SEPTEMBER-OCTOBER 2026

BCN Provider News



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Changes to maternity billing requirements starting Oct. 9, 2026

The American Medical Association, or AMA, will discontinue global, bundled payment codes for prenatal, delivery and postpartum care on Jan. 1, 2027, and replace them with individual evaluation and management, or E/M, or designated obstetric procedure codes.

To support a smooth transition and accurate reimbursement of services, we're implementing billing requirement changes starting on Oct. 9, 2026. The interim requirements only apply to prenatal visits for Blue Cross Blue Shield of Michigan commercial, Blue Care Network commercial, Medicare Plus Blue℠ and BCN Advantage℠ members expected to deliver on or after Jan. 1, 2027.

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What you need to do

Billing requirements depend on when the patient's first prenatal visit occurs.

Billing detail	For patients presenting for their first prenatal visit on or before Oct. 8	For patients presenting for their first prenatal visit on or after Oct. 9
Code	**E/M codes** are required for prenatal claims if the patient has three or fewer visits with the same provider group in 2026. **Use bundled codes** for prenatal claims if the patient has four or more visits with the same provider group in 2026.	**E/M codes** are required for patients presenting for their first prenatal visit on or after Oct. 9. **Exception**: Continue to bill using bundled prenatal codes if the patient has four or more visits with the same provider group in 2026.
Modifier	Use of the TH modifier isn't required.	The use of the TH modifier will be a prerequisite for processing all prenatal claims using the designated E/M codes.

What to expect next

We may require the usage of additional modifiers with the E/M codes starting Jan. 1, 2027. We'll communicate more information in the coming months.



Editor
Michael Gingerella
bcnprovidernews@bcbsm.com

Provider Communications
Catherine Vera-Burgos, Manager
Tracy Petipren
Deb Stacy
Laura Wilk

Graphics Design
Adam Pete

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BCN simplifies referral rules to focus on PCP's primary address

Effective Jan. 1, 2027, Blue Care Network is implementing new referral rules that will simplify the determination of whether a referral needs to be submitted to BCN or not for BCN commercial members.

The current process

Referral requirements vary based on the **region** assigned to the medical care group with which the member's primary care provider is associated.

Current referral rules are listed on page 10 of the
Michigan providers: BCN global referral, plan notification and prior authorization requirements document.

The new process

Effective Jan. 1, 2027, referral requirements will vary based on the **region** in which the primary care provider's primary address is located. All other referral rules remain unchanged.

This change allows primary care providers to affiliate with any BCN medical care group statewide. The primary care provider will follow the regional referral requirements that apply for the location where the physician's office is located. If a primary care provider has multiple locations, referral requirements will be determined based on the location of the primary address.

Specialists can check the primary care provider's primary address to determine whether they should look for a referral in the e-referral system or not.

The new referral rules

The following updated referral rules will be effective Jan. 1, 2027, and will be reflected in the *BCN Provider Manual* and the *Michigan providers: BCN global referral, plan notification and prior authorization requirements* document by Jan. 1.

When the primary care provider's primary practice address is in the Mid, West or Upper Peninsula region:

- Global referrals aren't required. The primary care provider must still manage the member's care and communication among providers is still recommended. The primary care provider can communicate with the specialist by phone or fax or through instructions on a prescription. Both the primary care provider and the specialist should include written documentation about the communication in the member's medical record.

When the primary care provider's primary practice address is in the East or Southeast region:

- The primary care provider must submit a global referral to BCN for the member to see a specialist. A global referral allows the specialist to perform necessary services to diagnose and treat a member in the office. It also facilitates the processing of claims.

  Reminder: Specialists may not submit global referrals to other specialists. If the specialist determines that services are needed outside of those specified by a global referral, including further diagnosis or treatment in an alternate treatment setting (either outpatient or inpatient), the specialist is responsible for submitting all required plan notifications or prior authorization requests.

  Exception: OB-GYNs may recommend BCN members see contracted specialists for obstetric-gynecologic services. However, they don't need to submit global referrals through the e-referral system.

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Grand Rapids Cascade facility to close Oct. 1, switch to electronic submission or new addresses for paper mail as soon as possible

Effective Oct. 1, 2026, we're permanently closing our facility at 611 Cascade West Pkwy SE, Grand Rapids, MI, and discontinuing all our Grand Rapids P.O. boxes. We've already shared the new addresses you should use if you need to send a paper claim in a **June 30 provider alert**.

Before sending paper mail, please consult the appropriate provider manuals for instructions on electronic submission. Here's **how to access our provider manuals**.

If you need to send us a paper claim, appeal or other correspondence, refer to the new addresses below before sending and update your records as appropriate.

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Type of documentation	New address (active immediately)
Claims	**For BCN Advantage** (Use same address you use for Medicare Plus Blue claims.) Blue Cross and BCN Claims P.O. Box 32593 Detroit, MI 48232-0593 **For BCN commercial** (Use same address you use for Blue Cross commercial claims. Note that this is now one address for both facility and professional claims.) Blue Cross and BCN Claims P.O. Box 312500 Detroit MI 48231-2500
Prospective editing reconsideration requests	Preferred method: **Submit electronically** for contracted providers and noncontracted providers handling commercial prospective editing denials. For noncontracted providers for BCN Advantage or Medicare Plus Blue: Blue Cross Blue Shield of Michigan Prospective Editing P.O. Box 32391 Detroit, MI 48232-0391
Checks	Recovery Team Technicians Blue Care Network (or BCN Advantage, as applicable) P.O. Box 773374 Detroit, MI 48277
Transplant claims — BCN commercial	Preferred method: Email to BCNCommercialClaimsTransplants@bcbsm.com. **Important**: Encrypt your email. You can use the **Blue Cross and BCN Message Center** by encrypting. 1. Click Register or Sign In. 2. Click Compose. Paper method: BCN Transplant Claims P.O. BOX 44110 Detroit, MI 48244-0110

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Type of documentation	New address (active immediately)
Medical records	Preferred method: **Submit electronically for claims or clinical information through e-referral.** Blue Cross Blue Shield of Michigan Attention: Medical Records Dept. MC 0010 P.O. Box 166 Detroit, MI 48231-0166
Pharmacy appeals	(This address and fax number haven't changed.) Fax: 1-877-442-3778 Mail: Blue Care Network Pharmacy Help Desk P.O. Box 321127 512C Detroit, MI 48232-1127
Member appeals — BCN Advantage	(This address hasn't changed.) BCN Advantage Appeals and Grievance Unit Mail Code A01C P.O. Box 44200 Detroit, MI 48244-0200
Member appeals for pharmacy — BCN Advantage	(This address hasn't changed) Part D appeals BCN Advantage Pharmacy Clinical Help Desk Mail Code 512J P.O. Box 441877 Detroit, MI 48244-1877
Member correspondence	Blue Care Network Member correspondence P.O. Box 32136 Detroit, MI 48232-0136

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Time-saving tips: Facility data attestation

Quick tips designed to save you time when working with us.

Time-saving tips is a series focused on helping you spend less time looking for answers and more time caring for your patients. Each month, we'll highlight simple tools, shortcuts, or improvements designed to make it easier to work with us — because we value your time and are committed to improving your experience.

This month, we're sharing resources that healthcare providers in facility settings can use to make regular attestation achievable.

Why attestation is important

Reviewing and correcting your data through regular and timely attestation ensures that:

- Members have the correct information about your providers and practice.
- Your information remains listed in our provider directory, which is accessible on the *Find Care* page on bcbsm.com.
- You are compliant with the federal Consolidated Appropriations Act (CAA Mandate).
- You can pass an audit by the Centers for Medicare & Medicaid Services.
- You remain affiliated with Blue Cross Blue Shield of Michigan and Blue Care Network.
- Your claim payments aren't interrupted.

If you fail to complete attestation:

- You'll be removed from our provider directory.
- Your claim payments may be interrupted.
- Your contract could end.

Facilities and organizational providers must attest every 90 days to five data elements: Name, specialty, address, phone number and digital contact information.

Tips for facilities and organizational providers

Because of differing requirements, we've separated most of our attestation materials by provider type. For providers in facility settings, here's what we recommend:

- To keep your facility staff aware of attestation requirements, bookmark and print our **Provider data attestation flyer** and post it around the office.
- Bookmark the document **Update and attest to facility and organizational provider information in the Provider Data Management tool within Availity Essentials™**. It's a short guide that contains information about:
  - Accessing Provider Data Management in Availity Essentials
  - Where to learn more about Provider Data Management
  - Which providers are organizational providers
  - Primary elements and sub-elements that you need to attest to and change when appropriate.
- Bookmark and check in with the **Provider Data Attestations page** on **bcbsm.com** for new and updated documents for both facilities and professional provider types.

How facility and organizational providers can attest

- Log in to our provider portal (**availity.com**) to use the Provider Data Management tool.
- For assistance, call Availity® Client Services at 1-800-AVAILITY (282-4548).

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

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Reminder: Attest to provider data as required

What you need to know

To remain listed in our provider directories, including *Find a Doctor*, professional practitioners, facilities and organizational (or allied) providers must attest to their information as required.

Professional practitioners, facilities and organizational (or allied) healthcare providers must attest to their information as required to:

- Ensure affiliation with Blue Cross Blue Shield of Michigan or Blue Care Network isn't interrupted.
- Keep contact information up to date.
- Make sure claims payments aren't interrupted.

You can bookmark or download our **Provider data attestation flyer** to use as a guide. You can also print and post the flyer in your practice or office.

Facilities and organizational (allied) providers

Every 90 days, facilities and organizational (allied) providers with Type 2 national provider identifiers must update and attest to the following basic provider information in the Provider Data Management tool in our provider portal, Availity Essentials™: name, specialty, address, phone number and digital contact information. Attestation is required even if no changes are needed. This is a requirement of the Consolidated Appropriations Act.

To learn more, see the document **Update and attest to facility and organizational provider information in the Provider Data Management tool within Availity Essentials**.

Professional practitioners

All professional practitioners, including those who practice at an office location or practice exclusively in an inpatient hospital setting, need to attest to their data.

Attestation must be completed in the CAQH Provider Data Portal, formerly known as CAQH ProView®, every 90 and 120 days. Here's what professional practitioners need to do:

Frequency	What to do
Every 90 days	Attest to the following data elements every 90 days: name, specialty, address, phone number and digital contact information. Attestation is required even if no changes are needed. This is a requirement of the Consolidated Appropriations Act.
Every 120 days	Attest to all other data elements every 120 days. This includes elements related to credentialing, licensing and elements other than those listed in the previous section. Credentialing status will end if practitioners fail to attest, and they'll need to reapply.

If professional practitioners don't attest in CAQH as required, they won't be included in the Blue Cross and BCN provider directories, including our *Find a Doctor* search tool.

If you're practicing exclusively in an inpatient hospital setting, you must indicate that on your CAQH credentialing application. This information is used to determine whether full credentialing is required.

CAQH is a nonprofit alliance of health plans and trade associations focused on simplifying healthcare administration. Blue Cross and BCN use CAQH to gather and coordinate our professional practitioner credentialing information. All healthcare practitioners, including hospital-based providers, must be registered with CAQH.

If you have questions about CAQH, call the CAQH Solutions Center at 1-888-599-1771 or go to **CAQH.org**.

For more information on attestation, go to our **Provider Data Attestations** page.

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On-demand opportunities available for training

Action item

Visit our provider training site to view mini modules on new and updated topics.

Blue Cross Blue Shield of Michigan and Blue Care Network continue to offer training resources for healthcare providers and staff. On-demand courses are designed to help you work more efficiently with us.

The following learning opportunities are available:

- **Blue Elect Plus POS for providers**

  This mini module gives an overview of this unique product to help providers and staff treat patients with this plan.
- **Effective searches in Benefits & Eligibility**

  This updated mini module includes reference to the virtual member ID card and how to locate the individual coverage level and additional benefit details for patients within the provider portal at availity.com.
- **Virtual ID card in the provider portal**

  This mini module shows providers how to locate and download a virtual copy of your patient's Blue Cross Blue Shield of Michigan or Blue Care Network member card.
- **InterQual® criteria in e-referral**

  This mini module reviews the steps to successfully submit the InterQual® Connect guidelines questions for a prior authorization request.
- **Provider Enrollment Tips**

  This video gives helpful tips on submitting enrollment and change requests and references important resources to support the enrollment process. New providers can also find this video on the **Enrollment page** on **bcbsm.com/providers**.

How to access provider training

To access our Provider Training site, **here are detailed instructions**.

If you need assistance with the site, contact **ProviderTraining@bcbsm.com**.

You can also directly access the **training website** if you don't have a provider portal account.

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Referrals to home healthcare for Medicare Advantage members: Grace period extended through Sept. 30 for acute care providers

Blue Cross Blue Shield of Michigan, Blue Care Network and tango are extending the grace period during which acute care providers don't need to submit referrals to tango for home healthcare services. With the extension, home healthcare providers can continue to submit referral requests directly to tango through Sept. 30, 2026.

We extended the grace period to give additional time for:

- Acute care providers to connect with tango and complete all transition activities
- Discharge planners and care teams to learn and acclimate to the tango operational model without disrupting patients' transitions into skilled home health episodes

During this time, tango, Blue Cross and BCN will also continue to refine the referral process.

If your organization has questions about the referral process, email the tango Provider Relations team at **providerrelations@tangocare.com**.

Notes:

- In a May 4, 2026, provider alert, we reported that the grace period would end for acute care providers on May 31, 2026.
- As a reminder, tango coordinates referrals and manages prior authorizations for Medicare Plus Blue℠ and BCN Advantage℠ members for home health episodes of care that start on or after March 1, 2026.

For additional information about home healthcare requirements for Medicare Advantage members, see the:

- **Home Health Care** page on **authorizations.bcbsm.com**
- **Home health referring provider** page on the *tango and WellSky Provider Resource Center for Blue Cross Blue Shield of Michigan and Blue Care Network* website

Tango and WellSky® are independent companies that review member healthcare services for appropriateness and medical necessity on behalf of Blue Cross Blue Shield of Michigan and Blue Care Network.



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Announcing updated guidelines for reviewing inpatient readmissions for Blue Cross commercial, BCN Advantage members

Following similar changes put forward by the Centers for Medicare and Medicaid Services and many other health plans, Blue Cross Blue Shield of Michigan and Blue Care Network are updating the guidelines we use to review inpatient readmissions for Blue Cross commercial and BCN Advantage℠ members for billing purposes.

Under the updated guidelines, Blue Cross and BCN will review admissions for Blue Cross commercial and BCN Advantage members readmitted to the hospital within 30 days of discharge. Currently, admissions for these members are reviewed within 14 days of discharge.

This 30-day readmission policy reinforces the importance of safe discharge, timely follow-up, medication management, and coordination among hospitals, physicians, and other care providers. It supports the shared goal of reducing avoidable readmissions and improving outcomes for members during a vulnerable period after hospitalization.

Although hospital influence over readmissions may be most direct in the first seven days, important factors such as discharge planning, medication reconciliation, follow-up appointments, patient education, and care coordination continue to shape outcomes well beyond two weeks. A 30-day review period better reflects the full window in which avoidable readmissions can be affected by the quality of transition planning.

The 30-day readmission review period will go into effect as follows:

Line of business	30-day readmission review effective date
BCN Advantage	Aug. 1, 2026 (**refer to provider alert posted July 1, 2026**)
Blue Cross commercial	Sept. 1, 2026

This change aligns with existing readmission review policies for BCN commercial and Medicare Plus Blue℠, making our policies consistent across our Blue Cross and BCN commercial and Medicare Advantage health plans. In addition, this change aligns with the Centers for Medicare & Medicaid Services readmission standards and the Medicare Star measure for Plan All-Cause Readmissions.

What this means for facilities

All readmissions to the same hospital within 30 days should be reviewed by the admitting hospital. Where appropriate, readmissions will be combined and reimbursed as a single diagnosis-related group, or DRG. Blue Cross commercial reimbursements will also include any applicable catastrophic case payments.

Here are some other articles in this issue that may be of interest

- *Talk with patients now about Health Outcomes Survey topics,* **Page 13**
- *Use new addresses for paper claims for Blue Care Network and Blue Cross commercial members,* **Page 19**
- *Reminder: Radiation oncology and therapeutic radiopharmaceuticals to be managed through the Oncology Value Management program starting Sept. 1,* **Page 23**
- *Release schedule for EviCore category assignments and practitioner performance summaries for PTs and OTs,* **Page 24**



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Reminder: Virtual Muscle and Joint Health Program available for some members

What you need to know

We're reaching out to our members who have coverage for this virtual exercise program and could benefit from participating. This program, through Hinge Health®, supplements the care provided by you at no cost to the member to help them prevent, treat or recover from muscle and joint pain.

The Virtual Muscle and Joint Health Program is available to members with Blue Cross Blue Shield of Michigan and Blue Care Network commercial health plans whose self-funded employer groups have elected to offer the program.

The program provides personalized virtual exercise therapy to individuals 18 and older with musculoskeletal conditions, complementing care provided by our network health care providers and physical therapists.

Participation in the program is free to members who have this coverage. Members don't need a referral or authorization. They can self-refer by downloading the Hinge Health app and completing a short application. Hinge Health then assesses the member and creates a customized virtual program that can include:

- Stretching and exercise sessions
- Condition-related education
- Motion-sensing technology to provide feedback on exercise form
- A care kit and Enso wearable device to manage pain, as needed

If your patient tells you they're participating in this program, we ask that you talk to them about how this program can contribute to their overall plan of care.

Learn more

For more information, see:

- **New Virtual Muscle and Joint Health Program**, in the Jan.-Feb. 2025 issue of BCN Provider News, page 4
- **Musculoskeletal services for virtual exercise therapy and joint and spine care**

Hinge Health, Inc. is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing virtual muscle and joint health services to individuals with musculoskeletal conditions.



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Talk with patients now about Health Outcomes Survey topics

Why is the Health Outcomes Survey, or HOS, important?

The goal of the HOS is to gather clinically meaningful health status data from Medicare Advantage patients to support quality improvement activities, monitor health plan performance and improve the health of this patient population.

Healthcare providers can significantly affect how patients assess their healthcare experience in response to HOS questions through discussions at your annual wellness visits.

HOS topics are included in Star Ratings

Questions relative to physical activity, improving bladder control and reducing the risk of falls are asked annually. The following are examples of questions included in these categories:

- In the past 12 months, did a doctor or other healthcare provider advise you to start, increase or maintain your level of exercise or physical activity?
- There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse or other health provider about any of these approaches?
- Did you fall in the past 12 months?
- Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things might include suggesting a cane or walker, an exercise or physical therapy program, or maybe a vision or hearing test.

To assist patients who receive the survey, and to reinforce the discussions you've had with them, here are some ideas for addressing these topics:

- **Bladder control** — Communicate that urinary leakage problems can be common as we grow older, but there are options available that can help manage incontinence. Potential options include behavioral therapy, exercises, medications, medical devices and surgery. You can also use informational brochures and materials as discussion starters for this sensitive topic.
- **Physical activity and improving or maintaining physical health** — Ask patients if they have pain and, if so, is it affecting their ability to complete activities of daily living? Ask what goals the patient has. If your patient is in pain, identify ways to improve the patient's pain. Perhaps a consultation with a pain specialist, rheumatologist or maybe physical therapy can be considered.
- **Fall prevention** — Promote exercise, physical therapy, strengthening and balance activities (such as yoga). Review medications for some that may increase fall risk, and discuss home safety tips such as removing trip hazards, installing handrails, using nightlights, and even suggest using a cane or walker if appropriate. Vision and hearing impairments can also cause falls, so testing might be appropriate.
- **Improving or maintaining mental health** — Empathize with the patient, incorporate annual depression screening into visits, such as PHQ-2 or PHQ-9, and discuss options for therapy with a mental health provider, when appropriate. Consider exercise, sleep habits, hobbies, volunteering, attending religious services, identifying stress triggers, reducing alcohol or caffeine intake, meditation and connecting with supportive family and friends.

It's important to note that many of the HOS questions ask patients whether their providers discussed these concerns with them. For this reason, we suggest that these topics become part of each patient's annual wellness visit.

Need more information related to HOS?

On our provider training site, we have several webinars on the Health Outcomes Survey, including an overview as part of the 2026 series of mini modules on the Centers for Medicare & Medicaid Services' Star measures. If you need help accessing our Provider Training site, see **How to access provider training**. You can also directly access the **training website** if you don't have a provider portal account.

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Medical policy updates

Blue Care Network's medical policies are posted on **bcbsm.com/providers**. To find them:

1. Go to **bcbsm.com/providers**.
2. Click *Resources*.
3. Scroll to "Looking for medical policies?" and click *Search medical policies*.

Note: Some Blue Cross and Blue Care Network commercial (non-Medicare Advantage) medical policies may have a separate Medicare Advantage medical policy. See the *Medical Policy Updates* PDF attachment for more information.

Recent updates to the medical policies include:

Covered services

- Bioimpedance Devices for Cancer Related Extremity Lymphedema
- Bone Morphogenetic Protein
- Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with High Bone Turnover
- Circulating Tumor DNA for Management of Non-Small Cell Lung Cancer (Liquid Biopsy)
- Cognitive Rehabilitation
- Gene Therapies for Sickle Cell Disease
- Genetic testing for dilated cardiomyopathy
- Genetic testing for FLT3, NPM1, CEBPA, IDH1 and IDH2 variants in acute myeloid leukemia
- Laparoscopic, Percutaneous, and Transcervical Techniques for Uterine Fibroid Myolysis
- Light and Laser Therapy for Vitiligo and Eczema
- Microprocessor-controlled & power prostheses and orthoses for the lower limb
- Speech and language pathology/swallowing rehabilitation
- Transplant-small bowel (isolated)

Noncovered services

- Laboratory Tests Post Transplant (Kidney, Heart, and Lung) and for Heart Failure
- Programs for disorders of consciousness (DoC)

Established services

- Cardiac Rehabilitation, Outpatient
- Chemical Peels
- Reconstructive Breast Surgery and Management of Breast Implants
- Reduction Mammaplasty (Breast Reduction) for Breast-Related Symptoms
- Remote Patient Monitoring and Remote Therapeutic Monitoring
- Surgical Treatment of Femoroacetabular Impingement

Mixed

- Genetic Testing for FMR1 Variants (Including Fragile X Syndrome)

Medical Policy Updates

Here's another article in this issue that may be of interest

- *Respond to calls and inquiries from HelpScript,* **Page 17**



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New Blue Cross Behavioral Health provider portal coming Jan. 1

Starting Jan. 1, 2027, Blue Cross Blue Shield of Michigan and Blue Care Network are transitioning to a new Blue Cross Behavioral Health℠ provider portal. Like the existing provider portal, the new provider portal will be accessed through Availity Essentials™ and providers will use it to submit prior authorization requests for behavioral health services (including autism treatment) for all lines of business.

Prior to Jan. 1, we'll be publishing a recorded demo with instructions on how to use the new Blue Cross Behavioral Health provider portal. Watch for information.

As a reminder, Blue Cross Behavioral Health manages prior authorizations for behavioral health services (including autism treatment) for Blue Cross commercial, Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ members.

Additional information

Look for future articles in *The Record* and *BCN Provider News* with additional details about the new Blue Cross Behavioral Health provider portal.

Our provider communications will also be updated as needed by Jan. 1.

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Quality MINUTE

Blue Cross Blue Shield Blue Care Network of Michigan

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This is another article in an ongoing series of quick tips designed to be read in 60 seconds or less and provide your practice with information about performance in key areas.

2026 pharmacy measures

We've added two pharmacy performance measures and detail a new exemption and focus areas in this article.

New measures: COB and Poly-ACH

Blue Cross Blue Shield of Michigan recently added the following performance measures to the Performance Recognition Program and Value-Based Reimbursements:

- Concurrent Use of Opioids and Benzodiazepine (COB)
- Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

Success in these measures is defined by keeping members out of the numerator. Once members are counted, they can't be removed.

We provide detailed guidance in the Poly-ACH and COB presentation. Access it through our provider portal:

1. Log in to the provider portal at **availity.com**.
2. Click on *Payer Spaces* on the menu bar, and then click on the BCBSM and BCN logo.
3. Click on the *Resources* tab and then *Secure Provider Resources (Blue Cross and BCN)*.
4. Click on *Member Care* on the menu bar, and then *Clinical Quality*.
5. Navigate to the *Pharmacy Clinical Resources*.
6. Click on *Polypharmacy Anticholinergics and Concurrent Use of Opioids & Benzodiazepines*.

New exemption: Statin Use in Persons with Diabetes (SUPD)

A new exemption excludes members who aren't on a statin **and have at least one** claim for a PCSK9 inhibitor or bempedoic acid. When members fill a medication that meets exemption criteria, they're removed from the denominator.

See the SUPD summary presentation for more information, located in the provider portal under *Pharmacy Clinical Resources*. To access it, follow steps 1 through 5 above, then click on *Statin Use in Persons with Diabetes (SUPD)*.

Focus areas: Medication adherence and SUPD

Medication adherence and SUPD for diabetes, hypertension and cholesterol remain top priorities for 2026. In addition to the monthly adherence files we deliver to your physician organization and medical care group, we now offer a new platform, **1health**, that lets physician organizations and medical care groups:

- Identify members included in medication adherence and SUPD Star measures
- Highlight actionable gaps
- Enable timely interventions to improve adherence and outcomes

To improve medication adherence and SUPD for your patients, we encourage you to reach out to your physician organization or medical care group to obtain the data available through the new 1health platform.

1health is an independent company that provides medication adherence support for Blue Cross Blue Shield of Michigan and Blue Care Network.

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BCN encourages flu vaccination with a gift card incentive for select members

Blue Care Network encourages members to obtain a flu vaccine for the 2026-2027 flu season. This season, we're also reaching out to select adults with BCN commercial coverage whose history indicates limited or no recent flu vaccination activity.

We're offering these members a $20 gift card if they obtain the flu vaccine at their local BCN participating pharmacy. To receive the gift card, members will need to create an account with the gift card vendor to complete a flu vaccine attestation.

Communications to eligible members with instructions begins in mid-September with reminders through early January. If one of your patients mentions this opportunity, please encourage them to participate. As studies have shown, a flu vaccine can prevent influenza, reduce complications and lower the risk of hospitalization, among other benefits (**Flu Vaccines Work, U.S. Centers for Disease Control and Prevention, May 28, 2026**).

Respond to calls and inquiries from HelpScript

HelpScript is an independent company that works with Blue Cross Blue Shield of Michigan and Blue Care Network to coordinate member enrollment in manufacturer copay assistance programs for certain high-cost medical benefit drugs. This service is available to many Blue Cross and BCN commercial members.

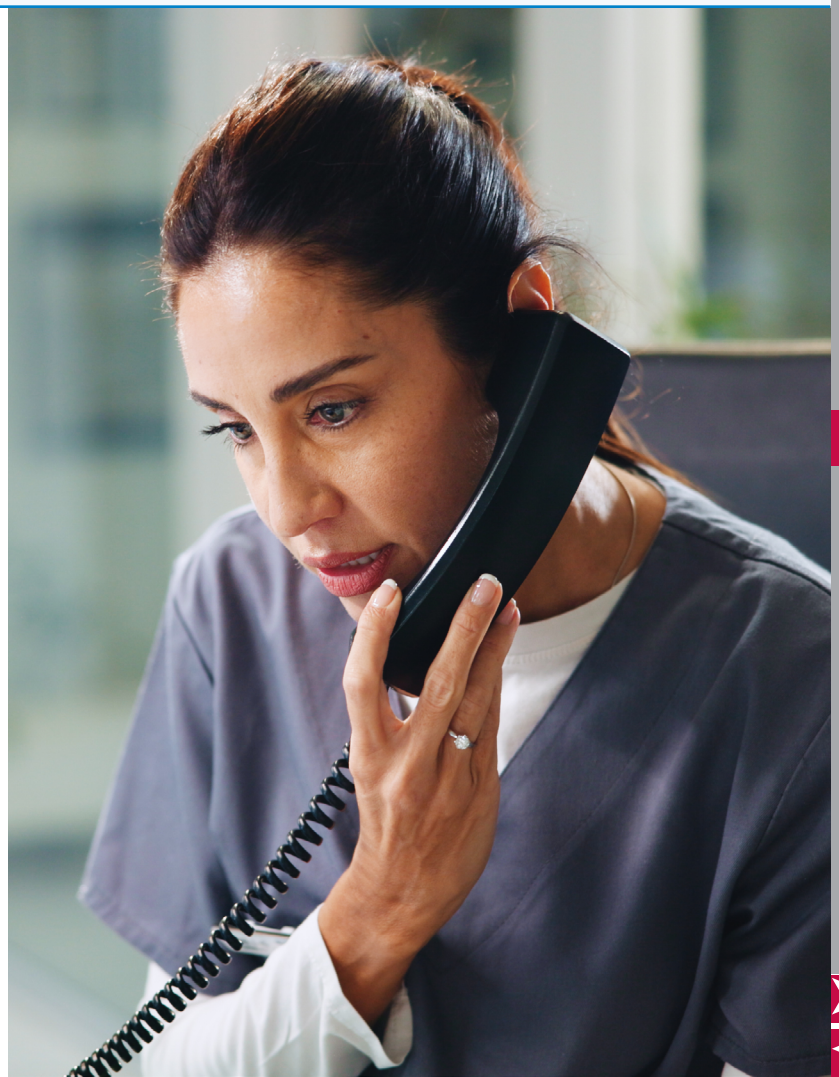
When a patient enrolls for manufacturer copay assistance, a HelpScript patient advocate will contact your office to share enrollment details, including how you'll receive funds from the manufacturer.

It's critical that billing and claims staff respond to calls from HelpScript to:

- Make it easier for you, the healthcare provider, to receive full reimbursement for drugs that are part of the program
- Improve medication adherence and clinical outcomes
- Ensure access to certain drugs with little or no cost to the member

Your office's billing department can call HelpScript at 1-833-807-4776 from 8 a.m. to 8 p.m. Monday through Friday.

To learn more about the HelpScript service, see the HelpScript section of the document titled **Drugs: For medication discounts, adherence and prior authorization determinations**.



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Pharmacy news roundup

To view all — including the most recent — pharmacy-related provider alerts

1. Log in to our provider portal (**availity.com**).
2. Click ***Payer Spaces*** on the menu bar and then click the BCBSM and BCN logo.
3. Click the ***Resources*** tab.
4. Click ***Secure Provider Resources (Blue Cross and BCN)***.
5. Click the ***Read Alerts*** button in the Alerts box.
6. Click ***Pharmacy*** on the left to limit your view to show only pharmacy alerts.

Here's a summary of pharmacy-related provider alerts from May and June 2026.

Tip: You can **subscribe** to Provider *Alerts Weekly* to receive a weekly email with links to the previous week's provider alerts.

May 2026

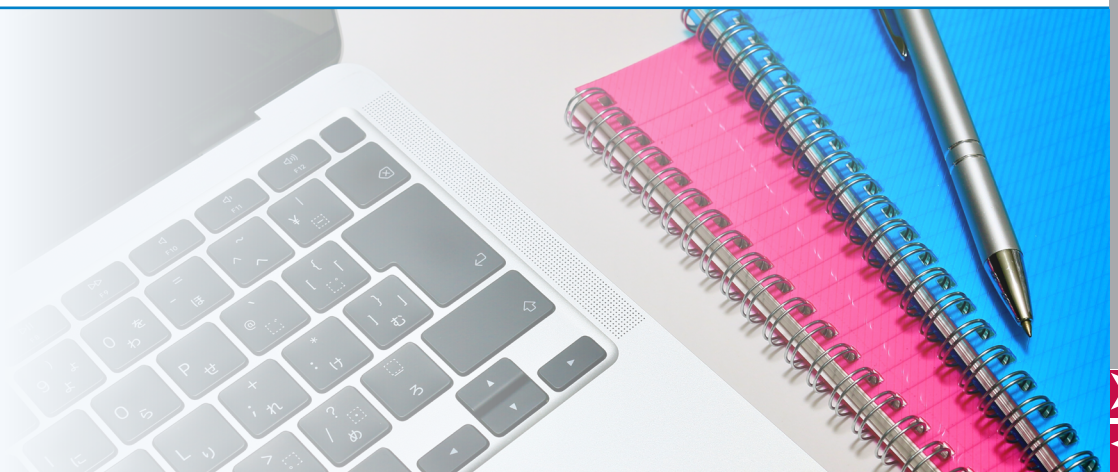
- **Check eligibility and benefits before prescribing CGM products for University of Michigan employer group members (PDF)**
- **Immgolis Intri IV to have a prior authorization and site of care requirement for most commercial members starting June 1 (PDF)**
- **Additional drugs to require prior authorization for Medicare Advantage members starting July 1 (PDF)**
- **Radiation oncology and radiopharmaceuticals to be managed through the Oncology Value Management program starting Sept. 1 (PDF)**
- **HelpScript enrollment service for manufacturer copay assistance will start July 1 for select medical benefit drugs for additional Blue Cross and BCN commercial members (PDF)**
- **Cinryze to require prior authorization for Medicare Advantage members starting June 1 (PDF)**
- **We're adding requirements for additional medical oncology drugs for most members starting Aug. 12 (PDF)**

June 2026

- **Reminder: We added a step therapy requirement to Izervay for dates of service on or after April 1 for Medicare Advantage members (PDF)**
- **We're adding requirements for additional medical oncology drugs for most members starting Oct. 1 (PDF)**
- **Boruzu to require prior authorization for Blue Cross commercial URMBT members starting Sept. 9 (PDF)**
- **Ranluspec to require prior authorization for most commercial members starting June 15 (PDF)**

Here's another article in this issue that may be of interest

- *Reminder: Radiation oncology and therapeutic radiopharmaceuticals to be managed through the Oncology Value Management program starting Sept. 1,* **Page 23**



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Use new addresses for paper claims for Blue Care Network and Blue Cross commercial members

We've changed the addresses for mailing paper claims for members with Blue Care Network commercial and BCN Advantage coverage. Additionally, we created one central Blue Cross Blue Shield of Michigan commercial address to replace the separate professional and facility addresses.

We know paper claims are rare, but if you need to send one, please update the addresses you use. To ensure we receive your paper claims for these members, please send them to the updated addresses as detailed below. You can use the new addresses starting immediately.

Effective Oct. 1, 2026, we'll no longer be able to receive paper claims at our existing P.O. boxes.

Line of business	Existing address (ends Sept. 30)	New address (active immediately)
BCN Advantage	BCN Advantage Claims P.O. Box 68753 Grand Rapids, MI 49516-8753	Blue Cross and BCN Claims P.O. Box 32593 Detroit, MI 48232-0593
BCN commercial	Blue Care Network Claims P.O. Box 68710 Grand Rapids, MI 49516-8710	Blue Cross and BCN Claims PO Box 312500 Detroit MI 48231-2500
Blue Cross commercial	**For professional claims:** Claims Division Blue Cross Blue Shield of Michigan P.O. Box 312500 Detroit, MI 48231-2500 **For facility claims:** Blue Cross Blue Shield of Michigan P.O. Box 310166 Detroit, MI 48231-0166	**For facility and professional claims:** Blue Cross and BCN Claims PO Box 312500 Detroit MI 48231-2500

Please see Use new addresses continued on Page 20

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You may notice that the new addresses for BCN are the same ones you use for Blue Cross Blue Shield of Michigan commercial and Medicare Plus Blue claims today. We hope that consolidating these addresses will make your job easier.

We'll update our provider manuals and other resources to reflect these changes.

Submit your claims electronically whenever possible

As you know, claims are only submitted on paper as an exception. The vast majority of claims can and should be submitted electronically. Instead of submitting paper claims, we encourage you to submit claims electronically through a HIPAA 837 electronic standard transaction.

For more information on electronic claim submission, see these resources:

- The Claims chapter within the *Blue Cross Commercial Provider Manual* and the *BCN Provider Manual*. Here are instructions for **how to access our provider manuals**.
- **For Providers: How Do I Sign Up for Electronic Data Interchange?**

For information on how to get connected to our provider portal, refer to the **Register for web tools** page at **bcbsm.com/providers**.

Prospective editing updates

In support of correct coding and payment accuracy, we provide information (organized by line of business) to keep you informed about forthcoming payment policy updates, new policies and coding reminders. To view, go to **Prospective editing updates** on **bcbsm.com**.

Here are some other articles in this issue that may be of interest

- *Changes to maternity billing requirements start Oct. 9, 2026,* **Page 1**
- *Grand Rapids Cascade facility to close Oct. 1, switch to electronic submission or new addresses for paper mail as soon as possible,* **Page 4**
- *Announcing updated guidelines for reviewing inpatient readmissions for Blue Cross commercial, BCN Advantage members,* **Page 11**
- *Pharmacy news roundup,* **Page 18**

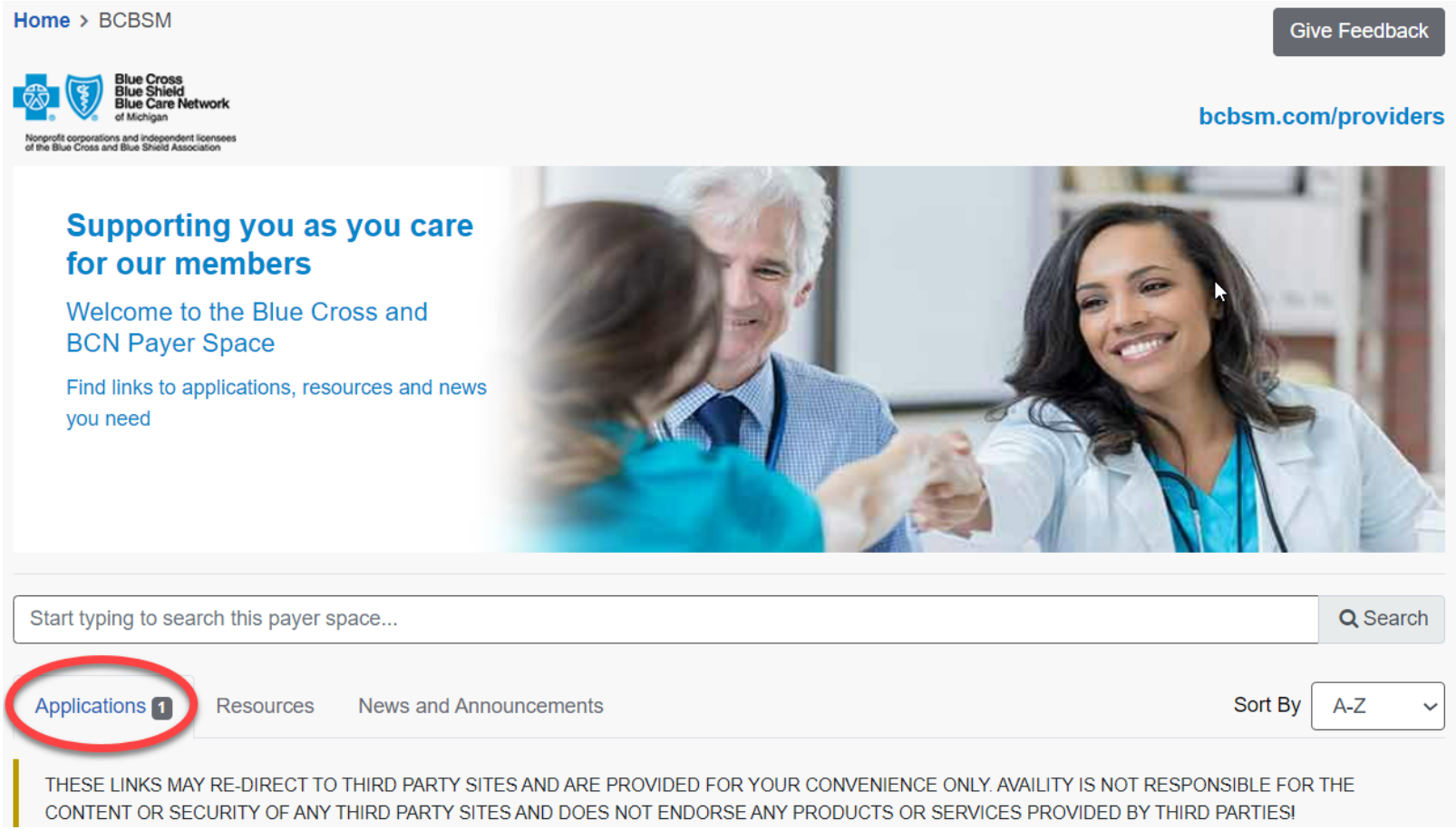


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Reminder: How to check the status of prior authorization requests to share with your patients

As a reminder, if a patient who has coverage through Blue Cross Blue Shield of Michigan or Blue Care Network asks about the status of a prior authorization request, you can check it for them by following these steps:

- Log in to our provider portal (**availity.com**).
- Click on *Payer Spaces* in the menu bar and then click on the *BCBSM and BCN logo*.
- Click on the applicable tile in the *Applications* tab through which you submitted the authorization request.



Additional information available for providers

Providers can also find a summary of services that require prior authorization through our **Summary of utilization management programs for Michigan providers** document on **authorizations.bcbsm.com**.

Note: For help using the e-referral tool, go to **authorizations.bcbsm.com** and click on **Training Tools** in the header.

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Correction: Changes to prior authorization requirements for select services managed by Blue Cross and BCN starting Feb. 1

In the **March 2026 Record** and **May-June BCN Provider News**, we published an article with incorrect information. We've corrected the information in the last row of the table. For dates of service on or after Feb. 1, 2026:

- Procedure code *87798 doesn't require prior authorization for BCN Advantage members. It continues to require prior authorization for BCN commercial members.
- Procedure codes M0237, M0238 and Q0237 no longer require prior authorization for BCN Advantage members.



Learn more about prior authorization process for Human Organ Transplant program

The Blue Cross Blue Shield of Michigan and Blue Care Network Human Organ Transplant program, or HOTP, makes prior authorization determinations for solid organ and bone marrow transplant procedures for Blue Cross and BCN commercial members.

Note: Cornea transplants, kidney transplants for members who have coverage through self-funded groups and skin transplants don't require prior authorization.

We published a new document titled **Human Organ Transplant program prior authorization process: Guidelines for solid organ and bone marrow transplants**. This document provides detailed information about:

- The steps hospital transplant financial coordinators must take to determine member eligibility for kidney-only transplants and submit the outpatient prior authorization request
- How to submit the prior authorization request for the inpatient stay at the time of the inpatient admission
- How to request an extension or reauthorization
- How to request a reconsideration review
- Where to find additional information

You can find this document on the **Transplant Services** page on **authorizations.bcbsm.com**.



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Reminder: Radiation oncology and therapeutic radiopharmaceuticals to be managed through the Oncology Value Management program starting Sept. 1

As we reported in a **May 27, 2026, provider alert**, radiation oncology services, including proton beam therapy, and therapeutic radiopharmaceuticals will be managed through the Oncology Value Management program, administered by OncoHealth, for dates of service on or after Sept. 1, 2026.

There's still time to attend a live webinar about this change. The remaining webinars are on the following dates and times:

- Thursday, Aug. 27 from 2 to 3 p.m.
- Thursday, Sept. 3 from 2 to 3 p.m.
- Wednesday, Sept. 9 from 11 a.m. to noon

If you aren't able to attend a live training session or you'd like to re-watch the training, a recording of the webinar is available on our Provider Training site by searching on *oncology*. (**Learn how to access provider training**.)

We also updated the **Oncology Value Management program through OncoHealth: Frequently asked questions for providers** with information about the expanded program, including where to submit retroactive prior authorization requests with dates of service before Sept. 1, 2026. It also includes information about the members who have requirements under the Oncology Value Management program, how to submit prior authorization requests and more. You can access the FAQ and other resources from the **Oncology Services** page on **authorizations.bcbsm.com**

OncoHealth is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing cancer support services.

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Release schedule for EviCore category assignments and practitioner performance summaries for PTs and OTs

EviCore by Evernorth® assigns physical and occupational therapists to categories that affect the information they need to supply when submitting prior authorization requests. PTs and OTs can view their category assignments through the practitioner performance summary.

When EviCore releases category assignments

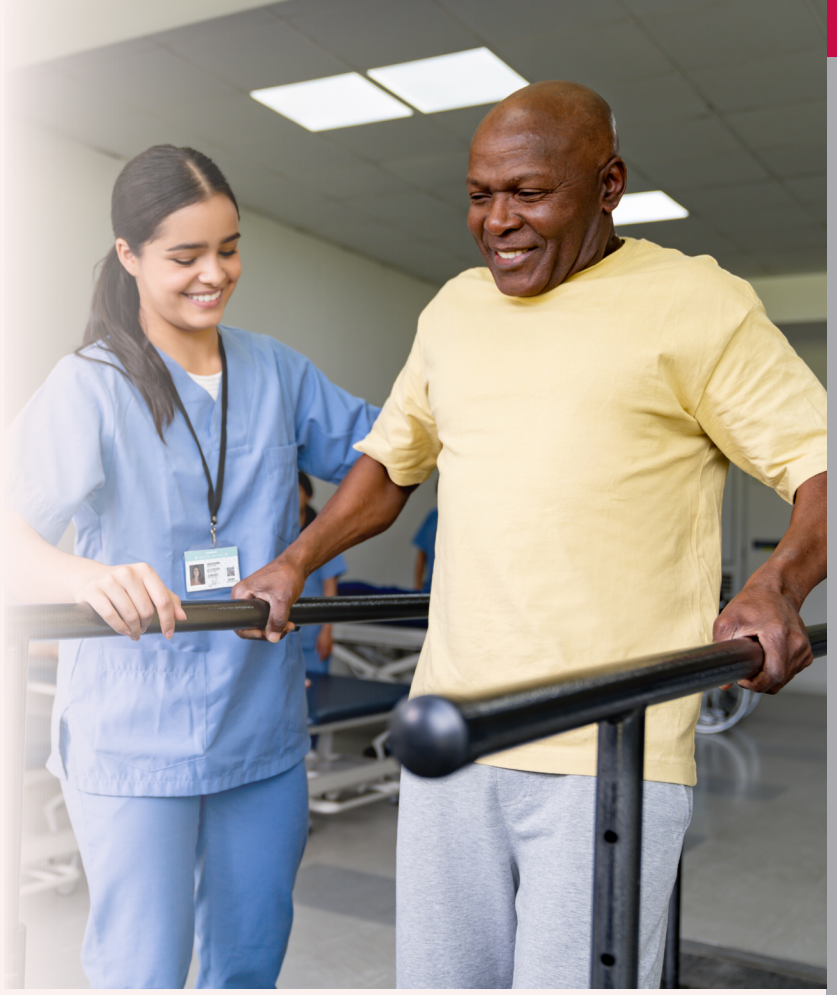
EviCore releases practitioner performance summaries with updated categories twice a year. The category assignment from the report is effective two months following the release of the report.

Report is released	Category assignment is effective
First business day of **February**	First business day of **April**
First business day of **August**	First business day of **October**

How to view practitioner performance summaries

As a reminder, EviCore no longer sends written notification of physical therapy utilization management category changes through postal mail. Instead, you can view practitioner performance summaries, which include your category assignment, through the EviCore provider portal. To do this:

1. Log in to Blue Cross and BCN's provider portal (**availity.com**).
2. Click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo.
3. Click the *eviCore Provider Portal* tile in the Applications tab.
4. In the EviCore provider portal, select *Practitioner Performance Summary* from the main menu.
5. Select the health plan (*Blue Care Network*) and a provider. Only providers you've added to your EviCore web user account are available to select.



6. Click the *UM Category* tab.

The EviCore provider portal displays the results of the most recent claims analysis and the key performance benchmarks EviCore used to determine your category.

How to appeal a category B assignment

If you believe there were circumstances that adversely affected your category assignment, you can request reconsideration within 15 days from the date on which EviCore published the new practitioner performance summary.

Submit the request for category reconsideration through the Practitioner Performance Summary area of the EviCore provider portal.

Please see Release schedule for EviCore continued on Page 25

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Background

EviCore assigns physical and occupational therapists to a category based on physical therapy visits per episode. They do this by retroactively reviewing physical therapy claims from a one-year period. The categories are:

- **Category A**: When submitting prior authorization requests, providers need to submit limited information about the patient's condition. EviCore approves the request for a block of visits over an extended duration. The provider determines the number of visits that are medically necessary within the approved time period.
- **Category B**: When submitting prior authorization requests, providers need to submit additional information, which varies based on the patient's age and condition and the type of request (initial or continuing). The number of visits EviCore approves varies based on the patient's condition, severity, complexity and response to treatment received.

Important: For hospitals or outpatient therapy centers that bill both physical and occupational therapy using the same NPI, the assigned category establishes the review requirements for both physical and occupational therapists. This is true even though the category is based only on physical therapy claims and occupational therapists aren't assigned to a category.

Additional information

To learn more about category assignments and practitioner performance summaries, see the following documents:

- **Musculoskeletal Specialized Therapy Program: Physical Therapy Practitioner Performance Summary and Provider Category FAQs**
- **Practitioner Performance Summary and Utilization Management Categories**

The above documents are available on the **PT, OT, ST and Physical Medicine Services** page on **authorizations.bcbsm.com**.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

EviCore by Evernorth is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage prior authorizations for select services. For more information, go to our **authorizations.bcbsm.com** website.

Here are some other articles in this issue that may be of interest

- *BCN simplifies referral rules to focus on PCP's primary address,* **Page 3**
- *Grand Rapids Cascade facility to close Oct. 1, switch to electronic submission or new addresses for paper mail as soon as possible,* **Page 4**
- *Referrals to home healthcare for Medicare Advantage members: Grace period extended through Sept. 30 for acute care providers,* **Page 10**
- *Pharmacy news roundup,* **Page 18**



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