

# BCN Provider News



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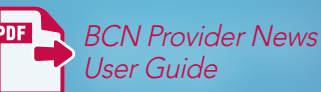
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*Dr. Todd Otten  
and patient, Wayne Frey*

## Best Practices: Charlotte physician uses motivational interviewing to help diabetic patients manage their care

Dr. Todd Otten attributes his success to helping patients control their blood sugar to a patient-centered approach and his passion for helping patients with diabetes, which dates back to his brother-in-law who has had struggles with the disease and his grandmother, who lost her vision due to diabetes complications.

The patient-centered approach respects a patient's responsibility for his or her own health care. With input from the doctor and office staff, the patient has a support system that can lead to better outcomes.

"Yes, I am the doctor, but you're the patient; this is a team effort," Dr. Otten tells his patients. He says the patient has to take responsibility for his or her own health care. "And that works because they're super excited when their numbers are good," says Dr. Otten, who practices in a hospital-based office in Charlotte.

Dr. Otten engages his patients with a technique he calls motivational interviewing, in addition to shared decision making. He discusses lab results with diabetic patients and before discussing medications, he says, "We need to find out what the barriers are for them. I don't have a canned answer. Everyone is an individual."

Dr. Otten follows algorithms from the American Diabetes Association in terms of drug selection. "But I talk to the patient first to learn their barriers — whether it be fear of needles, a cost issue or a polypharmacy issue," continues Dr. Otten.

Dr. Otten says he believes in making patients a key part of the decision process and that means finding solutions that are palatable to patients. "If they're afraid of needles, they can come in and we'll show them how to give themselves the injection," he says. "It's an interesting dynamic to convince someone that needs a medication or has to start insulin when they don't want to."

Please see [Best Practices](#), continued on Page 2

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## Best Practices, continued from Page 1

Bedside manner is also important. "But I'm also blunt with people," says Dr. Otten. "Most of my patients respond to that. They may need to make changes, and the question is 'How do I help them do that?'"

But there are times when it's not in the patient's interest to give them too much leeway. "If their blood sugar is not controlled, a patient may want another three months to see if they can lose some weight or make changes," says Dr. Otten. "If a patient is close to his or her goal and wants to avoid taking another medication, I'll give him or her a chance. But after that I say, 'You have to make changes or I have to prescribe medication.' Either they're going to do it or not. We're not going to do this game of 'give me another chance' month after month. It's too important."

### Reaching out to patients

The key to helping diabetic patients is to get them in the office to begin with. Office staff, including medical assistants, help track patients to make sure they get appropriate follow-up care. The office tracks patients through registry data received from insurance companies and has recently hired a quality coordinator to reach out to patients.

"The days of waiting for patients to come in with problems is changing," says Dr. Otten.

"We need to reach out to people and get them seen. We start with letters. If the response is poor, the quality coordinator and assistants make phone calls."

The staff is also well trained to look at refill patterns. They pay attention and will notice if patients are not refilling their prescriptions when they should. They also check to see which patients need a follow-up appointment.

"Staff training is important because we have a whole team doing chronic disease management. If you leave it up to the doctor alone, things can get missed," says Dr. Otten.

Cooperation between the doctor and staff is also important. "I encourage the staff to ask questions and I'll come back with other questions and see where things stand," explains Dr. Otten. "Sometimes it may lead to a visit instead of making snap decisions about what a patient needs."

"A lot of times physicians have a lot of pressure. We get into a routine and forget there's a person sitting in front of us with real concerns beyond what their numbers are," says Dr. Otten. "Those factors are important – often critically important – to getting them where they need to be. It's about taking care of the person and understanding what makes them tick, what's going to get them to change and keeping them out of the hospital."

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## Blue Care Network updates professional fees July 1

Blue Care Network will update fee schedules, effective with dates of service on or after July 1, 2016. This change applies to services provided to Blue Care Network commercial members.

We will use the 2016 Medicare resource-based relative value scale for most relative value unit-priced procedures for dates of service on and after July 1.

Changes in resource-based relative values can affect fees. Procedure code maximum fees will increase or decrease based on the new relative value units and Blue Cross Blue Shield of Michigan or BCN conversion factors.

In alignment with Blue Cross, the conversion factor used to calculate anesthesia base units for anesthesia procedures will increase and be aligned at \$58 throughout Michigan. Also effective July 1, the percentage weight for the QK or QY modifier will be adjusted from 60 percent to 56 percent, and the QX modifier will be adjusted from 40 percent to 44 percent.

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

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

**Note:** The Blue Cross Physician Group Incentive Program allocation (formerly known as the physician organization component) of professional fees remains the same this year. This component continues to be excluded from BCN professional fees.



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## New Michigan State student health plans have unique referral requirements

Blue Care Network will offer two new plans, effective Aug. 15:

- **MSU Graduate Assistant Health Plan** – Covers graduate assistants at Michigan State University
- **MSU Student Health Plan** – Covers students at Michigan State who don't have other health coverage

These new products have unique referral requirements for medical services. There is no change for behavioral health providers. This product follows standard BCN network and authorization rules for behavioral health.

To help manage the referral requirements for medical services, we've created a new provider network – the MSU Student Health Services Network. You need to know whether you're in this network in order to know how to handle referrals for these members.

The MSU Student Health Services Network is a unique network of BCN providers primarily in Michigan's mid region within 45 miles of Olin Health Center, a health clinic affiliated with MSU in East Lansing. Participation in the network will be posted on the **Blue Cross online provider directory** by Aug. 15.

Adult members are assigned a primary care physician within Olin Health Center. Pediatric primary care physicians are assigned from the MSU Student Health Services Network.

### Referral requirements

Referral requirements differ based on network status. The **clinical review program requirements** continue to apply. They have not changed. Here's what you need to know about referrals:

#### • Providers in the MSU Student Health Services

**Network:** Adult members and subscribers under the age of 18 need a global referral issued by the PCP submitted through e-referral for care outside Olin Health Center.

Specialists outside of Olin Health Center need a global referral on file with BCN and must submit a referral to BCN for services outside their office, for example a colonoscopy at a hospital within this network.

When submitting an e-referral request for a patient with this coverage, providers in MSU Student Health Services Network will show as "Preferred."

Here are the exceptions (where referrals do not need to be submitted to BCN – although standard BCN clinical review requirements continue to apply):

- Services provided by Olin Health Center
- Services provided to dependent children (members other than the subscriber or spouse who are age 17 and under)
- Certain member subgroups identified by Michigan State (such as visiting scholars and the College of Law)

- **BCN providers not in the MSU Student Health Services Network:** Care must be coordinated by the member's PCP but a referral does not need to be submitted to BCN. All BCN referral and clinical review requirements continue to apply.

### Levels of patient cost-sharing

There are three levels of patient cost-sharing:

Services provided by:	Member cost-sharing level
Olin Health Center	Lowest cost-sharing
BCN network provider, but not Olin Health Center	Higher cost-sharing
Provider not contracted with BCN and not with Olin Health Center	Highest cost-sharing

### Check eligibility and benefits

When you check eligibility for a member with this coverage on web-DENIS, by calling PARS (the Provider Automated Response System), or through an electronic 270/271 transaction, special messaging will alert you to the local network and special referral requirements for this product.

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## Looking for something in the provider manual or provider newsletter? Handy tips for an easier search

Ever been frustrated when you couldn't find something in the *BCN Provider Manual*? Can't find where you've seen something in *BCN Provider News*? Here's how to make your search easier and more productive.

**If you know which provider manual chapter or newsletter issue you want to search**, first open the chapter or the issue. Then:

1. Press Ctrl + F on your keyboard. (Press F while you hold down the Ctrl key.) This will open the Find dialog box.
2. Enter a search term in the Find dialog box.
3. Click *Next*.
4. Keep clicking *Next* until you find what you're looking for.

Each time you click *Next*, you'll be taken to another location in the chapter or news issue where your search term appears.

The Ctrl + F method of searching can be used in any document, not just in a provider manual chapter or a newsletter issue. For example, to find whether pain management services require authorization by BCN, you can open the **BCN Referral / Clinical Review Program** document and use the Ctrl + F search method to find "pain."

We suggest you use the fewest words possible in your search term; the more words you use, the fewer results you'll get. That's because the more words there are in your search term, the fewer the chances that all those words will appear together — and in the exact order in which you've arranged them — in the document you're searching. For example, instead of searching for "proton beam therapy," you'll get more results if you search for just "proton." All references using the word "proton" will come up in your search results and you can ignore the ones you don't need.

In another example, if you search for "physical therapy" instead of just "physical," you won't see results involving references to "physical / occupational / speech therapy," because they will not appear when you search for "physical therapy." They will appear in the results when you search for just "physical."

**If you don't know which provider manual chapter or which newsletter issue you want to search**, you can search the entire *BCN Provider Manual Portfolio* or a specific *BCN Provider News* archive. The portfolio is a collection of all the provider manual chapters plus some additional documents. The news archive is a collection of all the newsletter issues from a specific year.

The search process for both the provider manual portfolio and a provider news archive works the same way.

The steps for searching the provider manual portfolio are described in the document *Searching the BCN Provider Manual*. You'll find both the portfolio and the instructions for searching it by following these steps:

1. Go to **bcbsm.com** and log in to Provider Secured Services.
2. Click *BCN Provider Publications and Resources*.
3. Click *Provider Manual*.
4. Follow the directions in the box titled "Find something in the manual."

The search process used for the *BCN Provider News* archive is described in the document *How to use this archive*. If you need to find something in the newsletter and you don't know which issue to look in, take the following steps:

1. Go to **bcbsm.com/providers**.
2. Click *Our Provider Newsletters* in the top navigation.
3. Go to *BCN Provider News* and click on the archive.
4. Open the news archive for the year you want to search.
5. Open the document *How to use this archive*.



*How to search the manual*



*How to use this archive*

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*Lindsay Crabtree and Craig Ross of South Arbor Family Care in Ann Arbor.*

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## Smoking cessation contest winners

Congratulations to South Arbor Family Care in Ann Arbor and the office of Dr. Craig White in Greenville for winning the last two monthly office staff contests.

These two offices won for handing out our tobacco use surveys and Quit Guides to Blue Care Network commercial members aged 18 to 65. Each office will split \$1,000 in Visa gift cards among its staff.

Smoking cessation continues to be a top priority for Blue Care Network in 2016. When smokers receive advice from their health care providers, it can double their chances of quitting smoking successfully. We need you to help us reach out to our members who smoke so they get this important advice from you, their trusted provider.

If you have not previously received the surveys and quit guides and would like copies for patients, please call 248-799-6959 to request them.



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# Let patients know that Blue Care Network doesn't cover digital breast tomosynthesis

We continue to receive a large number of member appeals related to digital breast tomosynthesis, also known as 3D mammography.

Be sure to let your patients know that Blue Care Network and Blue Cross Blue Shield of Michigan don't cover this procedure for members, with the exception of Federal Employee Program® and Medicare Advantage members, including BCN Advantage<sup>SM</sup>.

As for any services we consider experimental, BCN recommends that providers request an authorization for this service when members request digital breast tomosynthesis. A denial from BCN waives provider liability and allows the provider to bill the member directly. Blue Cross members who choose to have the procedure when it's not covered should sign a waiver stating that they understand they will be financially responsible for the cost.

Digital breast tomosynthesis uses modified digital mammography equipment to obtain additional radiographic data to reconstruct cross-sectional "slices" of breast tissue. Conventional mammography produces 2D images of the breast.

BCN and Blue Cross consider digital breast tomosynthesis experimental for both the screening and diagnosis of breast cancer, and our contracts with providers exclude coverage for experimental services or procedures. Most other health care plans also consider the procedure to be experimental or investigational.

Keep in mind that if you determine that additional imaging is necessary for a patient, BCN and Blue Cross reimburse for other imaging procedures beyond conventional mammography.

## Blue Care Network is closed July 4

Blue Care Network offices will be closed July 4 for Independence Day. When BCN offices are closed, call the BCN After-Hours Care Manager Hot Line at 1-800-851-3904 and listen to the prompts for help with:

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

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

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

Do not use this number to notify BCN of an admission for commercial or BCN Advantage<sup>SM</sup> members. Admission notification for these members can be done by e-referral, fax or phone 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.



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# Cholesterol management is key in Million Hearts program to prevent cardiovascular disease

Cholesterol management is a key focus of the BCN Advantage's Chronic Care Improvement program, designed to prevent cardiovascular disease in BCN Advantage<sup>SM</sup> members.

The five-year program, started in 2012, is designed to prevent cardiovascular disease in BCN Advantage members. The program highlights member self-management strategies and partnership with physicians.

The core of our program is the ABCS, clinical interventions championed by Million Hearts®, a public initiative led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services to prevent 1 million heart attacks and strokes in the United States by 2017. The Million Hearts clinical interventions focus on improved management of the "ABCS" – **A**spirin for high-risk patients, **B**lood pressure control, **C**holesterol management and **S**moking cessation.

In this issue, we're focusing on cholesterol management.

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

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



Please see [Cholesterol management](#), continued on Page 9



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## Cholesterol management, continued from Page 8

We recognize that our BCN Advantage doctors and their health care teams are the first line of defense in the battle against high cholesterol levels in our members. We're committed to supporting you in your efforts to manage high cholesterol levels in your patients. With that in mind, here are some tools and tips you can share with your patients who have BCN Advantage:

- You can encourage your BCN Advantage patients to visit our website at [bcbsm.com](http://bcbsm.com) where they'll be able to take control of their health in new, easy ways online.
- Blue Care Network and Blue Cross Blue Shield of Michigan are now working with WebMD® Health Services, an independent company, to provide online health and wellness services to members. Members can log into their member accounts at [bcbsm.com](http://bcbsm.com) to check out our new wellness tools. On the new Blue Cross® Health & Wellness website, members can:
  - Take an interactive online health assessment
  - Take part in digital health assistant coaching programs
  - Access many helpful online resources, such as articles, videos and interactive quizzes

The Million Hearts website also has many valuable [resources](#) to help educate, motivate and monitor your patients.

## 2016 Performance Recognition Program

Blue Cross Blue Shield of Michigan and Blue Care Network's Performance Recognition Program rewards Blue Care Network Commercial and Medicare Advantage providers for their role in helping Blue Cross and BCN achieve the objectives of the Healthcare Effectiveness Data and Information Set, or HEDIS®, and the Centers for Medicare & Medicaid Services star ratings programs. The program rewards providers who encourage their patients to get preventive screenings and procedures as well as achieving patient outcomes such as cholesterol control. More information about this program is available in BCN Health e-Blue<sup>SM</sup>. The document is located in the "Resources" section under *Incentive Documents*. If you have any questions, contact your medical care group leadership or your BCN provider consultant. We appreciate your continued support of our physician incentive programs.

## Additional resource for practitioners

[Michigan Quality Improvement Consortium](#) guidelines provide up-to-date evidence-based recommendations for lipid screening and management.

1. Mozaffarian D, Benjamin EJ, Go AS, Arnett DK, Blaha MJ, Cushman M, et al. [Heart Disease and Stroke Statistics—2015 Update: A Report from the American Heart Association](#). *Circulation*. 2014 Dec 17 [Epub ahead of print].
2. CDC. [National Health Report: Leading Causes of Morbidity and Mortality and Associated Behavioral Risk and Protective Factors—United States, 2005–2013](#). *MMWR*. 2014;63(04);3–27.

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# Blue Care Network's Care Transition Program helps BCN Advantage patients after a hospital stay

Returning home from the hospital can be overwhelming and stressful. Many times people have questions about their care and are unsure of how to take care of themselves and manage their illness after they return home.

Blue Care Network's Care Transition program helps BCN Advantage<sup>SM</sup> patients transition from hospital to home. It also provides education and support to help your patients get well and stay healthy. The Care Transition program is a free service offered by BCN.

Our care coordinator nurses provide care coordination, education and support. We help your patients safely transition from hospital to home and help them avoid returning to the hospital or emergency room.

After we're notified of your patient's hospitalization, our care coordinators may contact the patient during his or her hospital stay to introduce the program and discuss next steps. The care coordinator nurses:

- Help coordinate any care and services the patient may need at discharge with the hospital staff and the primary care physician
- Call the patient frequently within the first 30 days after discharge to help offer support in the home and answer any questions or concerns
- Help the patient follow the discharge plan to safely transition from hospital to home

Through follow-up calls upon the patient's return to home, the care coordinator:

- Assists with arranging timely follow-up with the doctor and helps to provide transportation if needed
- Helps the patient understand and manage his or her medications
- Helps the patient understand the hospital discharge instructions and what he or she needs to do to manage any conditions
- Helps the member to recognize the signs and symptoms of possible complications and understand what to do next
- Coordinates needed tests, services or equipment, or arranging home for health care after discharge
- Offers other health services and related programs to support the member in his or her home
- Provides available community resources
- Educates about preventive health screenings, lab tests and other services the patient may need

To learn more about our Care Transition program, call 1-800-728-3010, from 8 a.m. to 5 p.m. Monday through Friday, and one of our care coordinator nurses will be happy to assist you.



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## Notice of Medicare Non-Coverage for BCN Advantage members

Medicare regulations require providers to use the Medicare approved form, *Notice of Medicare Non-Coverage*, to notify BCN Advantage<sup>SM</sup> members in writing, that BCN Advantage or the provider has decided to end his or her covered skilled nursing facility or home health agency care.

The *Notice of Medicare Non-Coverage* form also provides notification to the member of the right to a fast-track appeal if they disagree with the decision to end covered services. BCN must receive copies of all *Notice of Medicare Non-Coverage* forms signed by the member.

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

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

The form should only be given to members when one of these situations applies:

- Skilled nursing facility criteria are no longer met
- No further days are authorized by BCN
- A discharge date is scheduled within two days

Please see [Notice of Medicare Non-Coverage](#),  
continued on Page 12

## Important things to know about the *Notice of Medicare Non-Coverage*

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

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

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

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



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## Notice of Medicare Non-Coverage, continued from Page 11

It's important to use the correct *Notice of Medicare Non-Coverage* form, approved by Medicare that includes:

- The date that covered services are expected to end
- The date that the member's financial liability begins
- A description of special appeal rights for members that allow a fast-track appeal if the member disagrees with the decision to end covered services
- Detailed instructions about how the member may request an immediate appeal directly to KEPRO (Michigan's Quality Improvement Organization) including his or her address and phone number
- Instructions to the member about how to request an expedited review from BCN if the member misses the deadline to file for review from KEPRO
- The date of the member's signature

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

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

Contracted facilities should be using the appropriate *Notice of Medicare Non-Coverage* forms. The **forms** are available in PDF or Word format including instructions on how to complete the form on BCN's e-referral home page, or on web-DENIS.

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

Patient  
CareTalking to patients about diabetes  
prevention

By Felecia Williams, M.D.



At Blue Care Network, we spend a lot of time, resources, and money working to improve the health outcomes of our members with diabetes.

Here are some eye-opening statistics on diabetes:

- Of the approximately 29 million people in the United State with diabetes, 7.3 million, or 25 percent, of them are unaware they have diabetes.
- There are also 86 million people, or 33 percent of adults, with prediabetes.
- Of these 86 million, 90 percent don't know they have prediabetes.
- Without significant interventions, 15 to 30 percent of people with prediabetes will develop Type 2 diabetes, according to the National Institute of Diabetes and Digestive and Kidney Diseases.

Changes in the size and demographic characteristics of the U.S. population will lead to significant increases in the number of Americans with diagnosed diabetes. Those at high risk for developing diabetes in the United States are:

- African Americans
- Hispanic and Latinos
- Native Americans
- Alaska natives
- Asian Americans
- Pacific Islanders
- Women with a history of gestational diabetes
- Older adults

The Diabetes Prevention Program, funded by the National Institute of Diabetes and Digestive and Kidney Diseases, was a major multicenter clinical research study aimed at discovering whether modest weight loss through dietary changes and increased physical activity or treatment with metformin could prevent or delay the onset of Type 2 diabetes in study participants.

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From the medical director, continued from Page 13

At the beginning of the program, all of the participants were overweight and had blood glucose levels in the prediabetes range<sup>1</sup>. Researchers found that therapeutic lifestyle changes, modest weight loss (5 to 7 percent) and increased physical activity (150 minutes a week) significantly reduced the participants' chances of developing diabetes. The participants in the lifestyle intervention part of the study decreased their risk of developing diabetes by 58 percent. These lifestyle changes were even more effective than metformin in reducing the risk of developing Type 2 diabetes.

The National Diabetes Education Program has created the Small Steps. Big Rewards. Prevent Type 2 Diabetes campaign. The program provides tools and resources for health care providers to initiate and reinforce simple but meaningful conversations with their patients about the health benefits of making small lifestyle changes.

Physicians can be instrumental in encouraging patients to make incremental changes. Health care providers should consider enhancing their motivational interviewing skills in order to improve the effectiveness of their conversations. These skills can be invaluable in getting patients to embrace and implement changes and make better lifestyle choices.

Dr. Todd Otten, a doctor in Charlotte, uses motivational interviewing in treating his diabetic patients. See **Page 1** for details.

The rewards of behavior changes can include:

- Weight loss
- Improved mobility
- Reduced stress
- Improved sleep
- Decreased pain
- Improved blood pressure control
- Decreased cholesterol
- Improved overall quality of life

These positive changes are motivating and encourage patients to stick with the program.

Encourage patients to make half of their plate fruits and vegetables and opt for whole foods instead of processed foods. Meals should be colorful and contain variety. Discourage patients from drinking their calories. Patients should limit sugar, avoid sugary beverages, and monitor fat intake. Eating legumes, seeds, and nuts sparingly is a great way to increase fiber intake and satisfy protein requirements. Check out Kaiser Permanente's resource, **The Plant Based Diet: A Healthier Way to Eat**. The guide educates patients about the benefits of plant-based nutrition and how to get started.

Strategize with patients on ways to increase their physical activity. Ask patients about employer-sponsored wellness programs and encourage patients to participate. In addition to the health benefits, there are sometimes monetary rewards associated with participation. Exercise buddies or walking partners can provide encouragement, motivation and accountability. Reinforce the motto "Move it to lose it!" Remember, small steps can lead to big rewards.

1. National Institute of Diabetes and Digestive and Kidney Diseases <http://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp/Pages/default.aspx>



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## Allowable sites for telemedicine visits

For both BCN HMO (commercial) and BCN Advantage<sup>SM</sup> members, telemedicine visits are eligible for reimbursement only when the originating site — the site in which the patient is located at the time of the visit — is one of the following:

- Physician or practitioner office
- Hospital
- Critical access hospital (CAH)
- Rural health clinic
- Federally qualified health center
- Hospital or CAH-based renal dialysis center including satellite
- Skilled nursing facility
- Community mental health center

For BCN Advantage members, coverage for telemedicine visits mirrors that for Original Medicare. This means that there are additional site restrictions for BCN Advantage members. For these members, the originating site for the visit must be located within one of the following:

- A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract
- A county outside of an MSA

More information on Original Medicare coverage is found in the **MLN for Telehealth Services** published by CMS.

The information here clarifies the article titled “**New policy allows providers to bill certain telemedicine visits**,” published in the **April-May 2016 issue** of *BCN Provider News*.

In addition, the Claims chapter of the *BCN Provider Manual* outlines the requirements for billing both telemedicine visits and e-visits. Look in the section titled “Visits completed using telecommunications.”

As a reminder, telemedicine visits may be used for higher-complexity conditions and e-visits may be used for lower-complexity conditions. These types of visits differ in other ways, as well, as is explained in the Claims chapter.

To access the Claims chapter, do the following:

1. Visit **[bcbsm.com/providers](http://bcbsm.com/providers)**.
2. Log in to Provider Secured Services.
3. Click *BCN Provider Publications and Resources*.
4. Click *Provider Manual*.
5. Click *Claims (Billing)*.



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## Help patients receive appropriate prenatal and postpartum care

Blue Care Network is asking primary care physicians, family practitioners, pediatricians and gynecologists to help us educate members about the importance of prenatal and postpartum care.

There are certain timeframes set forth by the Healthcare Effectiveness Data and Information Set guidelines. They are outlined below.

### Prenatal visits

Schedule the patient's first visit within the first trimester of pregnancy or within 42 days of enrollment.

### Postpartum visit

Schedule the visit on or between 21 and 56 days after delivery for both vaginal and cesarean deliveries.

BCN case management nurses can provide support to members identified as high risk for complications during the perinatal period. These interventions include:

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

Refer to the following schedule:

Prenatal	Postpartum
<p>Schedule the patient's first visit within the first trimester of pregnancy or within 42 days of enrollment. At these visits, document the following in the medical records: Education about nutrition, prenatal vitamins with folic acid, substance abuse, alcohol consumption, tobacco cessation, expectant parent classes and importance of postpartum care.</p> <p>Remind patients considering pregnancy to make an appointment as soon as pregnancy is suspected.</p>	<p>Schedule postpartum visits on or between 21 and 56 days after delivery. At these visits document in the medical records the following: Physical exam including breast and pelvic exam, measurement of weight, vital signs including blood pressure, contraceptive options, education on sexually transmitted infection prevention and screening, and assessment for postpartum depression.</p>

### Resources

- **Maternal (or paternal) substance abuse** — BCN's behavioral health care department is available 24 hours a day, seven days a week to address substance abuse concerns. BCN members call 1-800-482-5982.
- **Maternal (or paternal) tobacco use** — BCN's smoking cessation program is available at [webMD.com](http://www.webMD.com) or call 1-855-326-5102.
- **Nutrition and weight management after delivery** — Select BCN members receive a more than 20 percent discount on Weight Watchers® program membership. Call 1-800-651-6000 to find a nearby Weight Watchers location.
- **Postpartum depression** — BCN's Depression Management Program focuses on member education about depression and the importance of adhering to a prescribed medication regimen. Practitioners and members can speak to a behavioral health case manager, from 8 a.m. to 5 p.m. weekdays at 1-800-482-5982. If a member is in a life-threatening situation, advise her to dial 911 or go to the nearest emergency room for assistance.

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## August is National Immunization Awareness Month

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

We'd like to remind providers to discuss the importance of immunization with parents of children, preteens and adolescents and to discuss booster shots and flu immunization with their adult patients.

### Immunization schedule

The recommended vaccination schedule is updated every 12 months by the **Centers for Disease Control and Prevention**. For the latest on immunization recommendations, Vaccine Information Statement forms and catch-up schedules go to the CDC website.

You can also look on the websites of the **Michigan Quality Improvement Consortium** site and the **Michigan Department of Health and Human Services**.



## 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

- Adoptive immunotherapy (CAR-T therapy)
- Sleep disorders: Diagnosis and medical management

### Covered services

- Low-level laser therapy



*Medical Policy  
Updates*

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## Criteria corner

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

### Question:

**In the new 2016 criteria book's subset "Infection Pneumonia Acute" the Clinical Risk Factors,  $\geq$  two has been changed to CURB-65 Criteria,  $\geq$  two. What does CURB-65 stand for?**

### Answer:

CURB-65 is a pneumonia severity scoring tool that predicts mortality in patients with community acquired pneumonia. CURB-65 stands for confusion, urea nitrogen, respiratory rate, blood pressure and 65 years of age and older.

Go to the [American Association of Family Physicians](#) to see how the scoring is completed.

### Question:

**In the new 2016 criteria book's subset, "General Medical" Acute Withdrawal Criteria, what is meant by rapid tranquilization? Would IV Ativan fit this criterion?**

### Answer:

Yes, IV Ativan could be applied to the criteria point for rapid tranquilization, as long as it was given due to a situation in which the patient required rapid tranquilization rather than as a part of the routine treatment plan. The following note, which is connected to this criteria point, explains rapid tranquilization as follows:

*Rapid tranquilization, also known as chemical restraint or emergency medication, is used to control behavior that presents an imminent threat of serious physical injury to self or others, and is not part of the routine plan of care. Routes of administration may include, but are not limited to, PO, IM or IV. Whenever rapid tranquilization is utilized, it is important to identify the triggers and warning signs leading up to the dangerous behavior, and to consider changes to the treatment plan to avoid continued emergency medication use. The patient and/or family should be involved in this identification and planning.*

Rapid tranquilization includes the administration of an antipsychotic or benzodiazepine.

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## COPD diagnosis should include spirometry

Comprehensive care of people with chronic obstructive pulmonary disease includes diagnosing the condition through spirometry, smoking cessation support if indicated, periodic assessment of the disease and management of stable COPD and exacerbations. Pharmacologic therapy is pivotal because it provides important options for improvement of symptoms and treatment of exacerbations.

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

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

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

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

### Spirometry as a diagnostic tool

According to BCN's clinical practice guidelines for the diagnosis and management of COPD, spirometry is needed to establish a diagnosis of COPD and provides a useful diagnostic tool for those patients with symptoms suggestive of COPD. (See table below). A postbronchodilator FEV1/FVC less than 70 percent confirms the presence of airflow limitation. BCN's guideline, *Guidelines for the Diagnosis and Management of Chronic Obstructive Pulmonary Disease*, recommends that you consider COPD in any patient 18 or older with respiratory symptoms and those with a history of exposure (for example, occupational exposure) to risk factors for the disease, especially smoking. Characteristic symptoms include cough, sputum production that can be variable from day to day and chronic or progressive dyspnea.

I: Mild COPD	II: Moderate COPD	III: Severe COPD	IV: Very Severe COPD
FEV1/FVC <0.70	FEV1/FVC <0.70	FEV1/FVC <0.70	FEV1/FVC <0.70
FEV1 ≥ 80% predicted	FEV1 50% ≤ and < 80% predicted	FEV1 30% ≤ and < 50% predicted	FEV1 < 30% predicted or FEV1 < 50% with deoxygenation

The 2016 Healthcare Effectiveness Data and Information Set measures the percentage of members 40 and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis. CPT codes used to identify spirometry testing for this measure include \*\*94010, \*\*94014-94016, \*\*94060, \*\*94070, \*\*94375 and \*\*94620.

Source

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

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\*CPT codes, descriptions and two-digit modifiers only are copyright 2015 American Medical Association. All rights reserved.

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# BCN's Case Management programs help you care for patients

Your patients who have complex medical needs can get personalized support from Blue Care Network's Case Management department. Registered nurse case managers work with you and your patients to develop a case management plan of care and promote self-management. Our case managers contact members by phone to provide education on disease, nutrition, medication and managed care processes as well as facilitate access to BCN and community resources as needed.

We identify members for case management through a variety of sources including inpatient admissions, physician and physician group referral, member and caregiver referral, chronic condition management referral and employer group referrals. BCN Advantage<sup>SM</sup> members may also be identified through completion of health assessments. BCN uses a predictive modeling approach to identify members from the entire BCN and BCN Advantage population who may benefit from case management.

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

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

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

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

You can find information about your members enrolled in complex case and chronic condition management on Health e-Blue<sup>SM</sup>. To learn more about BCN's case management program or refer a member to one of our programs, call us at 1-800-392-4247, from 8:30 a.m. to 5 p.m., Monday through Friday.

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

## Providers' rights with respect to case management

BCN values and recognizes the importance of providers' rights. We respect your right to:

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



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## Back-to-school tips for children with asthma, diabetes

As children prepare to return to school, there are important steps primary care physicians and staff can take to help ensure a student begins the school year prepared to manage his or her chronic conditions. The following checklists can help you do just that.

### For children with asthma

- Establish an Asthma Action Plan and provide the school with a copy for the child's record. The plan can be developed to fit the needs of the child. To obtain a copy of the Asthma Action Plan template:
  - Log in to web-DENIS.
  - Go to *BCN Provider Publications and Resources*.
  - Under Resources, click on *Forms*.
  - The *Asthma Action Plan* is located in the *Chronic condition management* section.
- Instruct the child and parents on all medications and the importance of having access to them at all times, especially rescue inhalers. Refill prescriptions as needed.
- Discuss asthma condition and triggers that may occur.
- Provide the necessary documentation for the school support staff to keep on file in the event of an emergency. Information should be accessible to teachers, coaches and other adults who supervise children at school.
- Talk with the child about how to manage his or her asthma while at school. Sometimes a child can become overwhelmed with managing his or her condition and needs to discuss the changes he or she is experiencing.
- Instruct the child to wear a medical alert bracelet, if necessary.

### For children with diabetes

- Establish a Diabetes Care Plan and provide the school with a copy for the child's record. The plan can be developed to fit the child's needs. To obtain a copy of the plan:
  - Log in to web-DENIS.
  - Go to *BCN Provider Publications and Resources*.
  - Under Resources, click on *Forms*.
  - The *Diabetes Care Plan* for School is located in the *Chronic condition management* section.

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

The Michigan Quality Improvement Consortium guidelines include information on assessment and treatment of acute and chronic conditions, and preventive services. The **guidelines** are available on the MQIC website.

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## 2016 InterQual® criteria take effect August 1, 2016

Blue Care Network's Care Management staff uses McKesson Corporation's InterQual criteria when reviewing requests for Blue Care Network and BCN Advantage HMO-POS<sup>SM</sup> members. InterQual criteria have been a nationally recognized industry standard for more than 20 years.

Other criteria resources that may be used are BCN medical policies, the member's specific benefit certificate and clinical review by the BCN medical directors for the most appropriate level of care.

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

BCN will begin using the following criteria on Aug. 1, 2016:

Criteria/Version	Application
InterQual® Acute – Adult and Pediatrics	Inpatient admissions Continued stay discharge readiness
InterQual® Level of Care – Subacute and Skilled Nursing Facility	Subacute and skilled nursing facility admissions
InterQual® Rehabilitation – Adult and Pediatrics	Inpatient admissions Continued stay and discharge readiness

Criteria/Version	Application
InterQual® Level of Care – Long Term Acute Care	Long term acute care facility admissions
InterQual® Level of Care – Home Care	Home care requests
InterQual® Imaging	Imaging studies and X-rays
InterQual® Procedures – Adult and Pediatrics	Surgery and invasive procedures
Medicare Coverage Guidelines Applies to BCN Advantage only	Services that require clinical review for medical necessity and benefit determinations
Blue Cross Blue Shield of Michigan/BCN medical policies	Services that require clinical review for medical necessity
BCN-developed imaging criteria	Imaging studies and X-rays
BCN-developed local rules	Exceptions to the application of InterQual criteria that reflect BCN's accepted practice standards
Behavioral Health Utilization Management Clinical Criteria	Behavioral health services that require clinical review for medical necessity



*InterQual Local Rules*

## Guidelines for bundling admissions

Blue Care Network reviews inpatient readmissions that occur within 14 days of discharge from a facility that's reimbursed by diagnoses-related groups, or DRGs, when commercial HMO and BCN Advantage<sup>SM</sup> members have the same or a similar diagnosis.

Please refer to the attached PDF to read the guidelines we use to determine when to combine two admissions into one for purposes of DRG reimbursement.

Guidelines are subject to change.



*Guidelines for bundling admissions*

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## Quality corner: Pharmacotherapy adherence for bipolar disorder

### What are the risks for patients with bipolar disorder not adhering to medications?

Patients with bipolar disorder may be prescribed medications including, but not limited to, mood stabilizers, various antipsychotic agents, such as risperidone and phenothiazine antipsychotics. However, a frequent issue among bipolar patients is non-adherence.<sup>1</sup>

According to an article in *BJPsych Advance*, “Over the course of a year, about three-quarters of patients prescribed psychotropic medication will discontinue, often coming to the decision themselves and without informing a health professional.”<sup>2</sup> These medications can shorten episodes and reduce relapse risks – imperative benefits that non-adherent patients may not experience.<sup>3</sup> When patients discontinue the use of their medication, it can lead to increased costs.<sup>4</sup>

### What is considered pharmacotherapy adherence in order to receive incentives?

This measure is fulfilled when patients who have bipolar disorder and are between 19 and 64 years old are dispensed and remain on a mood stabilizer or antipsychotic medication for at least 80 percent of the time between when they were initially given the medication and the remainder of the year.

This measure may be familiar to some because it is derived from the Healthcare Effectiveness Data and Information Set, or HEDIS®, measure determining adherence to antipsychotic medications for individuals with schizophrenia. For the purposes of the Behavioral Health Incentive Program, we have applied the premise of the measure to individuals with bipolar disorder, because that includes a larger member population.

The provider can receive \$100 each time this measure is complete.

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### What can behavioral health providers do?

If you are trying to help patients attain the 80 percent adherence threshold, or even if you work with a difficult population and just want to increase their adherence as much as possible, there are several ways to increase the chance of adherence.

- Ensure the patient and caregiver understand the disorder and the importance of adherence.
- Develop a strong relationship with the patient.
- Simplify the medication regimen.
- Address side effects.
- Address and treat possible comorbid illnesses.<sup>5</sup>

#### References

<sup>1</sup> <http://www.ncbi.nlm.nih.gov/pubmed/22401485>

<sup>2</sup> <http://apt.rcpsych.org/content/13/5/336>

<sup>3</sup> <http://www.ncbi.nlm.nih.gov/pubmed/22401485>

<sup>4</sup> <http://apt.rcpsych.org/content/13/5/336>

<sup>5</sup> <http://www.ncbi.nlm.nih.gov/pubmed/22401485>



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## An update on the Blue Care Network Behavioral Health Incentive Program

We are receiving more self-reported submissions for the 2016 Behavioral Health Incentive Program than ever before. To accommodate this growth, we have created an electronic method for submissions. Our traditional fax process is still available, but if you submit the information electronically instead, you are eligible for a \$10 increase in payment per submission. Instruction documents about the new electronic submission process are available on web-DENIS.

If you are sending a fax:

- Ensure that the patient is a commercial member.
- Double check that you haven't already submitted the form for that date.
- Review the form to make sure all the information is complete and that all writing is legible.

We want to give credit whenever possible and in order to do so, we must have accurate information.

For more details regarding faxing tips, please refer to the *Frequently Asked Questions* 2016 document, which has a section addressing faxing suggestions.

To view the 2016 program documents on web-DENIS, please follow these steps:

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

## Let us know what you think

BCN continues to review our incentive program. Please take a few minutes to give us your thoughts. Our **survey** addresses familiarity with the program, understanding of program policies, feedback for program improvement, and any barriers to participation. Regardless of whether or not you are participating in the Behavioral Health Incentive Program, we would like your feedback. Your responses are used when making decisions regarding design, strategy and evaluation for the 2017 program.

## HEDIS tips

### Follow-up care when prescribing medication for ADD, ADHD

Did you know? Blue Care Network provides ongoing information to our members about the importance of follow-up care when physicians prescribe medications for attention deficit disorder and attention deficit hyperactivity disorder. When members initially receive a medication, they are encouraged to follow all directions accurately and to take the medication consistently, as prescribed.

We inform members that they should see their doctor within 30 days of an initial prescription for an ADHD medication. We also instruct members that they should schedule two follow-up appointments within the next nine months on the medication. BCN members are eligible for gift card incentives for keeping these appointments. Overall, we stress continued communication with the member's doctor so that member feedback can help providers determine the most effective treatment when using these types of medications.

### Initiation and engagement of alcohol and other drug dependence treatment

Blue Care Network recognizes the critical importance of a swift response to members to initiate and engage in treatment for all adolescent and adult members who receive a diagnosis of alcohol or other drug abuse. Our goal is to make contact with members to recommend they initiate treatment within 14 days when they receive such a diagnosis. BCN recommends that all providers collaborate with us to direct members for treatment for alcohol and other drug abuse when making this diagnosis. This is important collaboration. Early intervention is vital in meeting our members' needs by supporting and making healthy lifestyle changes.

We are here to help. If you need help identifying contracted providers or getting our members admitted to treatment, contact the Behavioral Health Department at 1-800-482-5982.

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## Dr. Beecroft named fellow of the American Psychiatric Association



Dr. William T. Beecroft

Blue Care Network's Dr. William T. Beecroft, medical director of Behavioral Health, was named a fellow of the American Psychiatric Association at the 60th Convocation of Distinguished Fellows during the association's annual convention in May.

"Fellow status is an honor that reflects the dedication to the work of the American Psychiatric Association and signifies allegiance

to the psychiatric profession," said Yolanda Brunson, membership administrative manager.

In Dr. Beecroft's three years at BCN, he's been able to put his 35 years of practice experience to work adjudicating cases and helping to develop innovative programs with the encouragement of Dr. Duane DiFranco, BCN medical director, and Dr. Marc Keshishian, senior vice president and chief medical officer.

Here's a sampling of the innovations Dr. Beecroft and his team are bringing to BCN:

- Dr. Beecroft was in Orlando two days after his fellowship was awarded to present follow-up data to the Blue Cross and Blue Shield Association summit for BCN's successful Behavioral Health Incentive Program.
- Telepsychiatry is now a paid benefit, so commercial members in rural areas can use remote psychiatrists to provide services and medication evaluations.
- Dr. Beecroft worked with contracting to get Recovery After an Initial Schizophrenia Episode, or RAISE, clinical protocol covered for our members. RAISE is a National Institutes of Mental Health program that gives newly diagnosed schizophrenics a chance at living a more normal life by giving them the tools they need to stay out of the hospital. BCN is the only insurer to pay for this program as a benefit.
- A big project that is close to finalizing is an effort to keep autistic children out of the hospital and into more effective outpatient treatment options for the whole family.
- A similar project that could come to fruition by the end of the year presents a novel way for people who suffer from chronic mental illness to get the services they need without a hospital stay, saving hospitalization costs and offering them a better quality of life.

Dr. Beecroft also pilots compassion flights for **Wings of Mercy East Michigan**, a nonprofit organization that offers air transport at no cost for those who require specialized medical treatment at distant medical centers.

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## Blue Care Network mails brochure about antibiotics to select BCN members

Blue Care Network mailed a brochure about antibiotics to about 3,000 BCN members in April to educate them about the appropriate use of antibiotics.

BCN data show that 1,560 members were diagnosed with acute bronchitis in the past year and that 1,460 members under 18 were diagnosed with an upper respiratory infection in the past year. The mailing is intended as a general education piece for members, even if they were not prescribed an antibiotic as part of their treatment.

The brochure discusses the risks of taking antibiotics when unnecessary and explains how antibiotic resistance happens.

Providers have an opportunity to discuss the safe use of antibiotics with patients and answer questions they may have during office visits. Click on the PDF link below to see the brochure.





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## Changes to BCN Advantage medical drug prior authorization program

Authorization is no longer required for BCN Advantage<sup>SM</sup> members for the following drugs covered under members' medical benefits.

J code	Brand name
J0881	Aranesp <sup>®</sup>
J0885	Epogen <sup>®</sup> , Procrit <sup>®</sup>
J0178	Eylea <sup>®</sup>
J2778	Lucentis <sup>®</sup>
J2505	Neulasta <sup>®</sup>

For a full 2016 list of all medications and procedure codes that require authorization, refer to the *BCN Referral and Clinical Review Program*, available by visiting [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) and clicking on **Clinical Review & Criteria Charts**. Details on medical necessity criteria are posted on the same page. Just scroll down to the medical necessity criteria section and click **Clinical Information for Drugs Covered under the Medical Benefit That Require Medical Necessity Review**.

## Blue Cross and BCN drug lists updated, available online

Blue Cross Blue Shield of Michigan and Blue Care Network regularly update their drug lists. For the most recent updates, go to [bcbsm.com.rxinfo](http://bcbsm.com.rxinfo).

Please help ensure that our members get the care they need by talking with them about their drug copayment or coinsurance. Note that many members with a commercial drug benefit do not have coverage for Tier 3 drugs.

## Starting October 2016, specialty drug authorization requests should be submitted using new system

Starting October 2016, Blue Care Network is changing the way we accept authorization requests for specialty drugs paid under the medical benefit.

At that time, we will no longer accept specialty drug authorization requests through the e-referral system. Instead, providers will submit authorization requests for BCN members using a new electronic system. You'll be able to access the new system when you sign in to Provider Secured Services.

BCN has partnered with NovoLogix, an independent company with a web-based tool used to request prior authorization for specialty medications. You may already use this tool to submit authorization requests for specialty

medications for your Blue Cross Blue Shield of Michigan members. Starting in October, you'll be able to submit specialty drug authorization requests for members covered under BCN commercial plans and BCN Advantage<sup>SM</sup> plans, as well.

Additional information about the transition to the new system will be published in the September-October 2016 issue of *BCN Provider News*. In that issue, we will provide detailed information related to training opportunities and instructions for accessing the new system and submitting requests.

Our goal is to assist you in making a smooth transition to using the new system for your BCN commercial and BCN Advantage members.

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

Each year, approximately 400 Blue Care Network members survive a heart attack. Research shows that members who take their medications are less likely to have another heart attack or be readmitted to the hospital.

Guidelines recommend that patients use several different drugs to improve health and decrease the likelihood of a future heart attack. However, out-of-pocket costs can add up and make it hard for members to afford the medications their doctors have prescribed.

The Post-Myocardial Infarction Free Rx Event and Economic Evaluation (MI FREEE) study showed that removing patient cost-sharing for evidence-based medications significantly improved adherence among all patients, more significantly in non-whites.<sup>1,2</sup> Nonwhite patients experienced a 35 percent decrease in future vascular events or need for angioplasty or bypass surgery, and a 70 percent reduction in total health care spending.

BCN is introducing Mending MI Hearts on July 1, 2016. The program provides coverage of certain drugs at no member cost share when **all** the criteria listed at right are met. The member cost share for drugs included in this program bypasses the member's deductible, copayment and coinsurance.

To be eligible for Mending MI Hearts, the member must:

- Have commercial pharmacy and commercial medical coverage through BCN
- Have a new diagnosis of acute myocardial infarction occurring on or after July 1, 2016
- Participating members must be up to date with premium payments. If the member (or the member's employer group) isn't current with premium payments, the member's participation in this program will be determined by the policies governing coverage for those members.

## Which drugs are covered?

Mending MI Hearts covers prescribed drugs in these classes:

- Anti-platelets
- Beta-blockers
- RAAS-blockers
- Statins

Covered drugs must also be prescribed in keeping with any BCN prior authorization requirements, quantity limits and step therapy requirements.

## Important:

- This program does not apply to BCN Advantage<sup>SM</sup> members or members whose self-funded employer group has opted out of the program.

## References

1. Choudhry NK, Bykov K, Shrank WH, et al. Eliminating medication copayments reduces disparities in cardiovascular care. Health Aff. 2014.
2. Choudhry NK, Avorn J, Glynn RJ, et al. Full coverage for preventive medications after myocardial infarction. N Engl J Med. 2011.

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## BCN updates coverage policy for meningococcal type B vaccinations

Based on new guidelines from the Advisory Committee on Immunization Practices, Blue Care Network has expanded coverage for meningococcal serogroup B vaccine for certain members.

BCN now provides coverage for those 16-23 years of age, in addition to those at increased risk of meningococcal disease for members 10 years of age and older as previously recommended.

At-risk members include:

- People at risk because of a serogroup B meningococcal disease outbreak
- Anyone whose spleen is damaged or has been removed
- Anyone with a rare immune system condition called "persistent complement component deficiency"
- Anyone taking a drug called eculizumab (Soliris®)

- Microbiologists who routinely work with N. meningitidis isolates

Serogroup B meningococcal vaccine Trumenba® is two- or three-dose immunization, and Bexsero® is a two-dose immunization.

Please note that the current **ACIP recommendations** also include a booster or repeat dose of quadrivalent meningococcal vaccine (CPT code \*90733 or \*90734). When a member requests immunization for type B meningitis, take the opportunity to ensure that the member has received a booster for the more common forms of meningococcal disease.

\*CPT codes, descriptions and two-digit modifiers only are copyright 2015 American Medical Association. All rights reserved.



## Price Watch feature helps manage drug costs

Blue Care Network strongly encourages the use of low-cost drugs. Prices for some drugs are increasing rapidly or have stayed high despite their change to generic status, which can mean higher costs for patients.

BCN continues to monitor changes in the market and highlight alternatives to high-priced medications. Look for this Price Watch feature in upcoming issues. We'll identify drugs that have experienced price jumps or high cost generic medications and offer lower-cost alternatives for consideration.

### Price Watch

High-cost generic drug	Average cost per prescription	Lower-cost generic alternatives	Average cost per prescription for alternative
Frova®	\$648	Amerge®, Imitrex®, Maxalt®/MLT, Zomig®/ZMT	\$40
Intermezzo®	\$300	Ambien®/CR, Lunesta®, Sonata®	\$30



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With the implementation of ICD-10-CM and coding classification changes, documenting the nuances of diabetes is more important than ever.

Providers either report Type 1 diabetes for patients who don't produce insulin or Type 2 diabetes for patients who produce insulin but their bodies don't use it correctly.

To improve documentation and coding practices, it's essential that medical records provide details on all diabetes-related conditions to the highest level of specificity known.

When documenting diabetes, consider the following:

- Specify whether it's Type 1 or Type 2 diabetes.
- Is the diabetes due to a condition or a drug? If it's due to a drug, indicate which one.
- Is this a secondary type of diabetes? If so, what's the cause?
- Specify when diabetes is gestational.
- Was there an incidence of underdosing or overdosing (poisoning)? For example: Did the patient receive too much or not enough insulin?

**How to improve progress notes**

Only providers can diagnose a patient's medical condition, making documentation even more important. Even if a medical coder can recognize the inference of a condition, only **what is documented** can be coded.

For instance, if a patient has two medical conditions that are linked, then his or her provider needs to document that the conditions are related. This allows coders to use a combination code, which is a single code used to describe two diagnoses (a diagnosis with either an associated manifestation or complication).

**Example:** Type 1 diabetic mellitus with severe nonproliferative diabetic retinopathy with macula edema

Here are three examples of when a report lacks documentation or doesn't properly link two conditions:

1. A patient visits his podiatrist for an annual diabetic exam. The podiatrist documents a prescription for new shoes. The assessment shows the patient is instructed to return in one year.

**What's wrong with this documentation?**

- The medical coder can't code the patient's medical condition as diabetes because the provider didn't document the patient as being diabetic.
- The annual diabetic exam may have only been for monitoring purposes; it doesn't prove the patient has the condition.

2. A patient visits his podiatrist for an annual diabetes exam. The podiatrist documents a prescription for new shoes. The assessment shows the patient understands the importance of checking his feet, because his diabetic condition makes his feet prone to other health issues.

**What's wrong with this documentation?**

- The provider's note only states the patient is diabetic.
- The documentation needs to state any linked or additional diagnoses. Peripheral neuropathy maybe suspected based on the prescription for diabetic shoes, but the provider didn't document that condition.

3. A patient visits his podiatrist for an annual diabetes exam. The podiatrist documents a prescription for new shoes. The assessment shows peripheral neuropathy and that the patient understands the importance of checking his feet, because his diabetic condition makes his feet prone to other health issues.

**What's wrong with this documentation?**

- The documentation supports two separate diagnoses; therefore a combination code cannot be used.
- To link two medical conditions together, there needs to be verbiage in the record such as **"with," "due to" or "associated with."**

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## Coding corner, continued from Page 30

It's equally important for everyone involved in the patient's care to understand the relationship of the conditions found in the progress notes. Documenting the **cause and effect** of a condition in the medical record provides a complete picture of the patient's office visit.

The ICD-10 code assignment is crucial in determining the correct reimbursement for these face-to-face encounters and for tracking health care services provided for a diabetic condition.

Requirements for reporting diabetes mellitus and its associated illnesses are located in the *ICD-10-CM coding book*, "Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00 – E89)."

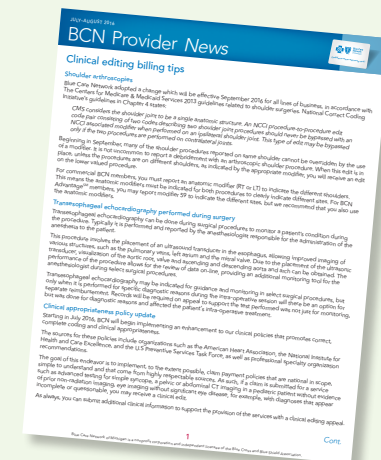
*None of the information included in this article is intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with applicable state and federal laws and regulations.*

## 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:

- Shoulder arthroscopies
- Transesophageal echocardiography (TEE) performed during surgery
- Clinical appropriateness policy update
- Reporting multi-line claims



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## Billing Q&A

### Question:

Where can I obtain a copy of the Blue Care Network provider fee schedule?

### Answer:

The BCN fee schedule is not available online. Please contact your provider consultant.

### Question:

Prevnar is recommended now as the immunization people should get for the pneumonia vaccine, but BCN continues to deny it for a diagnosis even though Z23 diagnosis, "encounter for immunization" is on the claim. When patients are asking for it, how should we handle this?

### Answer:

In most instances, the pneumococcal polysaccharide vaccine, 23-valent (PPSV23) is the appropriate vaccine to use. This vaccine can be used in members who are 2 and older after having received Prevnar pneumococcal conjugate vaccine, 13 valent, or PCV13, according to recommendations for those at high risk of invasive pneumococcal disease. And although the FDA has approved Prevnar for those 50 and older, and advertisements indicate "one and done," the CDC has only recommended it for a selected setting for those 19 to 64.



Some points to consider:

- BCN has no diagnosis restrictions for coverage of the pneumococcal polysaccharide vaccine, 23-valent (PPSV23) in adults.
- For the pneumococcal conjugate vaccine, 13-valent (PCV13), for BCN commercial members:
  - There are no diagnosis restrictions for members younger than 7 or 65 years of age or older.
  - Diagnosis restrictions for members ages 7 to 64 are in line with Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices recommendations, which can be found at the CDC website for vaccine recommendations. The footnote #8 has the details about use recommendations.
  - Diagnostic codes appropriate for the reason for the immunization, in conjunction with Z23, encounter for immunization, can allow the claim to process without a clinical edit.

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## Question:

Why aren't we getting paid when we do a read on a radiology procedure? We often receive a denial stating that clinical editing considers it a duplicate component. It does not make sense as the patient was seen in the ER and the films were sent to our radiology group for review.

## Answer:

BCN reimburses for only one interpretation and report on a radiology procedure. If additional reads or professional components are submitted for an individual radiology procedure, edits will be generated on those claim lines. These edits, when received, are noted by an explanation code that advises a duplicate component, such as the professional service or read, has already been paid.

While it has been our policy to process the first claim in, it is equally important to note that BCN does not reimburse for wet reads. Therefore, if all that is done is a wet read and not a full radiology interpretation and report, a claim should not be submitted for the professional component.

We expect that when a radiology code for a report and interpretation is submitted, a complete report is maintained and available in the patient's medical record.

At a minimum, the report should contain:

- Patient demographics
- Diagnosis (clinical information)
- Body of report
- Impression (diagnosis)

## 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. Do not include any personal health information, such as patient names or contract numbers, in your question to us.

For urgent or complex questions, contact Provider Inquiry or your provider consultant. Additional information may be required to answer your question accurately.



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# eviCore healthcare makes radiation therapy worksheets available for providers

eviCore healthcare has posted new radiation therapy worksheets on its Radiation Therapy Tools and Criteria web page.

eviCore's worksheets are tools you can use to assemble pertinent information before submitting an authorization request through eviCore's secure provider portal. If you answer the questions on the worksheet before submitting your request, your submission should go more smoothly. In addition, the percentage of requests requiring physician review should decrease.

To access these worksheets:

- Visit **evicore.com**.
- On the Solutions tab, click *Radiation therapy*.
- Scroll down and click **Radiation Therapy Physician Worksheets**, under the Educational Links heading.

The new radiation therapy worksheets that eviCore made available on April 15, 2016, are related to:

- Adrenal cancer
- Bile duct cancer
- Bladder cancer
- Gallbladder cancer
- Hepatobiliary cancer
- Kidney cancer
- Liver cancer
- Urethral cancer

The revised worksheets that were posted on April 15, 2016, are about:

- Breast cancer – The questionnaire was streamlined for ease of use.
- Radiation therapy clinical documentation
- Radiation therapy coding guidelines

## What eviCore does

As a reminder, BCN partners with eviCore healthcare (formerly known as CareCore National LLC and Landmark Healthcare, Inc.) to oversee the following:

- Select cardiology, radiation therapy and radiology services provided in BCN-participating freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices
- Outpatient physical, occupational and speech therapy services for BCN HMO<sup>SM</sup> (commercial) and BCN Advantage<sup>SM</sup> members delivered by independent physical therapists, outpatient therapy providers, physician practices and hospital-based outpatient therapy services
- Physical medicine services provided for BCN HMO members by chiropractors



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# Use correct treatment plan forms and fax number for authorization requests sent to eviCore for PT, OT, ST and physical medicine services

Make sure you're submitting authorization requests to eviCore healthcare for physical/occupational/speech therapy and physical medicine services (chiropractors) using the correct forms and the correct fax number.

## Use the appropriate forms

When submitting authorization requests to eviCore for physical / occupational / speech therapy and physical medicine services (chiropractors) for BCN members, select the forms available on the Landmark Connect secure provider portal.

The appropriate forms are available when you log in to the secure portal at [www.LMHealthcare.com](http://www.LMHealthcare.com). Click *Providers* and then click *Landmark Connect* to log in. The treatment plan forms are located on the Admin Resources tab, under Forms.

Some providers are using the forms found on the eviCore website, but those are not the correct forms for BCN authorization requests. Instead, you must continue to use the treatment plan forms available on Landmark Connect for PT/OT/ST and physical medicine (chiropractor) services for BCN members. If you are not already registered to access Landmark Connect, please contact the eviCore Customer Service department at 1-877-531-9139 and they will register an account for you.

## Use the correct fax number

Submit the completed treatment plan forms using the fax number listed on the forms, which is 1-888-565-4225.

If you are having difficulty submitting your treatment plans using the 1-888-565-4225 fax number, either try again or contact the eviCore Customer Service department at 1-877-531-9139 for additional options.

If you have questions, contact eviCore's Customer Service department at 1-877-531-9139. You may also contact your BCN provider consultant.

## Reminder

Requests for the approval of the evaluation and first treatment visit (for occupational and physical therapy), the first treatment visit (for physical medicine services provided by chiropractors) and the evaluation only (for speech therapy) must be submitted to BCN through the e-referral system or by calling BCN Care Management at 1-800-392-2512. After that, requests must be submitted to eviCore healthcare.



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## Announcing the new [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com)

If you've visited [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) recently, you might have noticed things have changed. On our new site, to find the Blue Care Network information you've used in the past, just click "BCN" along the top or at the left of any page. You'll find all of the BCN-related referral and authorization information in the section that opens.

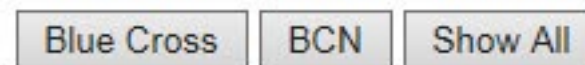
As time goes on, more information will be added to the Blue Cross section of the website.

When you first enter [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com), you're in the Home area where you'll find pages such as *Provider Search* and *Quick Guides*. This is information that may apply to both BCN and Blue Cross Blue Shield of Michigan. When a page first displays in the Home section, all BCN and Blue Cross information is visible. To see information specific to a certain line of business, click either the *Blue Cross* or the *BCN filter button* at the top of the content section. To see all of the information again, click *Show All*.

When you access one of these pages from within the BCN or Blue Cross section, though, only the information relevant to that line of business will be displayed and no filter buttons will appear.

The new site also includes a *Search* feature. Look in the upper right part of the page. You can choose to search the full site or just the BCN or Blue Cross sections of the site. Enter your search term, select where you want to search from the drop-down menu, and click *Go*.

Thank you to those who participated in the survey held earlier this year. Your input was used to determine some of the enhancements made to the site. If you have comments, please [send us feedback](#)



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## Changes in eviCore's reconsideration process for physical therapists' utilization categories

Effective immediately, eviCore healthcare has changed the process by which physical therapists request reconsideration of an assigned utilization category. The changes apply to category assignments that are effective Aug. 1, 2016. The changes affect reconsideration requests that are currently in progress.

If you are a physical therapist who provides services to BCN HMO (commercial) and BCN Advantage<sup>SM</sup> members, you'll want to familiarize yourself with the revised process. But first, some background.

### Why utilization categories are important

eviCore assigns physical therapists as Category A, B or C providers based on their risk-adjusted utilization of therapy. Category A therapists have the widest latitude in providing treatment without the need to have it authorized through eviCore, up to the member's benefit limit. Category B and C therapists are more restricted in the services they can provide without authorization.

When deciding on the appropriate category for each therapist, eviCore reviews the claims data reported for each provider within the framework of best practices in the field. The category assignments are made twice a year.

Please see [eviCore](#), continued on Page 38



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## The process to follow

For category assignments that are effective Aug. 1, 2016, the table provided here shows eviCore's revised process for requesting reconsideration. Therapists who want to request that eviCore reconsider the category they will be assigned as of August 1 must follow the steps outlined here.

Step	Action	Specific steps and time frames
1	Therapist initiates request for reconsideration of assigned utilization category.	Within 14 calendar days of the date of the utilization category assignment letter, the physical therapist must notify eviCore of his or her intent to initiate a reconsideration review. This notification must include a brief summary of the aspects that make the therapist's practice different from the practices of peers and may be sent by U.S. mail or by email to <a href="mailto:Provider.Services@evicore.com">Provider.Services@evicore.com</a> .
2	eviCore sends a request for data.	Within one business day of receiving a reconsideration request, eviCore sends the therapist a list of patient claim data included in the categorization reporting period. eviCore communicates instructions for the therapist to identify cases to be considered in eviCore's review of the reconsideration request.
3	Therapist identifies cases to be considered in review.	Within 14 days of the date eviCore sends the patient data, the therapist must identify specific cases to be considered in eviCore's review, describing aspects that contributed to the variance between the therapist's practice and the practice of peers within the network.
4	eviCore sends request for more data, as needed.	If more data are needed to complete the review, eviCore sends the therapist a request for additional data. The therapist must respond within seven calendar days of receiving the request or the request is considered withdrawn.
5	eviCore shares recommendation with BCN.	Within 14 calendar days of receiving all the information needed from the therapist, eviCore develops a recommendation for category assignment and shares it with BCN.
6	BCN decides whether to accept eviCore's recommendation.	Within seven calendar days of receiving eviCore's recommendation, BCN communicates its decision to eviCore on whether to accept the recommendation.
7	eviCore shares BCN's decision with provider.	Within one business day of receiving BCN's decision, eviCore shares the decision with the physical therapist.

Physical therapists affected by these changes have been notified by letter.

Please see [eviCore](#), continued on Page 39

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### Additional information

For additional information about referral and authorization requirements related to physical, occupational and speech therapy provided by therapists and physical medicine services provided by chiropractors:

1. Visit [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com).
2. Click *BCN*.
3. Click *Provider Manual Chapters*.
4. Click **Care Management** chapter. Look in the section titled "Managing PT, OT and ST / Managing physical medicine services by chiropractors."

You can also find more information by clicking **Outpatient PT / OT / ST** on the [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website.

### Reminder

BCN is contracted with eviCore healthcare to provide care management for the physical, occupational and speech therapy services members receive in office and outpatient settings, including outpatient hospital settings. eviCore also manages physical medicine services provided by BCN-contracted chiropractors for BCN HMO (commercial) members using select \*97XXX procedure codes.

eviCore is responsible for reviewing requests to authorize services and managing the benefit limits for physical, occupational and speech therapy services provided by therapists and physical medicine services provided by chiropractors.

## InterQual® criteria used as guidelines in reviewing acute inpatient medical admissions

While Blue Care Network uses McKesson's InterQual criteria as guidelines in reviewing acute inpatient medical admissions, BCN's medical directors will make the final determination about the most appropriate level of care based on their medical judgment. This was effective starting May 30, 2016.

Additional information about the InterQual criteria and about the process for reviewing these admissions is found in the **Care Management chapter** of the *BCN Provider Manual*.



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# Therapists and physical medicine providers in a group practice should select correct providers in electronic systems

Selecting the correct provider ID in each provider category in Blue Care Network's e-referral system and in eviCore healthcare's electronic system helps ensure that authorizations are assigned correctly and that claims pay correctly. This is especially important for rehabilitation service providers who practice within a group — including physical therapists, occupational therapists, speech therapists and chiropractors performing physical medicine services.

Here's what to do.

## BCN's e-referral system

When entering referrals or authorization requests for BCN members in the e-referral system, when services are provided within a group practice, it is important that practitioners do the following:

In e-referral, for the servicing provider, select the practitioner's ID that is affiliated with the group.

For all practitioners, selecting the correct provider IDs within BCN's e-referral system allows the case to transfer

into eviCore healthcare's electronic system correctly. It also ensures that the correct provider within the group is paid at the correct rate for the service provided.

In addition, for physical therapists, when the incorrect servicing provider is selected — that is, when the line is selected that does not show the group affiliation — the case may become incorrectly associated with a more restrictive utilization management category.

**Servicing Provider Search** [Close Window]

**Search** [Bookmarks]

Name: [ ] ID: 000000000 Specialty: All [v]  
 City: [ ] State: All [v] Zip: [ ]

[CANCEL] [SEARCH]

Network	Name	NPI	Address	Group Affiliation	Type	Specialty	Action
In	DOE, JOHN	000000000	12345 Main St. SOUTHFIELD MI 48075		Practitioner	Independent Physical Therapist	Bookmark
In	DOE, JOHN	000000000	12345 Main St. SOUTHFIELD MI 48075	REHAB SERVICES, INC.	Practitioner	Independent Physical Therapist	Bookmark

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## eviCore's electronic system

When requesting an extension on an authorized service within eviCore's electronic system (accessed through the secure provider portal at **www.LMHealthcare.com**), it is important that practitioners carry the same selection forward. Do the following:

In evicore's system, for the "treating practitioner," select the ID that is affiliated with the group.

**EForm - Select Practitioner**

<< Go Back to e-Forms Page

**Treating Practitioner**

☒ John Doe  
Physical Therapist  
12345 Main St.  
Southfield, MI 48075  
Tax ID XXXXX0000  
Affiliated Group : Rehab Services, Inc.

☐ John Doe  
Physical Therapist  
12345 Main St.  
Southfield, MI 48075  
Tax ID XXXXX0000

Next

## Additional information

For additional information about using BCN's e-referral system:

1. Visit **ereferrals.bcbsm.com**.
2. Click **BCN**.
3. Click *Training Tools*.
4. Click **e-referral User Guide**.

For additional information about using the eviCore electronic system, log in to the secure portal at **LMHealthcare.com** and look on the Admin Resources tab.

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## Guidelines for billing sleep studies, with updates on authorization requirements

It's important to be familiar with Blue Care Network's policies related to sleep studies so you can bill these services correctly and make sure they are authorized, as needed, before providing them.

### Providers must be contracted for sleep studies

Reimbursement for sleep studies is available only to providers who have specifically contracted with BCN to perform these services.

### General billing guidelines

Claims for sleep studies must be billed either electronically or using a CMS-1500 form. Bill sleep studies according to the guidelines outlined in the table that follows.

Service	Procedure codes	Other guidelines
Home sleep study	G0398, G0399, G0400 <sup>†</sup> *95800, *95806	Bill only in the home setting (POS 12). Bill as a global rate. Separate billing using modifier 26 or TC is incorrect.
Outpatient / clinic sleep study	*95782, *95783 *95801 <sup>†</sup> , *95805, *95807, *95808, *95810, *95811	Bill only in the office setting (POS 11), off-campus outpatient setting (POS 19) or on-campus outpatient setting (POS 22).

<sup>†</sup> Procedures associated with G0400 and \*95801 are not covered for BCN HMO (commercial) members. They may be covered for BCN Advantage<sup>SM</sup> members if they are medically necessary and are authorized by the plan.

\*CPT codes, descriptions and two-digit modifiers only are copyright 2015 American Medical Association. All rights reserved.

Please see [Sleep studies](#), continued on Page 43

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### Home sleep studies

Only providers who have signed a specific sleep testing agreement may provide home sleep studies to BCN members. Hospitals billing for services related to home sleep studies must also execute a specific sleep testing agreement and bill in accordance with BCN requirements.

Claims are payable only if they are billed globally. Claims submitted on a UB-04 claim form are not payable.

In addition, effective immediately, home sleep studies no longer require clinical review, but an authorization is still needed in the e-referral system so that claims can be paid. This means that there is no longer a need to complete a questionnaire in the e-referral system for home sleep studies.

### Sleep studies in outpatient and clinic-based settings

Attended sleep studies in the outpatient and clinic-based treatment settings are eligible for reimbursement for the following members when medically necessary and authorized by the plan:

- Pediatric members (17 years of age or younger) with symptoms of obstructive sleep apnea
- Adult members with symptoms of obstructive sleep apnea who completed a nondiagnostic home sleep study or who have exclusions or contraindications to having a sleep study in the home

In addition, effective Oct. 3, 2016, all requests to authorize outpatient facility and clinic-based sleep management studies for adult members 18 years of age and older will require the submission of evidence from the member's medical record. This evidence must confirm the specific condition the member has that would exclude or contraindicate a home sleep study. This applies to BCN HMO<sup>SM</sup> (commercial) and BCN Advantage members.

Providers can facilitate the authorization request by completing the sleep study questionnaire for outpatient facilities or clinic-based settings in the e-referral system. Any documentation from the patient's medical record that is required can be attached to the request within the e-referral system, through the Case Communication field.

### Additional information

To get information on which patients qualify for various types of sleep studies, refer to the **Sleep Management Program page** at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). On this page you'll also find the authorization requirements for these services — specifically, that authorization is required for all sleep studies for BCN HMO<sup>SM</sup> (commercial), self-funded and BCN Advantage members when the study is performed in an outpatient facility or clinic.



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