August 2017

We’re making changes to Benefit Explainer

Starting Aug. 14, you’ll see updates we’ve made to Benefit Explainer. These changes are part of our effort to provide you with a more positive experience when your claims are processed. Below are some highlights.

The following changes will be made to the Benefit Package Report, under the BPR tab.

- We’re adding two subsections under Coverage Limitations:
  - Benefit Limitations — This will display whether a member is responsible for payment.
  - Provider Payment Limitations — This will display whether a provider is responsible for payment.
- The Concurrent Services header is being removed.
- The Member Liability header is being renamed Member Cost Share.
• Under the Additional Information header, we’re removing Optional Modifier and Additional Documents. (BCBSM Provider Manuals and Medical Policy will be under the Additional Information header.)

To view screen shots and get more in-depth information about Benefit Limitations and Provider Payment Limitations, click here.

The following changes will be made to the Medical/Payment Policy Report under the Medical/Payment Policy tab.

• We’re adding two subsections under Coverage Limitations:
  ◦ Medical — This will display medical policy.
  ◦ Provider Payment Limitations — This will display payment policy.

• Under the Additional Information header, we’re removing Optional Modifier and Additional Documents. (BCBSM Provider Manuals and Medical Policy will be under the Additional Information header.)

To view screen shots and get more in-depth information about Medical and Provider Payment Limitations, click here.

If you have any questions, contact your provider consultant.

Register for AIM Specialty Health Prior Authorization Program webinar

We invite you to take part in the Blue Cross Blue Shield of Michigan and AIM Specialty Health Prior Authorization Program webinar at 10 a.m. Sept. 13, 2017. AIM handles our commercial and Medicare Advantage outpatient PPO prior authorizations for high-tech radiology, echo cardiology and in-lab sleep therapy.

This webinar will give you an overview of the AIM prior authorization program, and it’ll help you understand program enhancements since 2016. Some topics include:

• Services affected by the program
• Prior authorization guidelines
• How to register on AIM’s provider website
• An overview of AIM’s provider website for verifying authorizations

Click here to register. After registering, you’ll receive a confirmation email and instructions for joining the WebEx webinar.

The AIM radiology overview doesn’t include Blue Care Network products or any programs managed by eviCore. And WebEx training isn’t available on Mac operating systems.
Notice: We’ll update ClaimsXten™ for fourth quarter of 2017

Blue Cross Blue Shield of Michigan will update ClaimsXten for the fourth quarter of 2017.

We regularly update ClaimsXten to help ensure we’re using the most current CPT codes and guidance from the Centers for Medicare & Medicaid Services and specialty societies. We also reference information from industry seminars and publications, as well as Blue Cross payment policy revisions.

We reserve the right to make changes or corrections when required or when new information becomes available. In some instances, we may apply changes to ClaimsXten retroactively.

UAW Retiree Medical Benefits Trust coverage changing for Medicare members in 2018

Effective Jan. 1, 2018, the UAW Retiree Medical Benefits Trust (“the Trust”) will be transitioning coverage for its Medicare primary members in Michigan from the Blue Cross Blue Shield Traditional Care Network plan to the Medicare Plus BlueSM Group PPO plan. This means that on Jan. 1, 2018, many of your patients who receive coverage through the Trust will be enrolling into a Blue Cross Blue Shield Medicare Advantage PPO (MA PPO) plan.

You’ll likely continue to see these same retirees who will be Blue Cross Blue Shield Medicare Advantage members beginning Jan. 1, 2018. If you’re part of the Blue Cross Blue Shield MA PPO network, these members will be able to find your practice or facility in our online provider directory.

While most of our health care providers are familiar with our MA PPO product, there are some differences in benefits and care management. Later this year, we’ll publish information about these differences in coverage you might see for Trust members, starting in 2018.

As always, it’s important that you ask your patients about recent changes in insurance carriers and benefits, and also to request a copy of their new ID card when they come for services. You can also check member benefits and eligibility on web-DENIS.
HCPCS update: New codes added

The Centers for Medicare & Medicaid Services has added several new codes as part of its quarterly HCPCS updates. The codes, effective dates and Blue Cross Blue Shield of Michigan’s coverage decisions are below.

**Pathology and Laboratory/Professional Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Change</th>
<th>Coverage comments</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>0006U</td>
<td>Added</td>
<td>Not covered</td>
<td>Aug. 1, 2017</td>
</tr>
<tr>
<td>0007U</td>
<td>Added</td>
<td>Covered</td>
<td>Aug. 1, 2017</td>
</tr>
<tr>
<td>0008U</td>
<td>Added</td>
<td>Not covered</td>
<td>Aug. 1, 2017</td>
</tr>
<tr>
<td>0009U</td>
<td>Added</td>
<td>Not covered</td>
<td>Aug. 1, 2017</td>
</tr>
<tr>
<td>0010U</td>
<td>Added</td>
<td>Not covered</td>
<td>Aug. 1, 2017</td>
</tr>
<tr>
<td>0011U</td>
<td>Added</td>
<td>Not covered</td>
<td>Aug. 1, 2017</td>
</tr>
<tr>
<td>0012U</td>
<td>Added</td>
<td>Not covered</td>
<td>Aug. 1, 2017</td>
</tr>
<tr>
<td>0013U</td>
<td>Added</td>
<td>Not covered</td>
<td>Aug. 1, 2017</td>
</tr>
<tr>
<td>0014U</td>
<td>Added</td>
<td>Not covered</td>
<td>Aug. 1, 2017</td>
</tr>
<tr>
<td>0015U</td>
<td>Added</td>
<td>Not covered</td>
<td>Aug. 1, 2017</td>
</tr>
<tr>
<td>0016U</td>
<td>Added</td>
<td>Not covered</td>
<td>Aug. 1, 2017</td>
</tr>
<tr>
<td>0017U</td>
<td>Added</td>
<td>Not covered</td>
<td>Aug. 1, 2017</td>
</tr>
</tbody>
</table>

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

**Correction: PARS will provide claims information**

The article “PARS will provide claims information” in the June 2017 Record contained incorrect information.

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

Billing chart: Blues highlight medical, benefit policy changes

You’ll find the latest information about procedure codes and Blue Cross Blue Shield of Michigan billing guidelines in the following chart.

This billing chart is organized numerically by procedure code. Newly approved procedures will appear under the New Payable Procedures heading. Procedures for which we have changed a billing guideline or added a new payable group will appear under Updates to Payable Procedures. Procedures for which we are clarifying our guidelines will appear under Policy Clarifications. New procedures that are not covered will appear under Experimental Procedures.

You will also see that descriptions for the codes are no longer included. This is a result of recent negotiations with the AMA on use of the codes.

We will publish information about new BCBS groups or changes to group benefits under the Group Benefit Changes heading.

For more detailed descriptions of the BCBSM policies for these procedures, please check under the Medical/Payment Policy tab in Explainer on web-DENIS. To access this online information:

- Log in to web-DENIS.
- Click on BCBSM Provider Publications & Resources.
- Click on Benefit Policy for a Code.
- Click on Topic.
- Under Topic Criteria, click on the drop-down arrow next to Choose Identifier Type and then click on HCPCS Code.
- Enter the procedure code.
- Click on Finish.
- Click on Search.

<table>
<thead>
<tr>
<th>Code*</th>
<th>BCBSM changes to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>81415, 81416, 81417</td>
<td>Basic Benefit and Medical Policy, Group Variations Payment Policy, Guidelines</td>
</tr>
</tbody>
</table>

NEW PAYABLE PROCEDURES

Basic benefit and medical policy

Genetic testing: Whole exome and whole genome sequencing for diagnosis of genetic disorders
Whole exome sequencing, or WES, may be considered established for the evaluation of unexplained congenital or neurodevelopmental disorders in children when all of the following criteria are met:

1. The patient has been evaluated by a specialist with specific expertise in clinical genetics and counseled about the potential risks of genetic testing.
2. There is a potential for a change in management and clinical outcome for the individual being tested.
3. A genetic etiology is the most likely explanation for the phenotype despite previous genetic testing, such as chromosomal microarray or targeted single gene testing, or when previous genetic testing has failed to yield a diagnosis and the affected individual is faced with invasive procedures and testing as the next diagnostic step, such as muscle biopsy.

WES is considered experimental for the diagnosis of genetic disorders in all other situations.

Whole genome sequencing, or WGS, is considered experimental for the diagnosis of genetic disorders.

WES and WGS are considered experimental for screening for genetic disorders.

These procedures aren’t payable in an ambulatory surgical facility or office location.

This policy was effective March 1, 2017.

**Basic benefit and medical policy**

**Analysis of human DNA in stool samples as a technique for colorectal cancer screening**

The safety and effectiveness of DNA analysis of stool samples, using FDA approved tests, may be considered established as a screening technique for colorectal cancer. It may be a useful screening option in select situations.

The performance of Cologuard™ meets the recommendation for periodic colon cancer screening for three years.

**Inclusions** (must meet all of the following requirements):

- Screening of asymptomatic patients (no signs or symptoms of colorectal disease, including, but not limited to, lower gastrointestinal pain, blood in the
stools positive guaiac fecal occult blood test or fecal immunochemical test).

- At average risk of colorectal cancer, who have contraindications to colonoscopy or who despite advice to the contrary are unwilling to undergo colonoscopy for screening.
- Repeat studies are appropriate at three-year intervals in individuals who remain at average risk and meet other requirements above.
- Members must be willing to undergo a diagnostic study if the result of the test is positive, as required by FDA.

**Exclusions:**
The test isn’t indicated in the following (list may not be all inclusive):

- Symptomatic individuals
- Personal history of adenomatous polyps
- Personal history of colorectal cancer
- History of inflammatory bowel disease
- Family history of colorectal cancer or adenomatous polyps in a parent or other first degree relative, particularly when the age of cancer onset is 45 years or less
- Familial adenomatous polyposis
- Lynch syndrome

This policy was effective March 1, 2017.

This procedure isn’t payable in an ambulatory surgical facility or office location.

**Basic benefit and medical policy**

**Genetic testing for FNA of the thyroid**

Mutation analysis in fine needle aspirates of the thyroid is considered to be experimental.

The use of the Afirma gene expression classifier in fine needle aspirates of the thyroid that are cytologically considered to be indeterminate (follicular lesion of undetermined significance or follicular neoplasm) may be established in patients who have the following characteristics:

- Thyroid nodules without strong clinical or radiological findings suggestive of malignancy
- In whom surgical decision-making would be affected by test results
Gene expression classifiers in fine needle aspirates of the thyroid not meeting above outlined criteria are considered experimental.

This policy was effective March 1, 2017.

**Payment policy**

It’s not payable in an office location or ambulatory surgery facility. Modifiers 26 and TC don’t apply.

**Basic benefit and medical policy**

**Laboratory tests for heart transplant rejection**

The safety and effectiveness of gene expression profiling (AlloMap™) have been established for the detection of heart transplant rejection. It may be considered a useful therapeutic option when specified criteria have been met.

The breath test (for example, Heartsbreath™) for the evaluation of heart transplant rejection is considered experimental. The effectiveness and clinical utility of this test haven’t been clearly established.

This policy was effective March 1, 2017.

**Inclusions:**

Gene expression profiling (AlloMap) may be appropriate as a screening technique for heart transplant rejection in recipients who meeting all of the following criteria:

- At least 15 years old
- Six months post-heart transplant and

The recipient must have stable heart allograft function demonstrated by all of the following:

- Left ventricular ejection fraction ≥45 percent that has been confirmed by echocardiogram
- No evidence of congestive heart failure
- No evidence of severe cardiac allograft vasculopathy and

The recipient must have a low probability of moderate or severe acute cellular rejection as demonstrated by the following:

- Clinical assessment (for example, International Society for Heart and Lung Transplantation rejection status Grade of 0R or 1R)
No history or evidence of antibody mediated rejection

Exclusions:

- Gene expression profiling (AlloMap) for any other indication
- Breath testing (e.g., Heartsbreath)

Not payable in an ambulatory surgical facility or office location.

**UPDATES TO PAYABLE PROCEDURES**

**64566 Basic benefit and medical policy**

**Fecal incontinence: Investigational treatments**

The below listed therapies for the treatment of fecal incontinence are experimental. They haven’t been scientifically demonstrated to improve patient clinical outcomes better than conventional treatment. This policy was effective May 1, 2017.

- Transanal radiofrequency therapy
- Perianal electrical stimulation
- Posterior tibial nerve stimulation
- Pudendal nerve terminal motor latency measurement
- Injectable bulking agents
- Topical estrogen
- Autologous myoblast cell injections
- Eclipse system
- Transobturator posterior anal sling
- Magnetic anal sphincter device

**82523, 83518, 86294, 86386, 80300, 80301 Basic benefit and medical policy**

**Payable and non-payable labs**

The following labs are now payable in a doctor’s office:

- 82523
- 83518
- 86294
- 86386

The following labs are no longer payable in a doctor’s office:

- 80300
- 80301

**GROUP BENEFIT CHANGES**

**IBI Group**

Effective June 1, IBI Group, group number 71588, added the following plans.
Physician assistants must re-enroll with Blue Cross, BCN starting October 2017

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

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

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

Regarding dates of service on or after Feb. 1:

- PAs who have re-enrolled by Jan. 31 will be eligible for reimbursement for services within their scope of license either directly or under a group for all lines of business. PAs who have not will have their claims denied.
- PAs may choose to continue to be affiliated with physician groups and bill under the groups. If so, PAs should ensure they indicate the groups’ information when they contract and re-enroll.
- PAs will continue to be reimbursed at 85 percent of the physician fee schedule.
- Current BCN authorization and referral requirements will continue to apply.

Why are Blue Cross and BCN making this change?

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

**How to contract and re-enroll**

Starting Oct. 1, PAs can find and use the Blue Cross and BCN practitioner agreements and enrollment forms on [bcbsm.com](http://bcbsm.com).

For more information about this change from the state of Michigan, click [here](http://bcbsm.com). We’ll also provide additional information in upcoming editions of *The Record* and *BCN Provider News*.

*If you have questions, contact Provider Inquiry or your provider consultant.*

---

**Why do CAHPS<sup>SM</sup> and HOS surveys matter?**

Providing a positive patient experience not only improves patient outcomes, but it also simply makes good business sense.

**What are CAHPS and HOS?**

The **[Consumer Assessment of Healthcare Providers and Systems](http://www.aha.org/cahps)** and **Health Outcomes Survey** are patient-experience surveys developed by the Centers for Medicare & Medicaid Services.

CAHPS and HOS surveys ask patients to rate experiences with their health care providers and health care plan. The questions focus on how patients experienced or perceived key aspects of their care — not how satisfied they were with their care.

The annual surveys are sent to a sampling of Medicare Advantage members by a certified survey vendor.

- **CAHPS measures** members’ satisfaction with their overall health care experience.
  - The survey covers the following areas:
    - Health care in the last six months
    - Personal doctor
    - Getting health care from specialists
    - Health care plan
    - Medicare rights

- **HOS measures** patient-reported health outcomes:
  - It asks a random sampling of Medicare Advantage plan members about their health and the quality of the health care they received.
  - The members are surveyed two years after their experience to determine any changes in their self-reported health status.

**Why are CAHPS and HOS important?**
• A good patient experience is associated with positive clinical outcomes.
  ◦ A good patient experience has a positive effect on processes of care for both prevention and disease management. For example, diabetic patients demonstrate greater self-management skills and quality of life when they report positive interactions with their health care providers.
  ◦ Patients’ positive experiences with care can result in adherence to medical advice and treatment plans. This is especially true for patients with chronic conditions where a strong commitment from patients to work with their physicians is essential to achieving positive results.
  ◦ Patients with better care experiences often have better health outcomes. For example, studies of patients hospitalized for heart attacks showed that patients with positive reports about their care experiences had better health outcomes a year after discharge.
  ◦ Measures of patient experience can reveal important system problems, such as delays in returning tests results and gaps in communication that may have quality, safety and efficiency implications.

• Improving patient experience is good business because it correlates with key financial indicators.
  ◦ A good patient experience is associated with a lower medical malpractice risk. A 2009 study** found that for each drop in scores on a five-point scale of “very good” to “very poor,” the likelihood of a provider being named in a malpractice suit increased by 22 percent.
  ◦ Good patient experience results in greater employee satisfaction and less employee turnover. Patients usually keep or change providers based on their experience — and the quality of their relationship with the provider’s staff is a major predictor of patient loyalty.

What are the CAHPS and HOS questions?

<table>
<thead>
<tr>
<th>Survey name and measure</th>
<th>Survey question to patient</th>
<th>Recommendation to provider where applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAHPS: Annual flu vaccine</td>
<td>Have you had a flu shot since July 1, 2017?</td>
<td>Administer flu shot after July 1, 2017 and before Feb. 1, 2018.</td>
</tr>
<tr>
<td>CAHPS: Getting appointments and care quickly</td>
<td>In the last six months:</td>
<td>• If you’re behind schedule, have the front office staff update patients often and explain why. Patients are more tolerant of delays if they know the reasons.</td>
</tr>
<tr>
<td></td>
<td>• How often did you see the person you came to see within 15 minutes of your appointment time?</td>
<td>• Show respect to the patient if you’re behind schedule and apologize.</td>
</tr>
<tr>
<td></td>
<td>• When you needed care right away, how often did you get care as soon as you thought you needed it?</td>
<td>• Ensure that a few appointments are open each day for urgent visits,</td>
</tr>
<tr>
<td></td>
<td>• Not counting the times when you needed care</td>
<td></td>
</tr>
<tr>
<td>CAHPS: Overall rating of health care quality</td>
<td>Using any number between zero and 10, where zero is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the past six months?</td>
<td>Ask patients how they think you should improve their health care.</td>
</tr>
</tbody>
</table>
| CAHPS: Care coordination | - When you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?  
- When your personal doctor ordered a blood test, X-ray or other test for you, did someone from your personal doctor’s office follow up to give you those results?  
- Did your personal doctor talk to you about all the prescription medicines you were taking?  
- Did you get the help you needed from your personal doctor’s office to manage your care among these different providers and services? | - Before walking in the exam room, read the current complaints and determine if anything needs a follow-up from previous visits.  
- When ordering tests, let your patients know when they can expect results. Implement a system to ensure timely notifications of results.  
- Ask your patients if they saw another provider since you last met with them. If you know patients received specialty care, discuss their visit and if the specialist prescribed any additional medication. |
<table>
<thead>
<tr>
<th>HOS: Improving or maintaining physical health</th>
<th>• How often did your personal doctor seem informed and up to date about specialist care?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• During the past four weeks, has pain stopped you from doing things you want to do?</td>
<td></td>
</tr>
<tr>
<td>• Have you had any of the following problems with your work or other regular daily activities because of your physical health?</td>
<td></td>
</tr>
<tr>
<td>◦ Accomplished less than you would like</td>
<td></td>
</tr>
<tr>
<td>◦ Didn’t do work or other activities as carefully as usual</td>
<td></td>
</tr>
<tr>
<td>• Identify ways to improve the pain problem. Determine if your patient could benefit from a consultation with a pain specialist or rheumatologist.</td>
<td></td>
</tr>
<tr>
<td>• Consider physical therapy, cardiac or pulmonary rehab when appropriate.</td>
<td></td>
</tr>
</tbody>
</table>

| HOS: Improving or maintaining mental health | • During the past 12 months, did: |
|-----------------------------------------------|• You talk with a doctor or other health care provider about your level of exercise of physical activity? |
| • Empathize with the patient. |
| • Consider therapy with a mental health professional when appropriate. |
| • Offer ideas to improve mental health: Take daily walks, socialize, stay involved with family, own a pet, do crossword puzzles, volunteer, participate in a church, go to senior community centers or meditation. |
| • Consider a hearing test when appropriate as loss of hearing can be isolating. |

<p>| HOS: Monitoring physical activity | • Offer physical activity suggestions based on the patient’s ability. |
|---------------------------------|• Offer ideas for where patients can engage in activities such as senior classes at the Area |</p>
<table>
<thead>
<tr>
<th><strong>HOS: Improving bladder control</strong></th>
<th><strong>A doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?</strong></th>
<th><strong>Agency on Aging YMCA and community centers. These also offer opportunities for social interaction.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• In the past six months, have you accidentally leaked urine?</td>
<td>• When talking to patients, note that urinary leakage problems can be common as we grow older, but there are treatments that can help. This opens the conversation if they are too embarrassed to bring it up.</td>
<td></td>
</tr>
<tr>
<td>• How much of a problem, if any, was the urine leakage for you?</td>
<td>• Do they have leakage problems? Discuss potential treatments options, such as medications, exercises and surgery.</td>
<td></td>
</tr>
<tr>
<td>• Have you received other treatments for your current leakage problem?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note that the HOS measure for reducing the risk of falling was temporarily removed and will be put back in the 2019 HOS survey. However, it’s still an important topic to discuss with patients.

Ask patients if they experienced a fall. Many won’t report falls to their doctor in fear of losing their independence. Several medications can be responsible for falls, and dosage changes may be all that is needed.

Some things your patients might do to reduce the risk of falling are:

- Using a cane or walker
- Engaging in an exercise or physical therapy program
- Having a vision or hearing test
- Taking vitamin D


---

**Help patients by ensuring your data is accurate**
Blue Cross Blue Shield of Michigan and Blue Care Network members rely on our online provider directory for accurate, up-to-date provider information. Therefore, each quarter, we’re requesting that you review and confirm your demographic data with us. You can do this by going to the Atlas Systems PRIME-Hub website or submitting your electronic Big Group Audit, or BGA, or physician organization attestation roster to your assigned Provider Data Analytics analyst.

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

When you review and confirm, please pay close attention to:

- Your group or practice name. This should align with how you address patients when they contact your location and the name you do business as.
- Your practice or group locations. Remove or request suppression of administrative locations and group practice locations that aren’t actively seeing patients.
- Practitioner locations. They should be those locations where a specific practitioner provides direct appointments to our members.

If you have questions or need support with updating your data, visit bcbsm.com, call Provider Enrollment at 1-800-822-2761 or contact your provider consultant.

---

**Blue Cross, Blue Care Network no longer cover Evzio, effective Sept. 1**

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

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

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

<table>
<thead>
<tr>
<th>Available naloxone products</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug</strong></td>
</tr>
<tr>
<td><strong>Evzio</strong></td>
</tr>
<tr>
<td><strong>Narcan</strong></td>
</tr>
</tbody>
</table>
**Naloxone** 0.4mg/mL and 1mg/mL injection (vial and syringe) | $50 | Generic copay

**Cost for drug based on the average wholesale price.**

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

---

**Two FEP programs help members manage a chronic condition**

The Blue Cross Blue Shield Federal Employee Program offers programs to encourage members with a reported diagnosis of diabetes or hypertension to make healthier choices to reduce the progression of complications related to diabetes or heart disease.

The Hypertension Management Program provides eligible members 18 and older with a free blood pressure monitor through CVS Caremark. Members are automatically enrolled in the program if they complete the FEP Blue Health Assessment and report a diagnosis of hypertension, and if at least one medical claim has been processed during the past 12 months with a diagnosis of hypertension.

Through the Diabetes Meter Program, members with diabetes can receive, at no cost, one glucometer kit each calendar year. Members will still need to obtain a prescription for test strips and lancets for the new meter from their doctor.

Members with hypertension or diabetes are encouraged to participate in these programs. They are voluntary, free and confidential. The self-monitoring tools provided by these programs support members’ efforts to manage their chronic conditions.

For more information about these and other health care programs offered by the Blue Cross Blue Shield Federal Employee Program, contact FEP Customer Service at 1-800-482-3600 or visit [www.fepblue.org](http://www.fepblue.org).

---

**Facility**

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

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

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

Regarding dates of service on or after Feb. 1:

- PAs who have re-enrolled by Jan. 31 will be eligible for reimbursement for services within their scope of license either directly or under a group for all lines of business. PAs who have not will have their claims denied.
- PAs may choose to continue to be affiliated with physician groups and bill under the groups. If so, PAs should ensure they indicate the groups’ information when they contract and re-enroll.
- PAs will continue to be reimbursed at 85 percent of the physician fee schedule.
- Current BCN authorization and referral requirements will continue to apply.

Why are Blue Cross and BCN making this change?

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

How to contract and re-enroll

Starting Oct. 1, PAs can find and use the Blue Cross and BCN practitioner agreements and enrollment forms on bcbsm.com.

For more information about this change from the state of Michigan, click here. We’ll also provide additional information in upcoming editions of The Record and BCN Provider News.

If you have questions, contact Provider Inquiry or your provider consultant.
Here’s a closer look at enhancements to our process for handling high-cost claims

Blue Cross Blue Shield of Michigan has implemented several enhancements to our current process for handling high-cost claims to better meet the needs of our provider partners and customers. Enhancements include expediting prospective payments and expanding prepayment high-dollar reviews.

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

To help address these challenges, Blue Cross has established a strategic relationship with Equian, an industry leader in prepay solutions. On May 1, 2017, Equian began reviewing certain types of high-cost inpatient claims to detect and resolve errors before payment. Equian’s advanced analytics and service delivery model helps ensure the reviews are completed within five days, using only an itemized bill for input.

Blue Cross has already made several enhancements to the process. For example, the process of identifying outliers for review now occurs weekly versus monthly, since mid-April 2017. And many of the internal processes have been streamlined as well as high-dollar claim approvals. These changes are expected to accelerate the prospective payments by at least four weeks.

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

The enhanced high dollar process:

- Providers will submit their claims as they do today.
- A claim that meets the prepay criteria will pend in our systems.
  - The claims we’ll review are those greater than $25,000, Percent of Charge or DRG Outlier.
- To complete the review and processing of the claim, Blue Cross will request an itemized bill from the provider.
- The provider has 10 days to provide the itemized bill to Blue Cross.
  - If the provider doesn’t respond, the Blue Cross Payment Integrity Unit will follow up with the provider after 10 days.
  - If the provider doesn’t respond within 21 days, they will be contacted by their Blue Cross provider consultant.
- The itemized bill received from the provider is given to Equian for review — the claim is still pending.
- Equian’s review will focus on ensuring claims are billed according to Blue Cross guidelines.
- Equian’s review will be completed within five days and returned to Blue Cross.
• Blue Cross will review Equian’s findings on the claim within five days and determine what, if any, changes will need to be made to the claim and process the claim.
• Equian will send the results to the provider, which is referred to as the Forensic Review Report.

What happens next?

Within 10 days after the review is complete, Equian will follow up with the provider to inquire if they have questions or need clarification on the findings. Equian will also provide contact information. Equian will work to resolve and provide status on items that require further clarification.

Providers have 60 days from the date of claim payment to discuss any questions with Equian. To do this, providers should submit written explanations that substantiate the charges in question, medical record excerpts and any other supporting documentation to Equian in one of two ways:

• Email: reconsiderations@equian.com
• Mail: Equian LLC
  Attention: Reconsiderations
  600 12th St., Suite 300
  Golden, CO 80401

Equian will reply to the reconsideration request within 30 days from the date the request is received.

If there is no resolution between the provider and Equian, the provider can submit a second reconsideration request directly to Blue Cross. The second request must be submitted within 30 days of receipt of Equian’s response to the original reconsideration request.

The provider should submit documentation on the questioned charges, written explanations, medical records and other supporting documentation to Blue Cross by email at BCBSMPre-PayForensicReview@bcbsm.com.

The Blue Cross Payment Integrity Unit will review and respond to the request within 30 days of receipt from the provider.

Where can I get more detail?

On web-DENIS, a detailed look at the entire process will be available. The site contains a list of frequently asked questions, presentations and much more information. To access the documentation:

• Log in as a provider at bcbsm.com.
• Click BCBSM Provider Publications and Resources on the lower right of the page.
• Click Newsletters & Resources in the left navigation.
• Click Provider Training in the left navigation.
• Scroll down to the High-cost claims review process section to find the documents.
You can also read the previous articles in *April Record* and the [March/April issue of Hospital and Physician Update](http://www.bcbsm.com/newsletter/therecord/2017/record_0817/Record_all_articles.shtml).

If you have any questions, contact your provider consultant.

---

### Review, confirm your demographic data

Blue Cross Blue Shield of Michigan and Blue Care Network members rely on our online provider directory for accurate, up-to-date provider information. Therefore, we’re requesting that you review and confirm your demographic data with us throughout the year. The Provider Enrollment and Data Management team will also mail your demographic information to you twice a year and request that you update or confirm it.

If there are any changes or updates to your data, send them to the Provider Enrollment and Data Management team via:

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

If you have questions or need support with updating your data, visit [bcbsm.com](http://www.bcbsm.com), call Provider Enrollment at 1-800-822-2761 or contact your provider consultant.

---

### Pharmacy

#### Blue Cross, Blue Care Network no longer cover Evzio, effective Sept. 1

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

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

The following table includes additional information about Evzio and the covered alternatives.
### Available naloxone products

<table>
<thead>
<tr>
<th>Drug</th>
<th>Strength and formulation</th>
<th>Average cost** (per 2 doses)</th>
<th>Cost to the member as of Sept. 1, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evzio</td>
<td>0.4mg/0.4mL and 2mg/0.4mL injection</td>
<td>$4,900</td>
<td>Full cost (not covered)</td>
</tr>
<tr>
<td>Narcan</td>
<td>4mg nasal spray</td>
<td>$150</td>
<td>Preferred brand copay</td>
</tr>
<tr>
<td>Naloxone</td>
<td>0.4mg/mL and 1mg/mL injection (vial and syringe)</td>
<td>$50</td>
<td>Generic copay</td>
</tr>
</tbody>
</table>

**Cost for drug based on the average wholesale price.

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

---

**DME**

### Remember to follow the medical criteria guidelines when dispensing limb compression devices

If the patient is at high risk for venous thromboembolism prophylaxis, we’ll consider these devices for reimbursement if the following key medical criteria guidelines are met.

**DME providers:**

- Don’t consign and dispense limb compression devices from ambulatory facilities to patients who don’t meet the medical criteria (procedure codes E0650-E0676).
- Never submit claims for equipment or supplies used in ambulatory surgery facilities.
- You **can** bill items provided in an ambulatory facility for the patient’s home use.

**Ambulatory surgical facility providers:**

- Never submit separate claims for DME or prosthetic and orthotic items provided while in your facility. These items are part of your facility fee.
- Items you’ve provided to patients for home use must be billed by the participating DME providers.
Refer to Blue Cross Blue Shield of Michigan medical policy for more details about coverage and medical criteria.

No portion of this publication may be copied without the express written permission of Blue Cross Blue Shield of Michigan, except that BCBSM participating health care providers may make copies for their personal use. In no event may any portion of this publication be copied or reprinted and used for commercial purposes by any party other than BCBSM.

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

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.