*Update from Blue Care Network*

**High-tech radiology authorization requests must go through CareCore National effective July 1**

As part of a continuing effort to align itself with evidence-based standards, professional society guidance and local peer performance, Blue Care Network has contracted with CareCore National, LLC, to conduct clinical review of non emergent, high-tech radiology services performed in an outpatient setting. This process applies to BCN MOSM and BCN AdvantageSM products.

Effective July 1, 2014, BCN will require clinical review of select radiology services, including CTs, MRIs and nuclear scans, through CareCore National. Requests must be submitted to CareCore National prior to rendering services.

If a treating physician doesn't receive a *Medical Necessity Determination and Authorization* number from CareCore National prior to performing outpatient high-tech radiology procedures, we may not reimburse the claim.

The outpatient high-tech radiology diagnostic criteria used by CareCore medical directors have been reviewed by an expert physician review board with relevant medical specialties to ensure that they're in keeping with published research and guidelines from the appropriate specialty societies. You can view the coverage criteria at the [CareCore National website](#).

You must submit requests for these services through the CareCore National website or by calling CareCore National directly at 1 855 774 1317. Please note that CareCore National began taking requests on June 17, 2014, for dates of service on or after July 1, 2014.

You may access an FAQ about the program and a list of procedures requiring authorization at [referrals.bcbsm.com](#) under *Radiology Management*. If you have questions about this notice, please contact CareCore National Customer Service at 1 800 918-6924 and select option 2.

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**New functionality for Health e-Blue lets providers close diagnosis gaps for BCN Commercial individual and small group members**

Effective this summer, Blue Care Network is making some changes to Health e BlueSM that will allow providers to see the Diagnosis Evaluation Panel for certain BCN Commercial individual members. BCN is required to supply diagnosis information to the government for all members in a Qualified Health Plan. Those members include individual members who purchase health care plans through the Health Insurance Marketplace, those who purchase individual coverage from BCN and small group membership.

By entering the correct diagnoses or making clarifications to suspected diagnoses, providers can help BCN refer patients to the appropriate chronic condition management programs.

Providers will see the same information they can now view for their BCN AdvantageSM patients. Health e-Blue will display commercial individual/small group as a drop down box. Data can be entered the same as for BCN Advantage members. Please make sure data is entered for the correct product line.

Adding new members
When adding a new member, the following information needs to be correctly entered for that member to be viewed on Health e-Blue.

- 9-digit BCN contract member number
- Last name as it appears on the member’s ID card
- First name as it appears on the member’s ID card
- Date of birth
- Gender
- Phone number

*Diagnosis Evaluation Panel Instructions* are available on the BCN Health e-Blue home page. The document can be found in the Resources section.

If you have any questions, contact your provider consultant or use the BCN Health e-Blue Feedback button within Health e-Blue.

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**BCN provider affiliation agreements prohibit the concierge medicine model**

A concierge practice (sometimes referred to as a retainer practice) is a provider practice model whereby providers charge members (or require members to pay a third party) membership fees in exchange for enhanced services or amenities. As a benefit of paying the concierge fee, members typically receive:

- Immediate appointment access
- Care coordination among specialists, including referral coordination
- Extended or enhanced email and telephone communication
- Extended office visits
- Wellness programs, genetic and nutritional counseling, risk appraisals and wellness plans

The BCN Provider Group Affiliation Agreement, the BCN Practitioner Affiliation Agreement, and the BCN Advantage Amendments ("Affiliation Agreements") do not permit the concierge model. Such a model violates the non discrimination provision in the affiliation agreements because open and ready access to care is not provided to all BCN members at the same level.

BCN providers cannot, under the terms of their Affiliation Agreements, intentionally segregate members in any way or treat members in a manner or location different from other patients receiving health care services. More specifically, BCN providers cannot treat members differently based on payment level, benefit or reimbursement policies.

Additionally, many of the services that are considered to be enhanced in the concierge model are, when medically necessary, covered services under the affiliation agreements. Members who would benefit from appropriate preventive care or wellness counseling should receive those services within the context of usual covered office visits, written handouts and nurse counseling, for example. Under the terms of the affiliation agreements, providers should not require members to pay for services that are not medically necessary under the umbrella of an enhanced service.

BCN providers who wish to change from a traditional practice model to a concierge practice and already participate in a BCN network will no longer meet continued participation requirements. Upon notification of the change to a concierge practice, providers will be allowed to voluntarily withdraw from BCN networks with 60 days prior notice. If providers refuse to voluntarily withdraw from relevant BCN networks, BCN will terminate all affiliation agreements in accordance with the termination provision in the applicable agreement. This decision may or may not be appealed. Please refer to the applicable network agreement and provider manual (available on web DENIS) for more information.

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**BCN clarifies Blues provider networks for individual products**

Here’s some information to help you understand which provider networks are being used for the new Blue Cross Blue Shield of Michigan and Blue Care Network individual market products.

- Blue Cross® Premier plans use the BCBSM PPO network.
- Blue Cross® Preferred plans use the BCN HMO network.
- Blue Cross® Select plans use the BCN PCP Focus network.*
• Blue Cross® Partnered plans use the Blue Cross Partnered Network that primarily consists of physicians associated with Mercy Health (available only to residents of Kent, Muskegon and Oceana counties). *The PCP Focus network expanded from seven to 21 Michigan counties for group plans and is available in 19 Michigan counties for the 2014 Blue Cross Select individual market plans.

Your participation in the Blues provider networks has not changed from 2013 unless:

• You requested a change
• You were added to the new Blue Cross Partnered network (for residents of Kent, Muskegon and Oceana counties)
• Your status with the PCP Focus network changed as part of that network’s review and expansion

As a reminder, health care providers sign contracts to perform services within certain networks. Keep in mind that providers are required to accept new members within the network they are contracted with, whether a product was purchased on or off the Marketplace. The only exception is if a practice has been closed to new patients. If you have any questions about the contracting or reimbursement process, please contact your provider consultant.

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Healthy Michigan Plan has some requirements for appointment times, health risk assessments

Michigan's newly approved bill, called the Healthy Michigan Plan, authorized the expansion of the state's Medicaid program and became effective April 1, 2014. Blue Cross Complete experienced an increase of members for this new plan in our service area which includes Washtenaw, Livingston and Wayne counties. There are a few requirements for the members enrolled in Healthy Michigan.

• Members are required to schedule an appointment with their assigned primary care physician within 60 days of enrollment.
• Primary care physicians are required to have the appointment within 150 days of the member’s effective date with the plan.
• PCPs are encouraged to help members schedule an appointment.
• Blue Cross Complete will help coordinate appointment scheduling on behalf of the member.

Providers can identify Healthy Michigan members in NaviNet® in the Eligibility and Benefits Details section. The product line will display “Blue Cross Complete - Healthy MI”.

In addition, the panel roster report in NaviNet identifies Healthy Michigan members with HM # following the member name.

Health risk assessment required

Under the Healthy Michigan Plan, PCPs are responsible for completing a health risk assessment form at the time of the appointment.

• The HRA form is available on mibluecrosscomplete.com/providers and on NaviNet.
• Blue Cross Complete members will receive a copy of the HRA in their welcome packet that they may bring to their appointment.
• The HRA form must be completed legibly and in its entirety.
• Although the HRA form can be completed by a member of the clinical team, the PCP will need to sign it.
• Providers need to fax the entire form to 1 855 287-7886 within five business days of the appointment.
• A claim must be submitted with CPT code *99420 with modifier 25 to indicate that an HRA was completed.
• Blue Cross Complete will pay a $15 incentive upon receipt of the claim.
• If providers have questions about the status of the HRA, they can contact 1 888-312-5713.