Blue Cross complete of Michigan

Blue Cross Complete of Michigan

CONNECTIONS

January/February 2019

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Mandatory enrollment in Community Health Automated Medicaid Processing System

Effective January 1, 2019, all providers furnishing services to Michigan Medicaid beneficiaries, including providers participating in a managed care organization's provider network, are required to be screened and enrolled in the Michigan Medicaid program. The State of Michigan's Community Health Automated Medicaid Processing System is the state's web-based Medicaid enrollment and billing system.

Michigan Department of Health and Human Services will prohibit Blue Cross Complete from making payments to all typical rendering, referring, ordering and attending providers not enrolled in CHAMPS.

This requirement applies to all individuals who provide services of any type to Medicaid beneficiaries, including but not limited to health care providers, social services workers, pharmacies and family members who provide home care services to Medicaid recipients. This requirement also applies to providers who don't bill directly to Medicaid fee-for-service but receive payment through a Medicaid managed care plan.

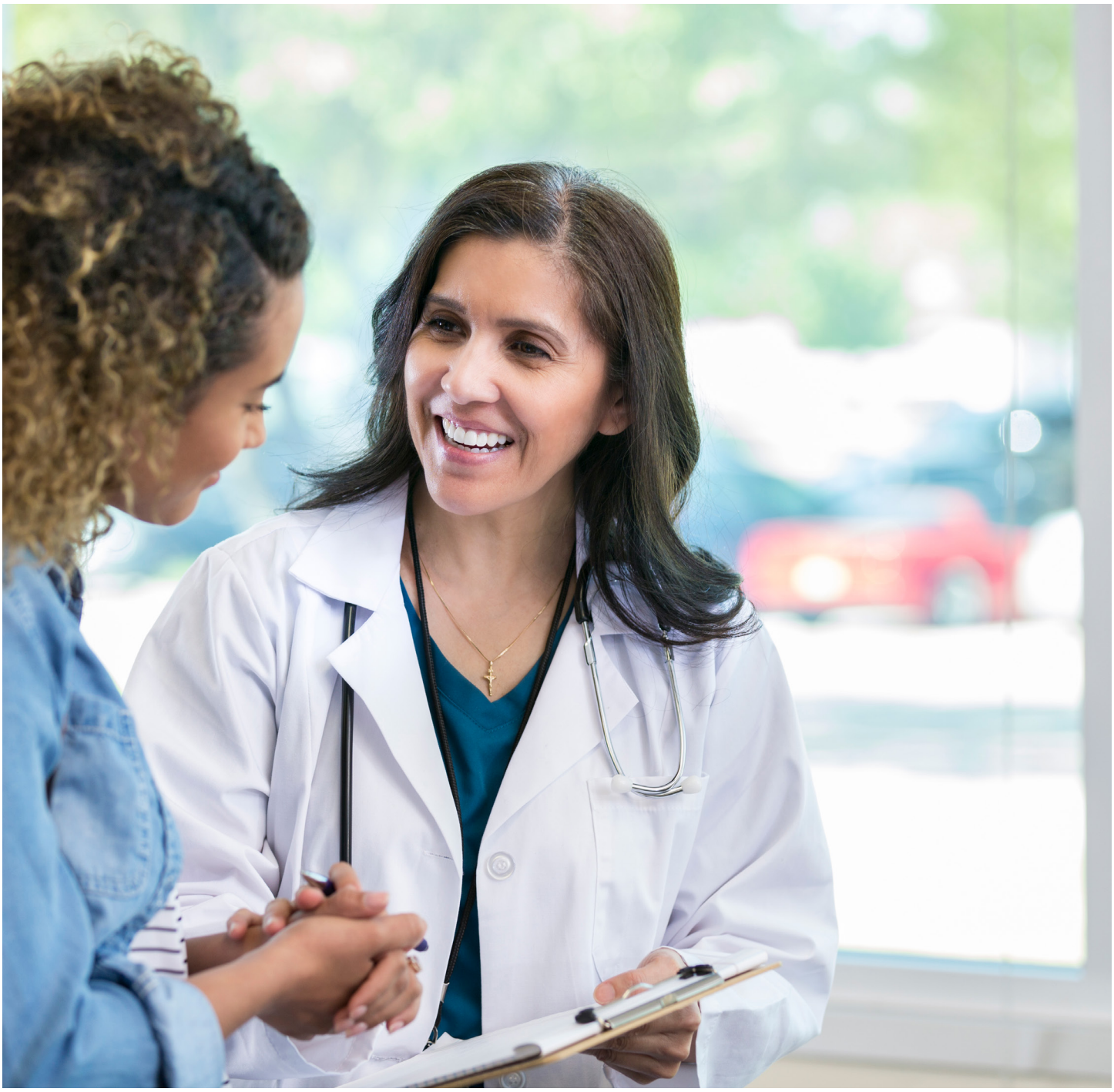
For instructions on how to enroll in CHAMPS, log in to **www.michigan.gov/medicaidproviders*** > Provider Enrollment.

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

Face-to-face encounter with provider required before durable medical equipment order made, per Affordable Care Act

On July 1, 2018, the Michigan Department of Health and Human Services implemented the Affordable Care Act Home Health rule that requires the beneficiary to have a face-to-face encounter with a physician or non-physician practitioner prior to the ordering of specified durable medical equipment and supplies. To educate practitioners regarding this rule, MDHHS has developed a practitioner fact sheet that is posted on the MDHHS website at: **www.michigan.gov/medicaidproviders*** > Billing & Reimbursement > Provider Specific Information > Physicians/Practitioners/Medical Clinics.

Questions regarding the face-to-face rule may be directed to **MSAPolicy@michigan.gov**.



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Quality Improvement program gives our members better care and service

As part of our accreditation with the National Committee for Quality Assurance, we report our Consumer Assessment of Healthcare Providers and Systems® survey results. Each year, Blue Cross Complete sends the CAHPS surveys to a random selection of members. The 2018 survey asked members about their health plans and invited them to rate the care and service they received from their doctors.

Here are some results from the adult survey:

- Member ratings for all health care, personal doctor and health plan increased for 2018. This means that members reported better ratings for the overall health care they received, improved ratings for their personal doctor, and better ratings for Blue Cross Complete as a health plan, which is now rated in the top 25 percent of all accredited health plans.
- Additionally, how well doctors communicate and care coordination ratings increased for 2018. This means that members gave improved ratings for how often they felt their doctors communicated well with them, and how often their personal doctor seemed informed and up to date about care they had received from another doctor.

Results for the child CAHPS survey:

- The getting care quickly score increased and was in the top 10 percent of all accredited health plans. This means that members said they were able to access care quickly and thought that Blue Cross Complete provided close to the best health care access possible for children.
- The customer service score also increased and was in the top 10 percent of all accredited health plans. This means that members felt they almost always received the information or help they needed, and were treated with courtesy and respect.

Both the adult and child CAHPS results identify opportunities for improvement for how well doctors communicate. Though both scores are in the top 50 percent of all health plans, they didn't meet our standard of being in the top 25 percent. Using the answers of "never," "sometimes," "usually" and "always," members were asked to rate how well their doctor explains things in a way that was easy to understand, how often their doctor listens carefully to them, shows respect for what they had to say and spends enough time with them. Providers should be striving to have members rate them with "always" at each and every interaction.

Blue Cross Complete also uses HEDIS®*. This measures how well we provide care to members. HEDIS compares the performance of all health care plans across the country. Blue Cross Complete scored in the top 10 or top 25 percent of health care plans in 2018 in these areas:

- Antidepressant medication management: acute and continuation phases
- Cervical cancer screening
- Chlamydia screening (total)
- Immunizations for adolescents — combo 1
- Medication management for people with asthma (75 percent compliance ages 5 – 11 and total)
- Pharmacotherapy management of COPD exacerbation — bronchodilator
- Pharmacotherapy management of COPD exacerbation — corticosteroid
- Statin therapy for patients with cardiovascular disease — statin adherence 80 percent
- Statin therapy for patients with diabetes — statin adherence 80 percent

This year, Blue Cross Complete will focus on improving timeliness of prenatal and postpartum care, adolescent well care visits, well child visits in the first 15 months of life, comprehensive diabetes care and lead screening in children. Blue Cross Complete is also committed to reducing disparities through population health management programs in the upcoming year.

For more information about these programs, call **1-888-288-1722**, Monday through Friday from 8 a.m. to 6:30 p.m. We also provide information at **mibluecrosscomplete.com**. For more information about the CAHPS survey, visit **cahps.ahrq.gov****.

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

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Blue Cross Complete adds influenza vaccination care gap

Childhood vaccinations protect children from many serious and potentially fatal diseases*. The HEDIS®** childhood immunization status measure includes 10 different vaccinations, including the influenza vaccine. To help ensure your patients are receiving this recommended vaccination and completing the vaccination series, we have added a new care gap for the influenza vaccination. See below for status information that will display for this care gap.

Influenza vaccination care gap status definitions:

- **Missing:** No influenza vaccination
- **Up to date:** At least two influenza vaccinations with different dates of service between 6 months and 2 years of age
- **Series incomplete:** One influenza vaccination between 6 months and 2 years of age

Influenza vaccination The purpose of this measure is to identify and track members who are due for influenza vaccination.	
Which members are included? (Denominator)	• Members with active coverage with the insurance plan as of the last day of the reporting period • Members who turn 2 years old during the reporting period
What provider data is included? (Numerator)	• Members who received at least two influenza vaccinations, with different dates of service, between 6 months and 2 years of age – Missing: No influenza vaccination – Up to date: At least two influenza vaccinations with different dates of service between 6 months and 2 years of age – Series incomplete: One influenza vaccination between 6 months and 2 years of age
Provider communication tools (How providers receive the information)	• Claims data is evaluated monthly for all members. In the event that there is no claim for this specific service, the system generates an automatic notice of care gap. Care gap status notification is provided by and accessible through NaviNet via: – Member eligibility "pop-up" alerts – Care gap query reports – Member clinical summary reports – Monthly NaviNet report updates reflect gaps in care for primary care physician practice panel membership – Panel membership results include indicators for this gaps in care measure as "missing,""up to date" or "series incomplete"

The influenza care gap alert will appear on your screen in **NaviNet** for members who are 2 years of age. Care gaps can also be viewed in NaviNet when checking a member's eligibility and benefits and through the reports inquiry or member clinical summary option.

If you need assistance accessing and resolving care gaps, please check out the **Resolve Care Gaps Help Page***** on NaviNet.

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

*Mayo Clinic Staff, "Childhood vaccines: Tough questions, straight answers" Mayo Clinic, February 12, 2016, www.mayoclinic.org/healthy-lifestyle/infant-and-toddler-health/in-depth/vaccines/art-20048334, accessed December 18, 2018.

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Refer patients to our Integrated Health Care Management program

The goal of our Integrated Health Care Management program is to improve the health and welfare of our members.

The following specific objectives direct our activities:

- Improve the health outcome measures of our members (as reflected by the HEDIS®* scores)
- Improve the coordination of care for our members — to include more consistent use of primary care physicians and more appropriate use of specialists
- Facilitate more efficient use of resources — including the appropriate level of care (setting and intensity)
- Improve the access to health care for our members
- Increase the empowerment of our members to embrace self-care behaviors

IHCM offers several programs that allow us to meet the specific needs of our members. Each program's focus is to maintain and improve the targeted population's health status through assessment, coordination of resources and promotion of self-management through education.

We welcome your referrals of patients 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.

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. Collaboration is an essential component of the care plan process to help ensure that all involved parties are in agreement.

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

Here are some of the interventions provided by our nurse case managers:

- **Coordination of care:** We help make sure the member is seeing his or her primary care physician. We also assist with referrals to specialists and make sure the primary care physician is aware of other care the member is receiving (e.g., specialists, 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.

Disease management programs: We have several disease-specific management programs. Interventions range from one-on-one nurse interaction for high-risk members to periodic educational mailings for low-risk members. The goal of all of our disease-specific management programs is to improve the quality of life for the involved members. We strive to accomplish this goal by providing risk-appropriate case management and education services with a special emphasis on promoting self-management.

- **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, **www.nhlbi.nih.gov/health-topics/guidelines-for-diagnosis-management-of-asthma**.**
- **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, **www.professional.diabetes.org/content-page/practice-guidelines-resources**.**
- **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**.**

We welcome your referrals of patients with Blue Cross Complete that could 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.

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Submit for inpatient long-acting reversible contraception reimbursement

On August 21, 2018, the Michigan Department of Health and Human Services announced that effective for dates of service on or after October 1, 2018, a separate reimbursement will be available for long-acting reversible contraception implants and intrauterine devices when the device is provided immediately postpartum in an inpatient hospital setting prior to discharge.

MDHHS stated that for payment of the LARC, the facility must submit a separate professional claim with place of service ***21-Inpatient Hospital***. Include the hospital as the billing provider and the practitioner performing the related procedure as the rendering provider.

MDHHS also stated that for IUD or contraceptive implants, the provider should use the appropriate health care common procedure coding system level II code and national drug code.

Also, per MDHHS, facilities participating in the federal 340B Drug Pricing Program are required to continue to bill 340B actual acquisition cost for the LARCs; drugs and devices obtained through the 340B program must be indicated on the claim using the U6 modifier.

Michigan Medicaid will continue to reimburse hospitals for related obstetrical services in accordance with the MDHHS's inpatient payment policies in effect on the date of discharge.

For additional billing information and details on reimbursement, see the MDHHS bulletin **MSA 18-22***.

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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Submit Clinical Laboratory Improvement Amendment number for reimbursement of claim

Effective October 11, 2018, claims submitted for laboratory services without the appropriate clinical laboratory improvement amendment identification number will be denied.

Centers for Medicare & Medicaid Services CLIA regulations apply to laboratory testing in all settings including commercial, hospital and physician office laboratories. You may verify your CLIA certification level and effective dates by accessing the CMS Laboratory Demographics Lookup tool*.

To help ensure your claims are processed quickly and accurately, follow the guidelines indicated below:

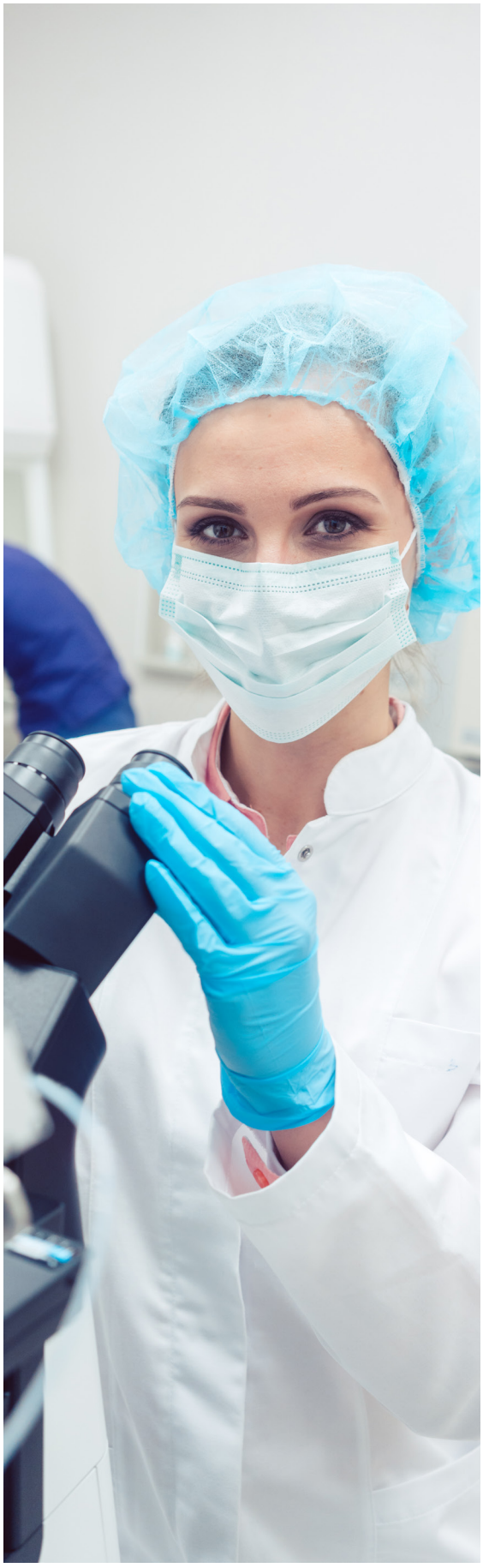
- For paper claims submitted on the CMS 1500, enter the CLIA ID in field 23 (prior authorization)
- For 837 professional electronic claim submissions, enter your CLIA ID number in Loop ID C2300, segment/data element REF02 where REF01 = X4
- The CLIA number entered must be specific to the location where the provider is performing on-site lab testing
- Claim payments can only be made for dates of service falling within the particular certification dates governing those services
- Submit only one CLIA number per claim field
- Providers are reminded to add the QW modifier to the procedure code for CLIA waived tests when required. For a list of tests that require QW modifier, you can confirm by visiting CMS Categorization of Tests*.

Please be advised that claims submitted with missing or inaccurate CLIA numbers will be denied. Denial reasons you may see on your remittance advice related to CLIA are associated to the following denial codes:

Industry denial code (CARC/RARC)	CLIA edit associated to denial code
ZMD	Missing CLIA number on claim
ZME	Claim has multiple CLIA numbers
ZMF	No CLIA number on our file
ZMG	CPT not covered by CLIA certificate type
ZMH	CLIA number does not cover date of service

Note: While the CLIA number is required, supplying the proper CLIA number doesn't guarantee payment as other claims processing guidelines apply.

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



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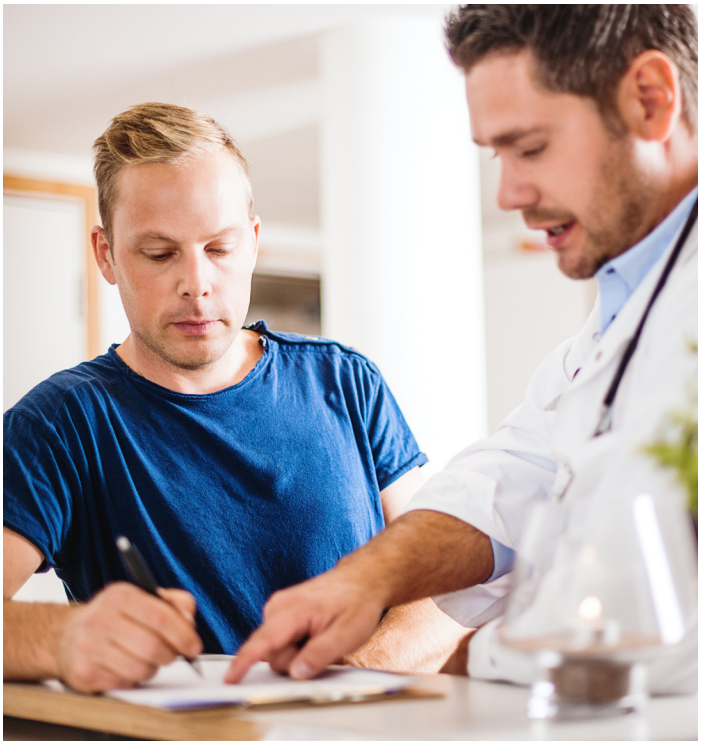
Help optimize care coordination by asking your patients to complete a HIPAA authorization form

The HIPAA privacy rule allows covered entities to access, use or disclose patient protected health information for the purposes of payment, treatment and health care operations. However, it has become common practice for conditions such as mental health, HIV or AIDS, substance use, sexually transmitted diseases and genetic conditions to necessitate the affirmative permission of a patient — by means of a HIPAA authorization form — before diagnostic records or other information can be shared with providers and other partners on the patient's care team.

Absence of a valid HIPAA authorization form may prevent the health plan and other care team members from providing the most efficient care coordination to your patients who are also Blue Cross Complete members. It's important for your patients to understand and complete a HIPAA authorization form to optimize information-sharing for care coordination.

Tell your patients about the importance of completing a HIPAA authorization form and ask them to complete it while in your office. If your practice doesn't have this form already in use, you can get one by contacting Blue Cross Complete Provider Inquiry at **1-888-312-5713** or your Blue Cross Complete provider account executive.



Physical activity guidelines for Americans

Published by the U.S. Department of Health and Human Services, the ***Physical Activity Guidelines for Americans, 2nd edition**** outlines the physical activity needed to maintain or improve overall health and avoid chronic disease.

New in the 2018 guidelines:

- Discussion of physical activity for preschool-aged children (3 – 5 years)
- More evidence of the health benefits of physical activity
- Risks of sedentary lifestyle
- Tested strategies for physical activity promotion
- Removal of the requirement for physical activity of adults to occur in bouts of at least 10 minutes.

Health professionals, communities and others can use ***Move Your Way campaign resources****, containing a variety of written and digital materials, as a way to explain the 2018 guidelines and educate their populations about the benefits of physical activity as well as healthy and safe activity levels.

The Centers for Disease Control and Prevention is also working with states and communities via ***Active People, Healthy Nation — Creating an Active America, Together℠**** to reinforce the benefits of physical activity. By increasing activity-friendly environments, this initiative intends to help Americans become more physically active by 2027 to improve overall health and quality of life and to reduce health care costs.

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How to submit a prior authorization request to Blue Cross Complete

You may submit a request for prior authorization to Blue Cross Complete in one of the following ways:

- Phone: Utilization management, **1-888-312-5713** (option 1, then option 4), Monday through Friday from 8 a.m. to 5 p.m.
- Fax: **1-888-989-0019**
- Website: NaviNet provider portal at **navinet.net***

In addition, if the requests are started in NaviNet, you can also view the status of the prior authorization in the portal.

Please be advised that there is a 14-day turnaround time for all standard prior authorization requests. The *Blue Cross Complete Provider Manual* at **mibluecrosscomplete.com/providers** lists additional time frames for authorization requests.

You'll find information on guidelines for prior authorizations on the Blue Cross Complete plan notification and prior authorization requirements grid at **mibluecrosscomplete.com/providers**. You can also contact your Blue Cross Complete provider account executive.

Help us keep the Blue Cross Complete provider directory updated

Please confirm the accuracy of your information in our online provider directory, so our members have the most up-to-date resources. Some of the key items we include in the directory are:

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

Fax: **1-855-306-9762**

Mail:
Blue Cross Complete of Michigan
Provider Network Management
100 Galleria Officentre, Suite 210
Southfield, MI 48034

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

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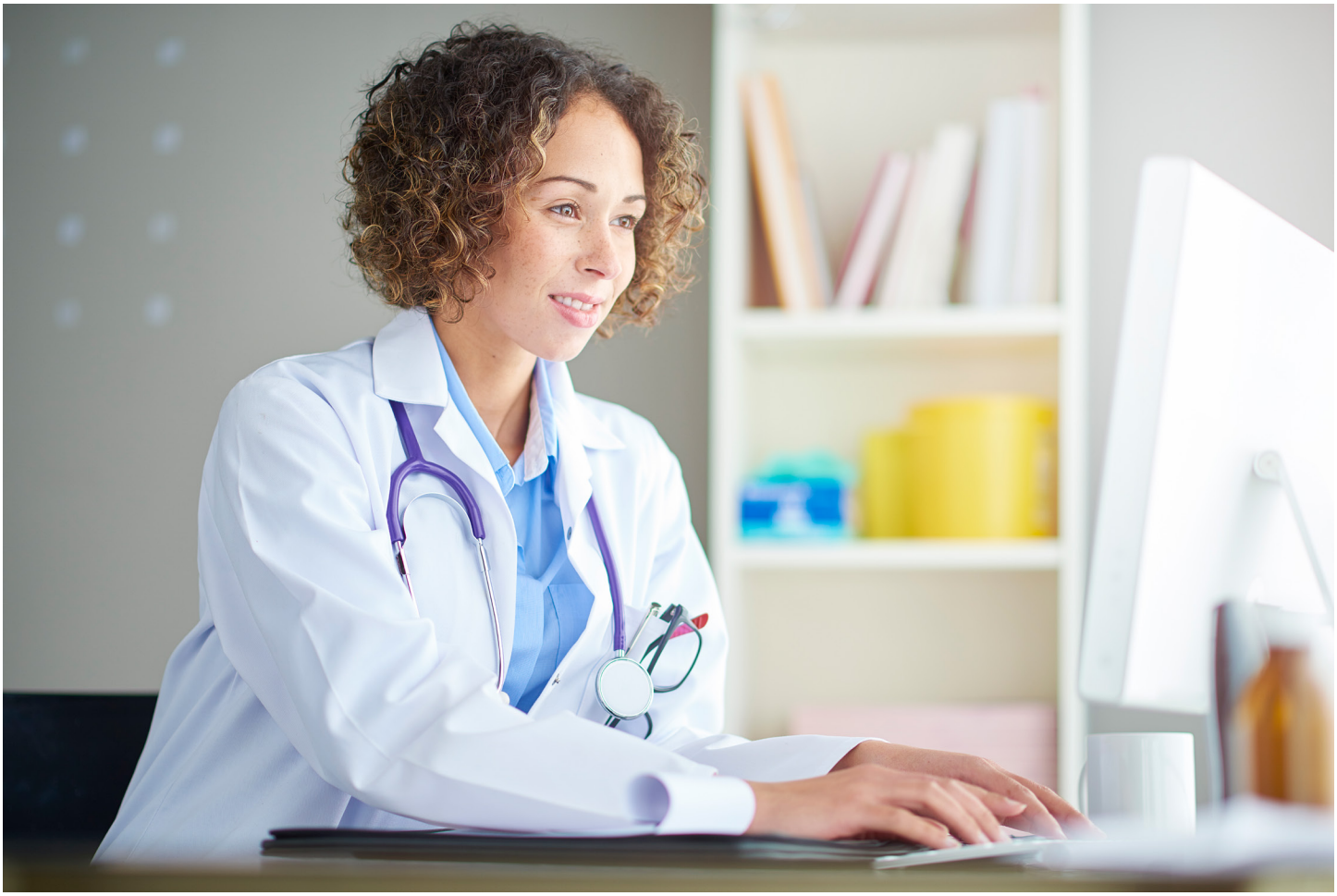

Report suspected fraud to Blue Cross Complete

Providers who suspect that another Blue Cross Complete provider, employee or member is committing fraud should notify the Blue Cross Complete Antifraud Unit as follows:

- 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

The Blue Cross Complete Antifraud 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 by:

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

You can make reports anonymously.

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Developing patient teach-back to improve patient education

Health care providers are implementing "teach-back" as a way to improve patient health care, rein in skyrocketing health care costs and reduce the number of calls from patients with follow-up questions. Teach-back involves providers allowing time for patients to speak back what they learned during the appointment. According to a landmark study published in the *Journal of the Royal Society of Medicine*, patients typically don't remember 40 percent to 80 percent of the information given — and approximately 50 percent of what is remembered is inaccurate or has been misunderstood. A patient's ability to absorb information can understandably be undermined by the stress, for example, of having received a negative diagnosis. When patients have the opportunity to put the information into their own words, they become more engaged and, as a result, are ultimately healthier.

The Agency for Healthcare Research and Quality offers these steps:

- Restate the information given in simple language (avoid medical jargon).
- Suggest that the patient put the information in his or her own words.
- Evaluate patient comprehension. "Were there any areas that seemed unclear?"
- Clarify information as needed.

Teach-back also allows the patient's family or caregivers who attend the appointment a chance to reinforce their understanding of the information given. When a patient has an involved and informed care team, the chances of a positive outcome increase. In addition, printouts and digital tools such as videos or digital modules are helpful in allowing the patient and team to refresh their memories of the patient education they received after they've left the office.

See the full article at ***Patient Engagement Hit: xtelligent Healthcare Media****.

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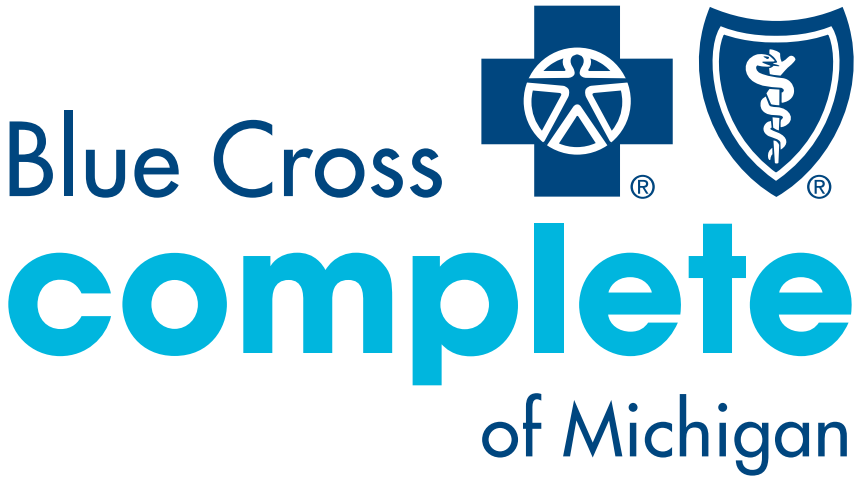

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