Blue Cross complete of Michigan

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CONNECTIONS

January/February 2022

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Drug list resources available for Blue Cross Complete

Drug list details

A comprehensive drug list for Blue Cross Complete is available on our website at **mibluecrosscomplete.com** under the ***Providers*** tab.

1. Click *Self-Service Tools*.
2. Scroll down to *Drug formulary*.
3. The drug list can be accessed and reviewed in two ways:
   - A printable PDF version is available by clicking on the ***Preferred Drug List*** (PDF) link.
   - You can also search by clicking the ***online drug list*** link.

The searchable version provides additional details about quantity limits, prior authorization and other coverage details not available on the printable version. This includes guidance on specialty medications.

The Blue Cross Complete drug list is generic-friendly. There are instances for which the Michigan Department of Health and Human Services mandates that a brand is preferred and must be used. This information can be found at **michigan.magellanrx.com**.*

1. Click *Documents*.
2. Click *Other Drug Information*.
3. Click *Brand Preferred Over Generic Products List*.

Otherwise, if a generic equivalent is available for a brand-name medication, claims processing will require that the generic equivalent be dispensed for the medication to be covered.

When a nonformulary drug or a formulary drug that has a nonpreferred status is inadvertently prescribed, prescribers and pharmacists are encouraged to work together to convert to a preferred drug, when appropriate.

HCPCS codes list

Prior authorization for health care common procedure coding system medications is required before they are covered by Blue Cross Complete. A list of HCPCS codes is available on our website at **mibluecrosscomplete.com** under the ***Providers*** tab.

1. Click *Self-Service Tools*.
2. Scroll down to *Drug formulary* and go to *Health care common procedure coding system medications*.
3. A printable PDF version is available by clicking on ***HCPCS PA List*** (PDF).

Clinical edits

Various clinical edits, including prior authorization, step therapy, quantity limits and age limits are included on the drug list for specific medications. Prior authorization and step therapy criteria are available on the state of Michigan's website at **michigan.gov/mcopharmacy**.*

It's important to remember that plans may be less stringent than the posted criteria for certain medications or non-PDL classes.

Quantity limits and age limits are established for some medications on the drug list. Quantity limits, or dose optimization edits, are typically established in line with approved dosing schedules. If an elevated dose is required above the approved quantity, the prior authorization process should be followed.

Age limits can be established for multiple reasons. Typically, age limits are implemented to reinforce safety protocol or to help refer a member to a more cost-effective dosage form, such as the use of a tablet for an adult rather than a liquid. In the event that a preferred dosage form isn't medically appropriate, the prior authorization process should be used.

As part of the prior authorization process, providers should complete the **Blue Cross Complete Medication Prior Authorization Request** or submit their request online. The online version helps to increase efficiency and, depending on the information provided, the system is able to provide an immediate decision for select medications.

To complete the online form or download the fax form:

1. Visit **mibluecrosscomplete.com**.
2. Click the ***Providers*** tab and click *Self-Service Tools*.
3. Scroll to *Prior authorization* under the *Drug formulary* heading.
4. For the online form, select **Medication prior authorization online form**.
5. For the printable fax form, select the **Medication prior authorization request form (PDF)**.

The online medication prior authorization form allows for paperless and secure data and document submission. If you prefer to use the PDF version, complete and fax it to **1-855-811-9326**. You can also call the PerformRx℠ Provider Services help desk at **1-888-989-0057**.

A prior authorization form must be fully completed and submitted with all appropriate documentation that may help us process the request. For example, you must include medical history, previous therapies tried and additional rationale. Incomplete forms or missing documentation may delay or prevent a request from being processed.

*Our website is **mibluecrosscomplete.com**. While website addresses for other organizations are provided for reference, Blue Cross Complete does not control these sites and is not responsible for their content.

Drug list resources available for Blue Cross Complete (continued)

Electronic prescribing

Beginning January 1, 2023, Michigan prescribers will be required to electronically transmit all prescriptions for controlled and non-controlled substance medications to pharmacies. Originally set for October 1, 2021, the Michigan Department of Licensing and Regulatory Affairs moved the deadline to align the state's e-prescribing requirement with the Centers for Medicare & Medicaid Services' similar requirement, pursuant to authority provided in **MCL 333.17754a(10)*** and per Public Acts **134***, **135*** and **136*** of 2020.

Although October 1, 2021, marked the implementation date for the federal requirement, CMS won't begin enforcing compliance with the rule until January 1, 2023. As of this date, prescribers who aren't compliant will be penalized. For more specific information about the Michigan EPCS ruling, see **Section 17754a of the Public Health Code***, as well as **Senate Bill 248*** and Senate **Bill 254*** from the Michigan Legislature, which detail the electronic prescribing requirements and exemptions.

Drug list changes

Drug list changes approved by the Common Formulary Workgroup, the MDHHS Fee-For-Service Pharmacy & Therapeutics Committee or the AmeriHealth Caritas Pharmacy & Therapeutics Committee are available by doing the following:

1. Visit **mibluecrosscomplete.com**
2. Click the *Provider programs* tab.
3. Scroll to the bottom of the page to the *Pharmacy* accordion under *Program overviews* and select ***Current Formulary Changes*** (PDF).

Depending on the type of drug list change, various forms of communication may be used.

Communication strategies may include letters, fax blasts, web documents and provider portal posts. Any necessary communication will be completed as early as possible prior to the implementation of a change. Most direct communications will be the result of a negative drug list change, such as the removal of a medication from the drug list or the addition of a clinical edit. You can anticipate that changes will occur at least quarterly. Additional changes may occur throughout the year to address population need changes or to accommodate new FDA-approved medications or indications.

Medical exception process

In the event that a nonpreferred or nonformulary drug is most appropriate for the member, the prior authorization process allows for a potential coverage consideration. As required, all formulary drugs listed on the Blue Cross Complete drug list are represented on the *Michigan Pharmaceutical Product* List for fee-for-service Medicaid. Although not all medications from the list are included on the plan's formulary, all medications on the MPPL must be considered for coverage under the pharmacy benefit. As with some nonpreferred formulary drugs, nonformulary drugs covered on the MPPL may be available through the prior authorization process.

Typically, if drug list criteria have been met and the preferred formulary drugs have failed or aren't medically appropriate, then a nonpreferred or nonformulary drug may be considered for coverage. Again, all supporting documentation must be submitted for us to consider covering a nonpreferred or nonformulary drug.

Carve-out medications

The state of Michigan has carved out a portion of the Blue Cross Complete pharmacy benefit. The medications listed below are covered under the fee-for-service portion of the benefit.

- Anti-anxiety
- Antidepressants
- Anti-epileptics
- Anti-hemophilic factors
- Anti-retrovirals for the treatment of HIV
- Antivirals for hepatitis C treatment
- Barbiturates
- Cystic fibrosis transmembrane conductance regulator agents

Note: Instead of billing Blue Cross Complete for the medications, the pharmacy must bill fee-for-service Medicaid, also known as the Magellan Medicaid Administration. Pharmacies will be alerted in a reject message if they submit a claim to Blue Cross Complete for a carve-out medication. For claims questions associated with these medications, contact the Magellan Medicaid Administration clinical call center at **1-877-864-9014**.

You can also find additional information on the state of Michigan's fee-for-service drug coverage at **michigan.magellanrx.com**.*

Out-of-pocket cost — pharmacy benefit

To prevent a potential barrier with medication affordability, Blue Cross Complete members don't have copayments at the pharmacy. Healthy Michigan Plan members are the only group with an out-of-pocket cost requirement. The copay tier is established by MDHHS and cost is reconciled through the member's MI Health account. More information can be found by visiting **michigan.gov/healthymiplan**.*

If you have any questions, contact your Blue Cross Complete provider account executive, Blue Cross Complete's Provider Inquiry department at **1-888-312-5713** or the Blue Cross Complete pharmacy help desk at **1-888-288-3231**.

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Prior Authorization Lookup tool available on Blue Cross Complete website

Confirming authorization requirements is as simple as entering a current procedural terminology code or a health care common procedure coding system code and clicking *submit* using Blue Cross Complete's Prior Authorization Lookup tool. This user-friendly resource allows users to enter a CPT or HCPCS code to verify authorization requirements in real time before delivery of service.

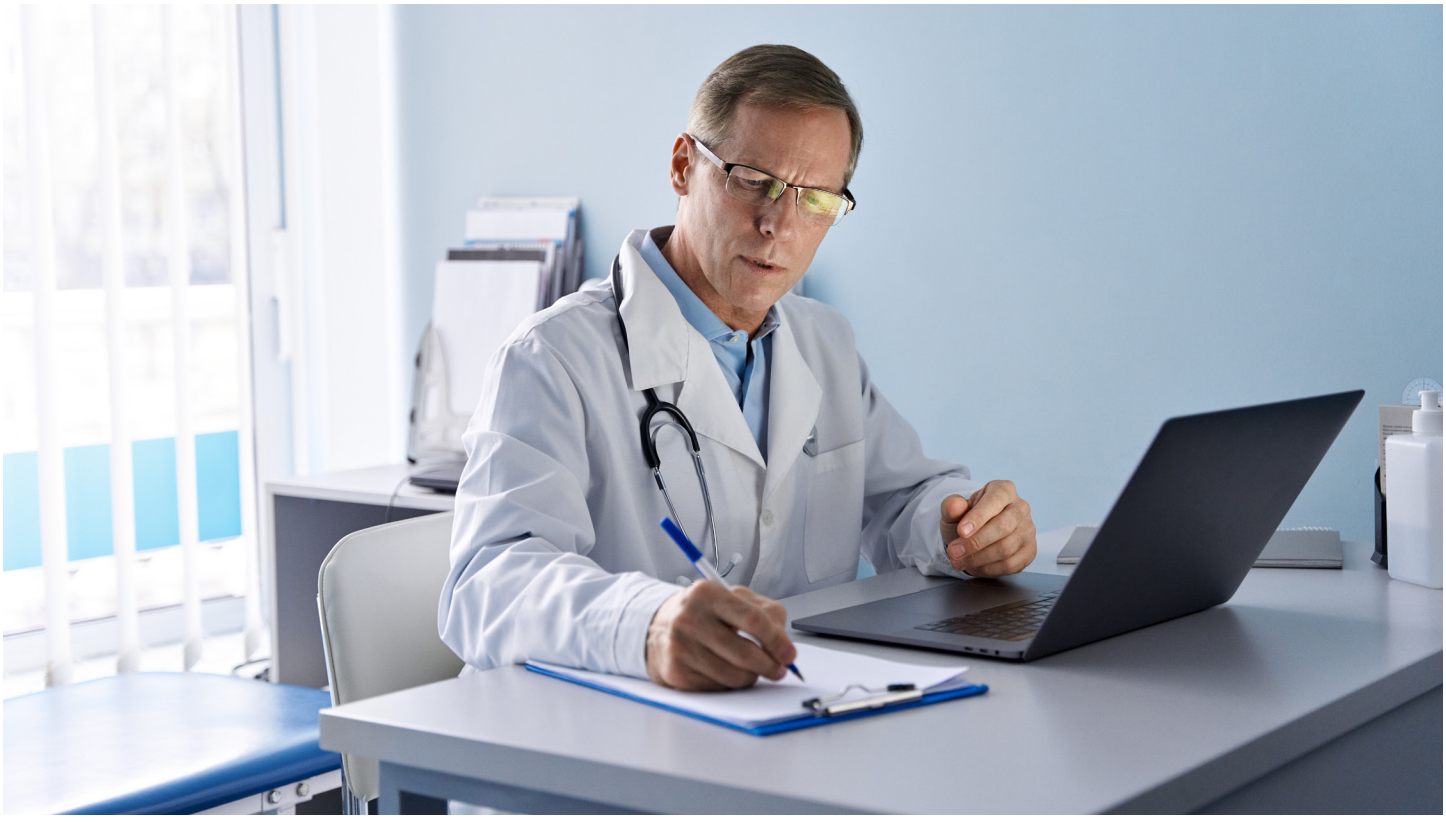
The Prior Authorization Lookup tool was designed to help reduce the administrative burden of calling Provider Services to determine whether prior authorization is required. The tool is easy to use and offers general information for outpatient services performed by a participating provider.

To try the Prior Authorization Lookup tool, visit mibluecrosscomplete.com and go to the *Providers* tab.

1. Click on *Self-Service Tools*.
2. Scroll down to *Prior Authorization Lookup*.
3. Enter a CPT or HCPCS code in the space provided.
4. Click *Submit*.
5. The tool will tell you if that service needs prior authorization.

Prior authorization requests **can't** be submitted through the tool and should continue to be requested through your current process. You can submit your requests electronically through NaviNet. Through your single login to NaviNet, you can request prior authorization and view authorization history. If you aren't already a NaviNet user, visit **Navinet.net*** to register.

If you have questions, please contact your Blue Cross Complete provider account executive or Blue Cross Complete Provider Inquiry at 1-888-312-5713.



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Practitioner rights

Providers contracted with Blue Cross Complete have rights. Understanding these rights helps clarify roles and responsibilities. In accordance with legal requirements and upon written request, Blue Cross Complete practitioners or prospective practitioners are given the opportunity to:

- Review credentialing application forms from the practitioner requesting participation to Blue Cross Complete.
- Review Blue Cross Complete's credentialing policies and procedures.
- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This doesn't include information collected from references, recommendations and other peer-review protected information. Either attest to the accuracy of that information or correct the information, if erroneous.
- Be notified if any credential information is received that varies substantially from application information submitted by the practitioner: actions on license; malpractice claim history; suspension or termination of hospital privileges; or board-certification decisions with the exception of reference, recommendations or other peer-review protected information. The practitioner will have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his or her application.
- Upon request, be informed of the status of the application — if application is current and complete, the applicant can be informed of the tentative date that his or her application will be presented to the credentialing committee for approval.

Practitioners or prospective practitioners must submit a written request to review information submitted in support of their credentialing or recredentialing application to:

- **Email: bccproviderdata@mibluecrosscomplete.com**
- **Fax: 1-855-306-9762**
- **Mail:**
  Blue Cross Complete of Michigan
  Attn: Provider Network Operations
  Suite 1300
  4000 Town Center
  Southfield, MI 48075

A two-week notice is required for scheduling a review date and time.

The practitioner is informed in writing of the dates and times available for the review.

Upon receipt of the practitioner's response, the date and time of the scheduled review are confirmed in writing.

If you have any questions, contact your Blue Cross Complete provider account executive or call Provider Inquiry at 1-888-312-5713.

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Learn more about Blue Cross Complete member rights and responsibilities

Members of Blue Cross Complete have rights and responsibilities. Understanding these rights and responsibilities helps members get the most out of their health care benefits.

Member rights

Member rights will be honored by all Blue Cross Complete staff and affiliated providers. Members have the right to:

- Understand information about their health care
- Get required care as described in the ***member handbook***
- Be treated with dignity and respect
- Receive Culturally and Linguistically Appropriate Services, or CLAS
- Privacy of their health care information, as outlined in the ***member handbook***
- Treatment choices, regardless of cost or benefit coverage
- Full participation in making decisions about their health care
- Refuse treatment
- Voice complaints, grievances or appeals about Blue Cross Complete and its services, benefits, providers and care
- Get clear and easy-to-understand written information about Blue Cross Complete's services, practitioners, providers and rights and responsibilities
- Review their medical records and ask that they be corrected or amended
- Make suggestions about Blue Cross Complete's rights and responsibilities policies
- Be free from any form of abuse, being restrained or secluded, as a means of coercion, discipline, convenience or retaliation when receiving services
- Receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand
- Request and receive:
  - The *Blue Cross Complete provider directory*
  - The professional education of their providers, including those who are board certified in the specialty of pain medicine for evaluation and treatment
  - The names of hospitals where their physicians are able to treat them
  - The contact information for the state agency that oversees complaints or corrective actions against a provider
  - Any authorization, requirements, restrictions or exclusions by service, benefit or a specific drug
  - The information about the financial agreements between Blue Cross Complete and a participating provider

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Learn more about Blue Cross Complete member rights and responsibilities (continued)

Member responsibilities

Members have the responsibility to:

- Know their *Certificate of Coverage* from Blue Cross Complete
- Know the contents of the ***member handbook*** and all other provided materials
- Call Customer Service with any questions at **1-800-228-8554**
- Seek services for all non-emergency care through their primary care provider
- Use the Blue Cross Complete provider network
- Be referred and approved by Blue Cross Complete and their primary care provider for out-of-network services
- Make and keep appointments with their primary care provider
- Contact their doctor's office if they need to cancel an appointment
- Be involved in decisions about their health
- Behave in a proper and considerate manner toward providers, their staff, other patients and Blue Cross Complete staff
- Tell Blue Cross Complete of address changes, any changes for their dependent coverage and any other health coverage
- Protect their ID card against misuse
- Call Customer Service right away if their card is lost or stolen
- Follow their doctor's instructions regarding care
- Make treatment goals with their physician
- Contact the Blue Cross Complete antifraud unit if they suspect fraud

Additional rights and responsibilities

In addition to these rights and responsibilities, members also have the right to:

- Ask for and get information about how our company is structured and operated
- Have their health information stay confidential
- Use their rights without changing the way they're treated by us, health care providers or the state of Michigan
- Ask for the professional credentials of their provider
- Ask for any prior authorization requirements, limits, restrictions or exclusions
- Ask about the financial responsibility between Blue Cross Complete and any network provider
- Know if there are any provider incentives, such as pay for performance
- Ask about stop loss coverage

Members also have the responsibility to tell their doctor and Blue Cross Complete about their health and health history.

If you have any questions, contact your Blue Cross Complete provider account executive or Blue Cross Complete's Provider Inquiry department at 1-888-312-5713.

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Blue Cross Complete offers language assistance

Blue Cross Complete serves a diverse population. As a result, providers may see patients who don't speak English or have limited English proficiency. Almost 7% of our members speak a different language, such as Spanish, Arabic, Chinese, Bengali or other less common languages. To help ensure information is accurately reported and understood, Blue Cross Complete offers certified translation and interpretive services in more than 200 languages.

These services include:

- Interpreting conversations with providers or health care staff
- Translating health care plan documents
- Getting plan documents in different formats

For language assistance, providers and members can call Customer Service at **1-800-228-8554**.

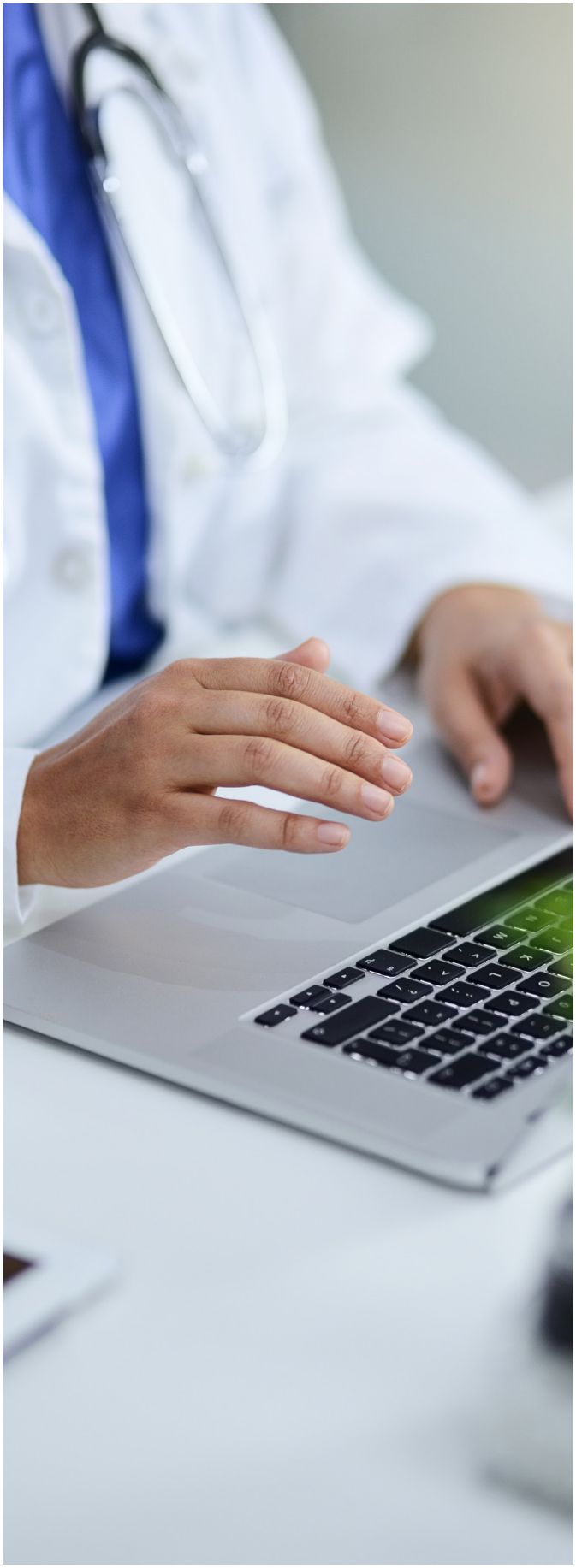
To learn more about the culture and demographics in Michigan, visit **Data USA***:

- Click *Cities & Places*.
- In the search bar, type in "Michigan."
- In the results, select Michigan (state).
- Categories include:
  - Diversity
  - COVID-19
  - Economy
  - Civics
  - Education
  - Housing & Living
  - Health

Continuous cultural competency training and education is a critical component in helping providers reduce health disparities. Blue Cross Complete understands the importance of enhancing awareness of social and cultural factors that influence the delivery of care. For more resources, visit **mibluecrosscomplete.com**:

- Click the *Providers* tab.
- Click *Training*.
- Scroll down to ***Cultural diversity training***.
  - ***Cultural awareness and responsiveness training opportunities***
    - ***Blue Cross Complete's Culturally and Linguistically Appropriate Services training***
  - **Lesbian, gay, bisexual, transgender, queer, intersex, asexual cultural competency training opportunities**

If you have any questions, contact your Blue Cross Complete provider account executive or Blue Cross Complete Provider Inquiry at 1-888-312-5713.



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Refer patients to our Integrated Health Care Management program

Blue Cross Complete offers an Integrated Health Care Management program that provides a population health strategy for comprehensive disease management and complex case management. These services focus on proactive medical care coordination, support and assistance to members with medical, behavioral and social issues that affect their quality of life and their health outcomes.

Blue Cross Complete members are eligible for the program if they have specific health risks due to complex health conditions, require a high level of care coordination and typically access medical services from multiple providers' sites. Members with the following identified issues or diagnoses may be referred to the program:

- Asthma
- Cancer
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Depression management
- Diabetes
- Ischemic heart disease
- Kidney management
- Pregnancy — high risk
- Sickle cell anemia
- Transplants — bone marrow and human organ

Note: This list isn't all-inclusive.

Both adult and pediatric members are eligible for IHCM and are automatically enrolled unless they choose to opt out. The program is designed to help members understand their condition and achieve and maintain control of their disease. Collaboration is an essential component of process, as success increases when everyone involved is in agreement. Our care managers will seek input from you for the care plan, potential interventions and goals. We'll also contact other appropriate members of the treatment team, including behavioral health providers, if applicable.

The following specific objectives direct our activities:

- Ensure members have access to the appropriate health care services, health plan benefits and community resources
- Improve the health outcome measures of our members (as reflected by the **HEDIS®*** scores)
- Decrease the burden of disease complication through early identification and intervention
- Improve member self-management by providing education and self-management tools
- Increase member compliance with treatment plans through education about the disease process through self-monitoring interventions
- Improve the member's functional status and quality of life
- Coordinate and facilitate health care services
- Assist in communication with the member's primary care provider
- Promote evidence-based treatment guidelines
- Encourage participation in our **Tobacco Quit Program**, as applicable, at no cost to the member

Some of the interventions provided by our nurse case managers include:

- **Coordination of care:** We help make sure the member is seeing his or her primary care provider. We also assist with referrals to specialists and make sure the primary care provider is aware of other care the member is receiving (for example, specialists or emergency room).
- **Patient education:** We make sure the member understands the disease and treatment regimen.
- **Self-management:** We provide guidance that motivates the member toward compliance and self-management.

How to refer members to the Integrated Health Care Management program

Providers can directly refer members that agree to ICHM for disease, case and complex case management services by calling **1-888-288-1722**.

When calling to make a referral, providers should have the following information available:

- Member's name, date of birth and enrollee ID number
- Member's address and current phone number
- Reason for member referral
- Name of contact person at the provider's office
- Provider phone and fax numbers
- Specify if provider's office prefers to be contacted by phone or fax with follow-up on member outreach activities

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Refer patients to our Integrated Health Care Management program (continued)

Disease management programs

Blue Cross Complete also offers several disease-specific management programs with interventions ranging from one-on-one nurse interaction for high-risk members to periodic educational mailings for low-risk members. The goal of our disease-specific management programs is to improve the quality of life for members by providing risk-appropriate case management and education services with a special emphasis on promoting self-management.

When calling to make a referral, providers should have the following information available:

- **Asthma:** The asthma management program is for members of all ages. We especially promote member compliance with controller medications. Our program is based on current asthma practice guidelines from the **National Heart Lung and Blood Institute**.*
- **Diabetes:** The diabetes management program is for members of all ages. The goal is to prevent or reduce long-term complications. Our program is based on current diabetes practice guidelines from the **American Diabetes Association**.*
- **Cardiovascular disease:** The heart failure management program emphasizes self-management interventions, such as daily weight measurements and medication compliance. Our program is based on current **heart failure guidelines from the American College of Cardiology Foundation and the American Heart Association**.*

Note: This list isn't all-inclusive.

Complex care management

This program targets members with complex medical conditions that could include multiple comorbidities or a single serious diagnosis, such as HIV or cancer. Our nurses work one on one with these patients to meet their care needs.

Maternity management (Bright Start®)

This program targets pregnant members who have high-risk medical or social determinants of health needs.

We welcome your referrals of members with Blue Cross Complete that you feel would benefit from our programs. Call us at **1-888-288-1722**, and we'll reach out to the member to design a specific care plan.

Provider rights and responsibilities when members receive complex case management services

Providers treating members who are participating in Blue Cross Complete's Integrated Health Care Management program have the right to:

- Obtain information about Blue Cross Complete, including its programs and services, its staff and its staff qualifications
- Be informed about how Blue Cross Complete coordinates the interventions and plan of care for individual members
- Know how to contact the care manager responsible for managing the case and for communicating with the provider's patients
- Be supported by Blue Cross Complete and work collaboratively in decision-making with members regarding their plan of care
- Receive courteous and respectful treatment from Blue Cross Complete staff and know how to communicate complaints to Blue Cross Complete

Providers are responsible for participating in a member's integrated care management program by:

- Providing relevant clinical information as requested
- Taking action to follow up on reported information
- Participating in the member's plan of care

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

Bright Start is a registered trademark of AmeriHealth Caritas.

Transition of care

Members receiving services from a provider prior to enrollment with Blue Cross Complete are able to continue receiving services for 90 days. This may also include certain prescriptions without prior authorizations. Members must have a relationship with a specialist, primary care provider or other covered provider prior to enrolling with Blue Cross Complete to establish continuity of care. For more information, view Blue Cross Complete's **Transition of care requirements** at **mibluecrosscomplete.com**.

Clinical practice and preventive care guidelines

Blue Cross Complete promotes the development, approval, implementation, monitoring and revision of uniform evidence-based clinical practice and preventive care guidelines for practitioners. Such guidelines promote the delivery of quality care and reduce variability in physician practice.

Evidence-based guidelines are nationally known to be effective in improving health care outcomes. Blue Cross Complete endorses the clinical proactive and preventive care guidelines developed by the Michigan Quality Improvement Consortium and uses Change Healthcare's InterQual® criteria to make utilization management determinations regarding bariatric surgery.

Our quality improvement program encourages Blue Cross Complete's adherence to clinical practice and preventive care guidelines. Ongoing monitoring of compliance is conducted through medical record reviews and quality studies. Approved clinical practice guidelines are available to all Blue Cross Complete primary care providers, primary care groups and specialists.

Guidelines and updates are accessible to all providers at **mibluecrosscomplete.com** in the provider section under *Resources*. Blue Cross Complete also distributes clinical practice guidelines to members and prospective members upon request. Blue Cross Complete will mail clinical practice guidelines to those who don't have fax, email or internet access. The MQIC guidelines can be accessed by visiting **mqic.org*** and clicking on *Current guidelines*.

In addition to the MQIC and InterQual guidelines, Blue Cross Complete maintains internal guidelines regarding the diagnosis and management of the following:

- Abdominoplasty
- Anesthesia services for gastrointestinal endoscopy
- Chronic obstructive pulmonary disease or COPD
- Orthognathic surgery

These guidelines can be accessed at **mibluecrosscomplete.com**; go to *Providers*, click *Resources* and scroll down to ***Clinical resources***.

More information about the guidelines can be found in Section 3 of **Blue Cross Complete's Provider Manual**. At **mibluecrosscomplete.com**, click *Providers* and then *Provider Programs*.

If you have any questions, contact your Blue Cross Complete provider account executive or call Provider Inquiry at 1-888-312-5713.

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MDHHS tips for Healthy Michigan Plan and completing HRA

The Michigan Department of Health and Human Services has developed four short videos for providers with tips and best practices to primary care offices on the Healthy Michigan Plan Health Risk Assessment and the Healthy Behaviors Incentives Program.

Produced in partnership with Michigan State University Institute for Health Policy, Michigan Public Health Institute and the Michigan State Medical Society, the videos demonstrate how to successfully complete the HRA online to facilitate in-person or telehealth visits.

1. **Healthy Michigan Plan Healthy Behaviors Incentives Program and COVID-19***

   Overview of how the Healthy Michigan Plan Healthy Behaviors Incentives Program can assist with managing risk factors which may contribute to a more severe COVID-19 infection, best practices for participating in the program through telehealth, and how the HMP HRA can assist with screening for social determinants of health. For more information, please visit **Michigan.gov/HealthyMichiganPlan* and Michigan.gov/Coronavirus**.*

2. **Completing the Health Risk Assessment***

   An introduction to the HMP HRA and a step-by-step guide for providers to completing the HRA, including all four sections and the primary care provider attestation.

3. **Submitting the Health Risk Assessment***

   This video provides suggestions for integrating the HMP HRA into clinic workflow and how to submit the form once it is completed.

4. **Overview Healthy Behaviors Incentive Program***

   This video is an overview of the Healthy Michigan Plan Healthy Behaviors Incentive Program, which includes the HMP HRA, Preventive Services and Wellness Programs.

For more information, visit the Healthy Michigan Plan website at Michigan.gov/HealthyMichiganPlan.*

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Importance of reducing low birth weight

For a newborn, every ounce of weight matters. According to the **March of Dimes**,* weighing less than 5 pounds, 8 ounces at birth may lead to a lifetime of health complications. A low birth weight baby may have difficulty breathing or fighting off infections. Later in life, they're also more likely to have intellectual and developmental disabilities and long-term health problems such as diabetes and heart disease. Communities of color disproportionately affected by racism are at increased risk of pregnancy complications. The Michigan Department of Health and Human Services has identified low birth weight as a statewide **health disparity**.* African-American women living in **Detroit*** have higher rates for low birth weight than state and **national averages**.*

Blue Cross Complete reminds OB-GYN providers who serve Michigan women they can help improve low birth weight outcomes and eliminate health disparities in maternal and infant health. Encourage members who are or may be pregnant to **schedule a prenatal visit during their first three months of pregnancy**, or within 42 days of enrolling with Blue Cross Complete.

Once the baby arrives, members should **schedule their postpartum visit within seven to 84 days after delivery**. If members need a ride to appointments, they can make arrangements with Blue Cross Complete's transportation provider, ModivCare, at **1-888-803-4947**. TTY users should call **711**.

Smoking

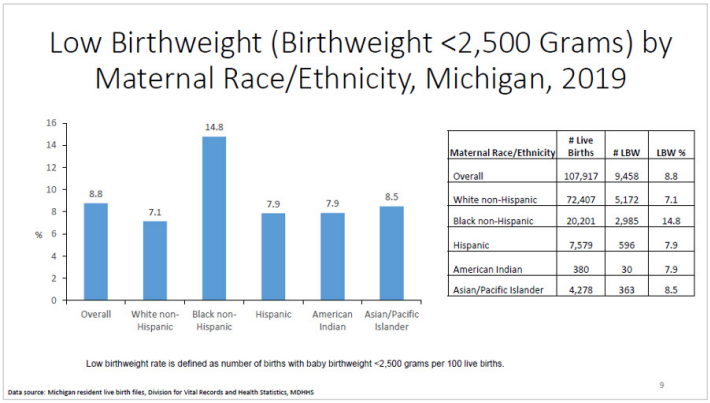
Smoking during pregnancy significantly increases the risk of having a preterm birth or a low birth weight baby. According to the Centers for Disease Control and Prevention, one out of every five babies born to mothers who smoke — including e-cigarettes and marijuana — is born too small or too early. A woman who smokes while pregnant is also more likely to have a pregnancy outside the womb, which usually results in a miscarriage. What's more, smoking after the baby is born increases the baby's risk for asthma and sudden infant death syndrome.

If you have a patient who smokes, quitting will help no matter what stage of family planning a member is in. Blue Cross Complete has a confidential, no-cost Tobacco Quit program with special resources for pregnant women. This includes nine counseling calls, a dedicated female quit coach and rewards for sticking with smoking cessation appointments. Encourage eligible members to enroll by calling the Tobacco Quitline at **1-800-QUIT-NOW (784-8669)**, 24 hours day, seven days a week.

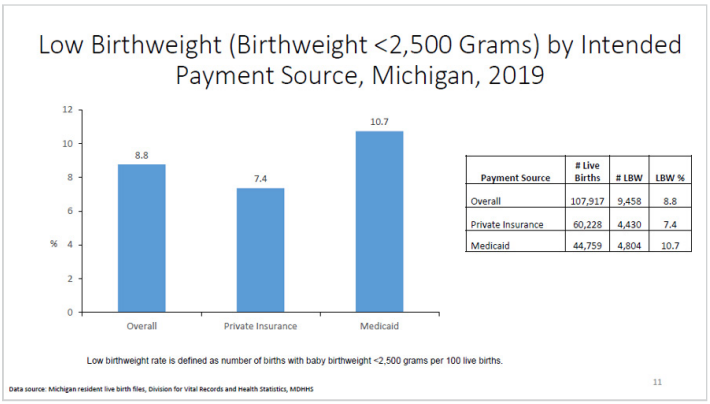
Drug benefits include over-the-counter and prescription medicines. See the Pharmacy Services section of Blue Cross Complete's ***Provider Manual*** for additional coverage information. For more information, call Blue Cross Complete's Provider Inquiry department at **1-888-312-5713**.

Community Resource Hub

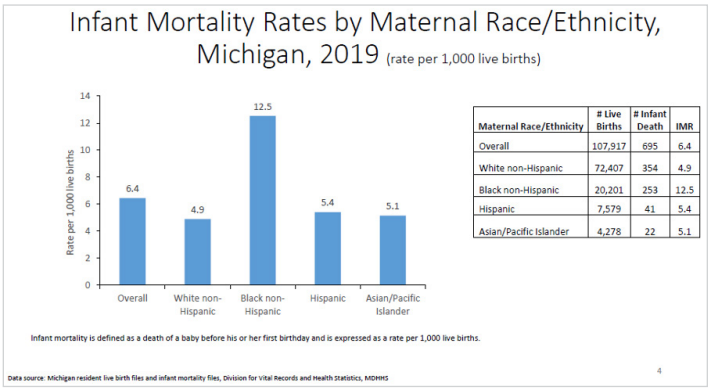
Blue Cross Complete can connect pregnant members to food, housing, utilities, clothing, behavioral health services, ride services, resources for alcohol misuse and more. If your member needs immediate assistance, call our Rapid Response and Outreach Team at **1-888-288-1722**. TTY users should call **1-888-987-5832**. RROT is available from 8 a.m. to 5:30 p.m., Monday through Friday. More resources are available through our ***Community Resource Hub*** at **mibluecrosscomplete.com/resources**. Users can enter a ZIP code and select the category that fits their need.



Maternal Race/Ethnicity	# Live Births	# LBW	LBW %
Overall	107,917	9,458	8.8
White non-Hispanic	72,407	5,172	7.1
Black non-Hispanic	20,201	2,985	14.8
Hispanic	7,579	596	7.9
American Indian	380	30	7.9
Asian/Pacific Islander	4,278	363	8.5



Payment Source	# Live Births	# LBW	LBW %
Overall	107,917	9,458	8.8
Private Insurance	60,228	4,430	7.4
Medicaid	44,759	4,804	10.7



Maternal Race/Ethnicity	# Live Births	# Infant Death	IMR
Overall	107,917	695	6.4
White non-Hispanic	72,407	354	4.9
Black non-Hispanic	20,201	253	12.5
Hispanic	7,579	41	5.4
Asian/Pacific Islander	4,278	22	5.1

*Our website is **mibluecrosscomplete.com**. While website addresses for other organizations are provided for reference, Blue Cross Complete does not control these sites and is not responsible for their content.

Utilization management

Blue Cross Complete utilization management contact information

Providers and members can contact Blue Cross Complete about utilization management issues, such as plan notification or authorization requests, using one of the following methods.

- Call utilization management at **1-888-312-5713 (press 1, then 4)** from 8 a.m. to 5 p.m., Monday through Friday.
- For urgent or emergency requests outside of the above listed normal business hours and on weekends and holidays, call **1-888-312-5713 (press 1, then 4)** but request an urgent review with the reviewer on call.
- Telecommunications devices for the deaf/text telephone services are available for the hearing impaired by calling **1-888-765-9586**.

Certified translation services are available to all Blue Cross Complete providers and eligible members whose primary language isn't English or who have limited English proficiency or low literacy proficiency.

Translation and interpretive services are available in more than 200 languages. Call **1-800-228-8554** to:

- Obtain immediate services over the phone.
- Schedule an appointment for services to be delivered. Let our staff know if you need the services over the phone or in person.
- For TTY services, call **1-888-987-5832**.

For more information, contact your Blue Cross Complete provider account executive or call Provider Inquiry at **1-888-312-5713**.

Availability of criteria for Blue Cross Complete utilization management determinations

Criteria used for utilization management determinations are available upon request to all Blue Cross Complete practitioners, providers and members free of charge.

Members, practitioners and providers are made aware of the availability of review criteria and how to obtain clinical criteria used for a utilization management determination through the *Provider Manual* and member handbook and written utilization management determination letters. Upon request, Blue Cross Complete personnel will fax a copy of the criteria used in the review. Blue Cross Complete will mail criteria to those who don't have fax, email or internet access.

To request criteria, contact Blue Cross Complete at **1-888-312-5713**. TTY users should call **1-888-765-9586**.

Providers can request criteria for utilization management decisions

Blue Cross Complete's utilization management department responds to authorization requests in accordance with the following guidelines:

- Decision-making related to authorization requests is based only on the existence of coverage and appropriateness of the care and service.
- Practitioners and other individuals aren't rewarded for issuing denials of coverage.
- Decision-makers for authorization requests don't receive financial incentives for decisions that result in underutilization.

Providers have the right to request the information used to make a decision. This includes benefit guidelines and other criteria. Blue Cross Complete will mail guidelines and criteria to those who don't have fax, email or internet access. To request this information, providers should call utilization management or write the appeals coordinator at the following address:

Appeals Coordinator
Blue Cross Complete of Michigan
P.O. Box 41789
Charleston, SC 29423

If you have any questions, contact your Blue Cross Complete provider account executive or Blue Cross Complete's Provider Inquiry department at **1-888-312-5713**.

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Review criteria used for Blue Cross Complete utilization management determinations

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Help us keep the Blue Cross Complete provider directory up to date

Accurate provider directory information is critical to ensuring members can easily access their health care services. Please confirm the accuracy of your information in our online provider directory so our members have up-to-date resources. Some of the key items in the directory are:

- Provider name
- Phone number
- Office hours
- Hospital affiliations
- Address
- Fax number
- Open status
- Multiple locations

To view your provider information, visit **mibluecrosscomplete.com**, then click the ***Find a doctor*** tab and search your provider name. If any changes are necessary, you must submit them in writing using Blue Cross Complete's *Provider Change Form* also at **mibluecrosscomplete.com**. Go to the ***Providers*** tab, click ***Forms*** and then click ***Provider Change Form***.

Send completed forms by:

- Email: **bccproviderdata@mibluecrosscomplete.com**
- Fax: **1-855-306-9762**
- Mail:
  Blue Cross Complete of Michigan
  Provider Network Operations
  Suite 1300
  4000 Town Center
  Southfield, MI 48075

You must also make these changes with NaviNet.* Call NaviNet at 1-888-482-8057 or email support@navinet.net. If you have any questions, contact your Blue Cross Complete provider account executive.

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***NaviNet** is a contracted vendor that provides a payer-provider web portal on behalf of Blue Cross Complete through which member information can be accessed including but not limited to tracking claims status.

Reporting suspected fraud to Blue Cross Complete

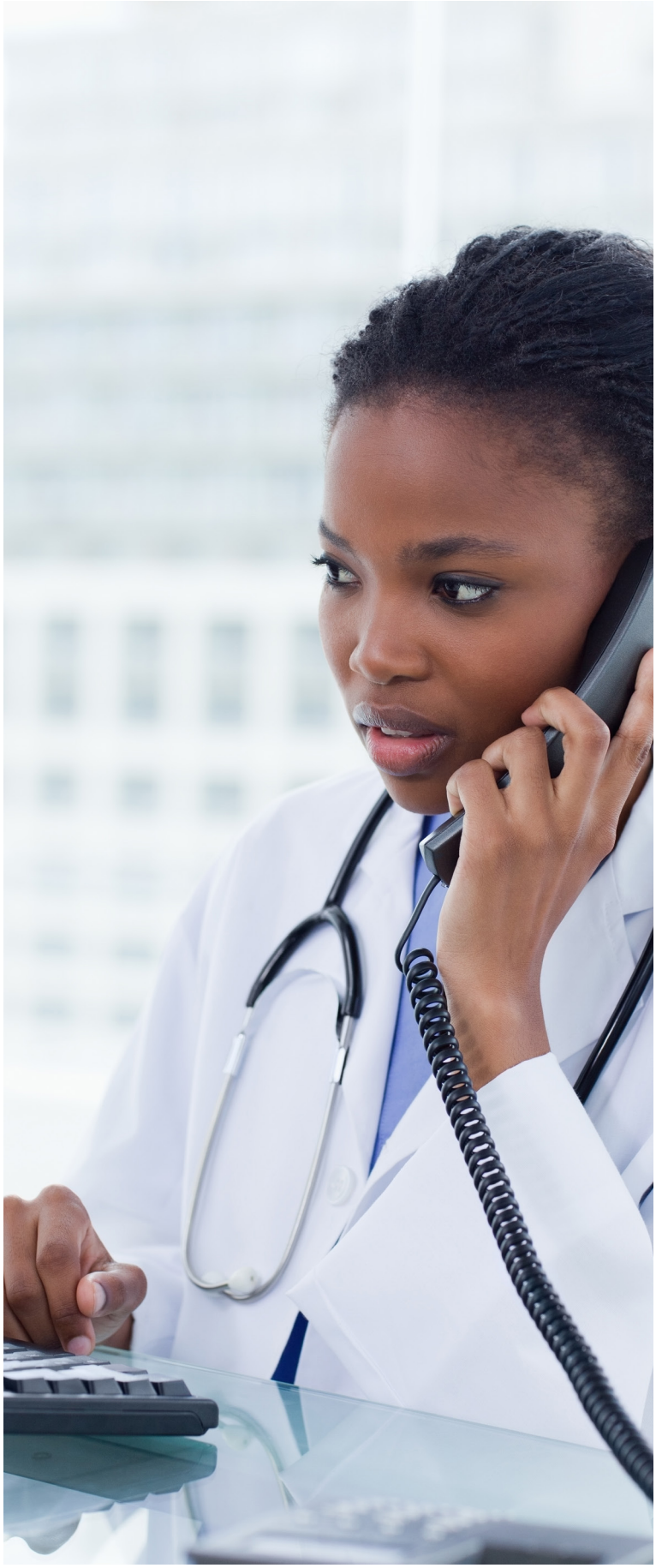
If you suspect another Blue Cross Complete provider, employee or member is committing fraud, notify Blue Cross Complete's Special Investigations Unit:

- Phone: **1-855-232-7640 (TTY 711)**
- Fax: **1-215-937-5303**
- Email: **fraudtip@mibluecrosscomplete.com**
- Mail:
  Blue Cross Complete
  Special Investigations Unit
  P.O. Box 018
  Essington, PA 19029

Blue Cross Complete's Special Investigations Unit supports local and state authorities in investigating and prosecuting fraud. You can also report suspected fraud related to Blue Cross Complete to the Michigan Department of Health and Human Services Office of Inspector General in one of the following ways:

- Website: **michigan.gov/fraud**
- Phone: **1-855-643-7283**
- Mail:
  Office of Inspector General
  P.O. Box 30062
  Lansing, MI 48909

You can make reports anonymously.



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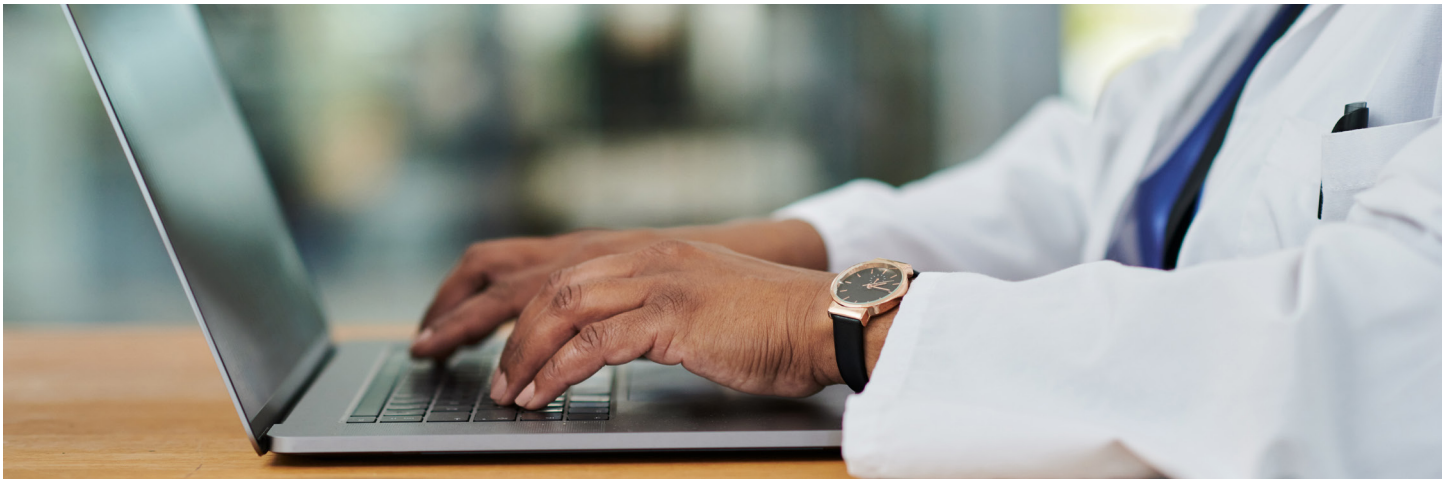

Keep medical records up to date for your patients

Providers are required to maintain accurate and timely medical records for Blue Cross Complete members for at least 10 years in accordance with all federal and state laws. Providers must also ensure the confidentiality of those records and allow access medical records by authorized Blue Cross Complete representatives, peer reviewers and government representatives within 30 business days of the request at no charge.

As a reminder, medical records must include, at a minimum:

A. A record of outpatient and emergency care

B. Specialist referrals

C. Ancillary care

D. Diagnostic test findings, including all laboratory and radiology

E. Therapeutic services

F. Prescriptions for medications

G. Inpatient discharge summaries

H. Histories and physicals

I. Allergies and adverse reactions

J. Problem list

K. Immunization records

L. Documentation of clinical findings and evaluations for each visit

M. Preventive services-risk screening

N. Other documentation sufficient to fully disclose the quantity, quality, appropriateness and timeliness of services provided

Medical records must be signed, dated and maintained in a detailed, comprehensive manner that conforms to professional medical practice, permits effective medical review and medical audit processes, and facilitates an organized system for coordinated care and follow-up treatment.

Providers must store medical records securely and maintain written policies and procedures to:

- Allow access to authorized personnel only.
- Maintain the confidentiality of all medical records.
- Maintain medical records so that records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information.
- Train staff periodically on proper maintenance of member information confidentiality.

Blue Cross Complete provides training and evaluates providers' compliance with these standards. If you have any questions, call your provider account executive or Blue Cross Complete Provider Inquiry at 1-888-312-5713.

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