 at ereferrals.bcbsm.com. Click BCN and then click Clinical Review & Criteria Charts. At this location, you’ll find a document that outlines all the requirements as well as authorization criteria and a preview questionnaire for each service, which you can use to familiarize yourself with the questionnaire that will appear in the e-referral system.

*CPT codes, descriptions and two-digit modifiers only are copyright 2016 American Medical Association. All rights reserved.
Use these tips to transition PT, OT, ST and physical medicine cases

Blue Care Network has a year-end transition plan for the physical, speech and occupational therapy authorization process. The same process applies to physical medicine services provided by chiropractors.

For members whose plan year is the calendar year

All 2017 treatment authorizations for physical therapy, occupational therapy, speech therapy services and for physical medicine services by chiropractors will end Dec. 31, 2017, for members whose coverage follows a calendar year plan.

If an episode of care began in 2017 and is expected to continue into 2018, the following apply:

- An initial evaluation or re-evaluation isn’t necessary to continue an active episode of care into 2018.
- You must enter a new referral before the first treatment in 2018 either through the e-referral system or by calling BCN Care Management at 1-800-392-2512.
- A member doesn’t need a new referral from the member’s primary care physician to complete the active episode of care.

Providers should enter their own referrals for all patients receiving services in December 2017 that will carry over into January 2018. The referral “begin” date should be the date of the first appointment in 2018. You may enter the 2018 referral into the e-referral system in December 2017. If you are unable to use the e-referral system, you may contact Care Management at 1-800-392-2512. For more information or for instructions on how to use the e-referral system, contact your BCN provider consultant or refer to the e-referral User Guide.

Approvals for 2018 must meet these requirements:

- The member must be an eligible BCN member on the date the services are provided.
- The services received must be a benefit covered under the member’s contract.
- Benefits must be available or remaining as defined by the member’s contract.

Please see PT, OT, ST, continued on Page 47
Providers should enter the 2018 referral into the e-referral system with the information listed below.

**Physical Therapy**

<table>
<thead>
<tr>
<th>Procedure code</th>
<th>Submit applicable procedure code</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Enter date of the first visit for 2018</td>
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<tr>
<td>Count</td>
<td>1</td>
</tr>
<tr>
<td>Date span</td>
<td>60 days</td>
</tr>
</tbody>
</table>

- Category A and B therapy referrals are processed according to their tier level; therapists receive a determination letter.
- Category C providers who have patients currently under care or new patients who begin treatment in January will receive a letter approving three therapy visits. The three-visit approval will be granted through Jan. 31, 2018. Be sure to submit a treatment plan prior to the third visit to avoid the risk of lapse in treatment due to lack of authorization. Beginning Feb. 1, 2018, new referrals revert to the established policy of one evaluation and one visit for all new patients seen by Category C providers.

**Occupational Therapy**

<table>
<thead>
<tr>
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<tbody>
<tr>
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<tr>
<td>Count</td>
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<tr>
<td>Date span</td>
<td>60 days</td>
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eviCore healthcare processes occupational therapy referrals according to the established process; therapy providers receive a determination letter.

**Speech Therapy**

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<tbody>
<tr>
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<tr>
<td>Count</td>
<td>1</td>
</tr>
<tr>
<td>Date span</td>
<td>60 days</td>
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</tbody>
</table>

Requests automatically pend for speech therapy. eviCore healthcare processes speech provider referrals, according to the established process; therapy providers receive a determination letter.

Speech therapy providers should submit a treatment plan as soon as they determine that care is required for 2018. eviCore healthcare will review for medical necessity and send a determination letter. BCN Care Management accepts requests for transition cases by phone or through the e-referral system. Please call Care Management at 1-800-392-2512.

**Physical medicine services provided by a chiropractor**

<table>
<thead>
<tr>
<th>Procedure code</th>
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<td>60 days</td>
</tr>
</tbody>
</table>

For members whose plan year is other than the calendar year

Most BCN plans apply benefits on a calendar year basis, but some groups administer benefits on a plan year with a renewal date other than Jan. 1. Providers can verify this information when checking eligibility on web-DENIS or PARS (Provider Automated Response System). If you identify a member with a plan year that begins on a day other than Jan. 1, adjustments to the start and end date of an authorization are subject to the benefit year renewal date. BCN and eviCore healthcare work together to administer benefits accordingly.

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