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Blue Distinction Specialty Care takes aim at opioid use disorders

Blue Cross Blue Shield of Michigan, along with the Blue Cross and Blue Shield Association, has launched another tool in its battle against opioid use disorders — a Blue Distinction® Center designation for substance use treatment and recovery.

The new program focuses on the treatment of substance use disorders, including opioid use disorders, across the spectrum of care delivery. Facilities with residential, inpatient, intensive outpatient, or partial hospitalization services will be considered for designation.

Blue Care Network Medical Director Dr. William Beecroft said the company will assess each applicant's evidence-based treatments, outcomes and use of medication-assisted interventions for initial and ongoing treatment.

Other important factors include family involvement and social support, long-term outpatient services and professional or community resources, such as 12-step programming and faith-based and recovery networks.

Please see [Blue Distinction](#), continued on Page 2

Provider survey about online tools highlights what providers like and what they'd improve

We're looking for ways to improve our online tools for providers. A provider survey we recently conducted told us there are many features you like about our online service tools, but you also suggested improvements.

Here's what providers said they like about our secure provider website:

- There are minimum system outages
- Providers receive adequate web support
- Providers like that they:
 - Only need a name and date of birth for a member search in web-DENIS
 - Can access coordination of benefit information
 - Can check claim status for dependents
 - Can obtain claim status information
 - Have access to e-referrals.bcbsm.com, our electronic referral and authorization system

Please see [Provider survey](#), continued on Page 3

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Blue Distinction, continued from Page 1

"Facilities that use a holistic, comprehensive intervention strategy to handle each individual are the most likely to qualify for participation," Beecroft said.

Designated facilities must also offer medication-assisted treatment — a way to treat opioid addiction that includes a medication component and behavioral therapy.

About 130 Americans die every day from an opioid overdose, according to the Centers for Disease Control and Prevention.

For more information about Blue Distinction Specialty Care and for a complete list of designated facilities in the 11 specialty care areas, visit bcbsm.com/bluedistinction.

The Substance Use Treatment and Recovery Blue Distinction designation is one of 11 nationally designated programs that reward a commitment to delivering improved patient safety and better health outcomes.

The Blue Distinction Specialty Care program is also helping people find quality specialty care in 10 other areas:

- Bariatric surgery
- Cancer care
- Cardiac care
- Cellular immunotherapy
- Fertility care
- Gene therapy
- Knee and hip replacements
- Maternity care
- Spine surgery
- Transplants

Take our Blues Brief survey

Blue Cross Blue Shield of Michigan and Blue Care Network want to know how satisfied you are with the monthly (professional), quarterly (facility) and specialty versions of our one-page provider newsletter.

Let us know by completing a short **survey**. The survey closes March 31, 2020. Your responses will improve future Blues Brief publications.

Find *Blues Brief* on bcbsm.com/providers and on Provider Secured Services under *BCBSM Newsletters and Resources* or *BCN Provider Publications and Resources*.

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Provider survey, *continued from Page 1*

Room for improvement

Survey respondents helped us identify opportunities to improve our provider web tools. Specifically, respondents said they want:

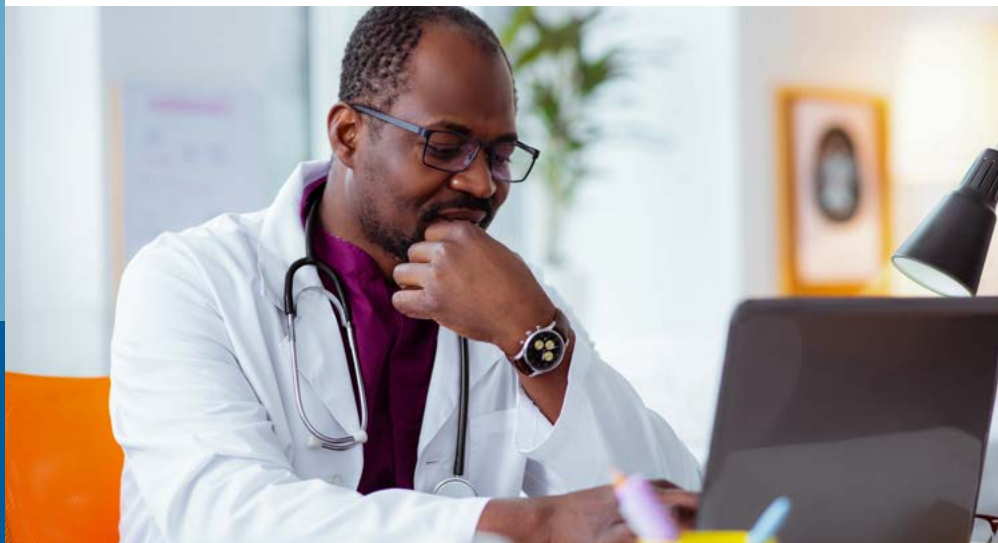
- The ability to check referral and authorization requirements by patient at a CPT code level
- Consistent benefit and eligibility functionality across all product lines
- Access to a graphic of a real patient ID card (both front and back)
- Benefit Explainer to be easier to use
- An accumulator for counting patient visits for services with limits
- A search function for content on the website
- An automated claims appeal process
- The ability to scan and upload documents when needed

Next steps

We're exploring options for improving our provider web tools while keeping the features you like. We hope to announce improvements in a future issue of this newsletter. Stay tuned.

How we conducted the survey

We conducted an online survey in September 2019 with follow-up interviews by an outside research firm. We targeted physicians and office and hospital staff members responsible for obtaining patient information from our website. A total of 159 people responded; 27 participated in an in-depth interview.



We're expanding CAQH ProView to include delegated credentialing practitioners

Blue Cross Blue Shield of Michigan is expanding the use of the CAQH ProView 3.0 application to include enrollment demographic and credentialing data for delegated credentialing practitioners.

We're doing this to:

- Streamline the data exchange process between delegated practitioner groups and Blue Cross
- Allow data to be exchanged consistently and more efficiently
- Improve our provider data quality for our members to view in our directories

We'll accept automated data feeds from CAQH ProView 3.0 into Portico, our provider data repository. This automated process will make it easier for us to maintain provider data and reduce duplication of data submission for the delegated groups.

We'll still require you to complete a supplemental document and submit Blue Cross and BCN required documentation (for example, contract signature document and Tax ID).

We'll begin beta testing this electronic data exchange with the University of Michigan Medical Group and Genesys PHO for initial enrollment and changes in the first quarter of 2020 and for recredentialing during the summer.

If you have any questions, call Provider Enrollment and Data Management at 1-800-822-2761, from 8 a.m. to 4 p.m., Monday through Friday.

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We need your Facility Provider Application for the re-credentialing process

Facilities are required to complete and return the Facility Provider Application as part of the re-credentialing process with Blue Cross Blue Shield of Michigan and Blue Care Network. We re-credential our participating facilities to ensure continued compliance with our qualification standards. We use the application data to verify and update facility demographic information stored in our provider payment database and in our directories.

Failure to complete and return this application will result in termination.

When you receive it, mail or fax the completed application to us within 30 days.

Mail:
Corporate Credentialing and Program Support
Mail Code H201
Blue Care Network
20500 Civic Center
Southfield, MI 48076

Fax: 1-866-900-0250 (Attach the cover letter as first page)

If you have any questions, call Corporate Credentialing and Program Support at **1-248-226-5274** or **1-248-327-5023** from 8 a.m. to 4 p.m. Monday through Friday, or email profcredentialing@bcbsm.com.

Clinical review decisions are based solely on appropriateness of care

Utilization decisions regarding care and services are based solely on the appropriateness of care prescribed in relation to each member's medical or behavioral health condition.

Blue Care Network's clinical review staff doesn't have financial arrangements that encourage denial of coverage or service that would result in underutilization.

BCN-employed clinical staff and physicians don't receive bonuses or incentives based on their review decisions.

Review decisions are based strictly on medical necessity within the limits of a member's plan coverage.



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BCN medical directors are a resource for physicians

Plan medical directors work throughout the state with affiliated practitioners and providers to ensure appropriate care and service for Blue Care Network members. They:

- Provide clinical support for utilization management activities, including investigation and adjudication of individual cases
- Assist in the design, development, implementation and assessment of clinical protocols, practice guidelines and criteria that support the appropriate use of clinical resources
- Adjudicate provider appeals
- Work with physicians and other health care providers to improve clinical outcomes, appropriate use of clinical resources, access to services, effectiveness of care and costs
- Serve as a liaison with the physician community

Providers may discuss decisions with BCN physician reviewers

Blue Care Network demonstrates its commitment to a fair and thorough process of determining utilization by working collaboratively with participating physicians. BCN's plan medical directors may contact the treating health care practitioner for additional information about any review deemed necessary. When BCN doesn't approve a request, we send written notification to the appropriate practitioners and providers, and the member. The notification includes the reason the service wasn't approved as well as the phone number of BCN's plan medical directors to discuss the decision.

If you're a practitioner and would like to discuss a denial of an authorization request with one of our plan medical directors, request a phone appointment by following the

process outlined in the document titled **How to request a peer-to-peer review with a BCN medical director**. To discuss an urgent case after normal business hours, call 1-800-851-3904. This number is for non-behavioral health cases only.

For more information on peer-to-peer reviews, see the article on **Page 34**.

How to obtain a copy of utilization management criteria

Upon request, Blue Care Network provides the criteria used in the decision-making process for a specific authorization request. For a copy, call Utilization Management at 1-800-392-2512 from 8:30 a.m. to 5 p.m. Monday through Friday.

You can also fax your request to us. First, complete the **BCN Criteria Request Form** (found on ereferrals.bcbsm.com) and fax it to 1-866-373-9468. (Note: This applies to non-behavioral health authorizations requests only.)

The process for requesting utilization management criteria is also available in the Care management chapter of the *BCN Provider Manual*.

Due to licensing restrictions, we can't distribute complete copies of the InterQual® criteria to all practitioners and providers. However, all contracted hospitals have the electronic version of the criteria as part of BCN's licensing agreement.

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How to request a member transfer

In some circumstances, a primary care physician can request that a member be removed from his or her practice and assigned to another primary care physician. This applies to both BCN HMOSM (commercial) and BCN AdvantageSM members.

Submit a Member Transfer Request Form

The member's current primary care physician must complete and submit the *Member Transfer Request Form* to BCN.

The form is on the last page of a frequently asked questions document and is available on BCN's Forms page:

1. Visit bcbsm.com/providers.
2. Log in to Provider Secured Services.
3. Scroll down and click *BCN Provider Publications and Resources*, on the right.
4. Click *Forms*.
5. Click *Member Transfer FAQ and Request Form*, under the "Member transfer" heading.

You'll also find a link to the *Member Transfer FAQ and Request Form* on the Health e-BlueSM home page and in the BCN System of Managed Care chapter of the *BCN Provider Manual*.

Criteria for requesting a member transfer

Review the FAQ to make sure your request meets the member transfer criteria. The criteria involve a member's:

- Financial obligations
- Behavior
- Geographic distance from the physician office
- Seeing a primary care physician in a different office
- Lack of response to outreach by your office

The FAQ also outlines details for submitting the request and your responsibilities once the request has been submitted.

Remember, BCN must approve the request before the member can be transferred.

BCN staff available to our members for utilization management issues

Did you know that we're available for our members (your patients) to discuss utilization management issues at least eight hours a day during normal business hours?

We accept inbound collect or toll-free calls; we return calls the same day or the next business day.

Our staff members identify themselves by name, title and organization when receiving or returning calls. We also provide language assistance free of charge to discuss utilization management issues with our members. We offer TTY assistance for the hearing impaired.

Tell your patients to call the number on the back of their member ID card for information about our communication services.

See related article, "Behavioral health providers may discuss decisions with BCN physician reviewers," [Page 20](#).



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Blue Cross updates its concierge medicine policy

As a reminder, health care providers must comply with their affiliation agreements. Blue Cross Blue Shield of Michigan affiliation agreements require providers to:

- Submit claims for covered services (for example, services covered under a member's benefit plan) directly to Blue Cross.
- Accept our payment for covered services as payment in full.
- Only charge the member the applicable copay or deductible (or both) for the covered service.
- Not discriminate against members based on payment level, benefit or reimbursement policies.

About concierge medicine

In a concierge, or "retainer," practice, patients pay membership fees to a health care provider or third-party vendor for enhanced services or amenities. As a benefit of paying this fee, members typically receive:

- Easy appointment access
- Extended office visits
- Enhanced email and telephone communication with doctors
- Care coordination (including referrals) between the concierge practice and specialists
- Wellness programs and plans, genetic and nutritional counseling, risk appraisals

Policy changes

Blue Cross Blue Shield of Michigan has made some changes, as follows, to its concierge medicine policy since we wrote about it in the July 2015 *Record*:

Health care practitioners who wish to use this model in their practice won't be eligible for any value-based reimbursement through Blue Cross and Blue Care Network programs such as, but not limited to, Physician Group Incentive Program-related value-based reimbursement opportunities through the Patient-Centered Medical Home designation program or other programs.

Also, practitioners must ensure that the requirements of the concierge model are permitted by their affiliation agreements with Blue Cross.

Providers may charge a concierge fee if:

- Patients aren't required to pay the concierge fee to become or continue to be a patient in the practice.
- Patients aren't required to pay the concierge fee to obtain access to the provider and are only permitted access to ancillary providers, such as physician assistants or nurse practitioners, if they don't pay the concierge fee.
- The services or products being offered as part of the concierge fee aren't considered "covered services" under our affiliation agreements, but instead aren't covered under a member's benefit plan. Because benefit structures vary significantly among our members, providers are expected to understand each member's benefit structure to ensure that covered services aren't included in the concierge fee.
- Patients who don't pay the concierge fee continue to receive the same level of access and services as they previously received.
- Providers continue to meet Blue Cross and BCN performance standards regarding access and service.

The concierge level of service is clearly over and above usual practice in Michigan. Complaints from members who experience a decline in service level may result in Blue Cross concluding that the practice is noncompliant with the nondiscrimination clause of our affiliation agreements.

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Reminder: Direct reimbursement available to clinical nurse specialists

As was stated in previous articles, clinical nurse specialists can participate in Blue Cross Blue Shield of Michigan's Traditional and TRUST PPO networks and Medicare Plus BlueSM, as well as BCN HMOSM and BCN AdvantageSM, starting Jan. 1, 2020.

Participating clinical nurse specialists will receive direct reimbursement for covered services within the scope of their licensure at 85% of the applicable fee schedule, minus any member deductibles and copayments. This change affects Blue Cross and BCN benefit plans that cover services that clinical nurse specialists are licensed to provide. To find out if a patient has coverage, check web-DENIS for member benefits and eligibility or call Provider Inquiry at 1-800-344-8525.

Clinical nurse specialists can find enrollment forms and practitioner agreements on bcbsm.com. To find enrollment information, click on *Providers* and then on *Join Our Network*. Specific qualification requirements are identified within each agreement.

All applicants to the TRUST PPO, Medicare Plus Blue, BCN HMO and BCN Advantage networks must pass a credentialing review before participation. We'll notify applicants in writing of their approval status.

New Blue Cross and BCN members to be issued alphanumeric subscriber IDs in 2020

Blue Cross and Blue Care Network will begin issuing alphanumeric subscriber IDs to new members, starting July 1, 2020.

New IDs will begin with the letter M after the prefix. For example, a new subscriber ID will look like this: XYZM91234567.

The alphanumeric subscriber IDs (de-identified IDs, which appear on subscribers' ID cards) are being implemented to avoid duplication with existing Social Security numbers, align with other health plans and to automate manual processes formerly used to correct the duplicate numbers.

This doesn't apply to existing members at this time.



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Online Training



Sign up for additional training webinars

Provider Experience is continuing its series of training webinars for health care providers and staff. They're designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

Here's how to register for the upcoming training webinars:

Webinar name	Date and time	Registration
Blue Cross 201 – Claims Appeals Overview	Tuesday, March 17, 9:30 to 10:30 a.m.	Click here to register
Blue Cross 201 – Claims Appeals Overview	Tuesday, March 17, 1 to 2 p.m.	Click here to register
Blue Cross 201 – Claims Appeals Overview	Tuesday, March 31, 9:30 to 10:30 a.m.	Click here to register
Blue Cross 201 – Claims Appeals Overview	Tuesday, March 31, 1 to 2 p.m.	Click here to register

Blue Cross 201 provides in-depth learning opportunities for providers and builds on information shared in our *Blue Cross 101: Understanding the Basics* webinar. This session focuses on the claims and appeals process for Blue Cross Blue Shield of Michigan, Blue Care Network, Medicare Plus Blue PPOSM and BCN AdvantageSM facility and professional claims.



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Medicare Part B medical specialty drug prior authorization list is changing in March

We're adding medications to the Medicare Plus BlueSM PPO and BCN AdvantageSM Part B medical specialty prior authorization drug list. These specialty medications are administered in outpatient sites of care, such as a physician's office, an outpatient facility or a member's home.

For dates of service on or after March 16, 2020, you'll need to request authorization for the following medications through the system specified below.

Through the NovoLogix[®] online tool

- J3590 Adakveo[®]
- J3490 Scenesse[®]
- J3490 Reblozyl[®]

Through the AIM Specialty Health[®] ProviderPortalSM

- J9309 Polivy[™]
- J9036 Belrapzo[™]
- J9118 Asparlas[™]
- J9313 Lumoxiti[™]
- J9356 Herceptin Hylecta[™]
- Q5116 Trazimera[™]
- Q5117 Kanjiti[™]
- Q5118 Zirabev[™]

How to bill

For Medicare Plus Blue and BCN Advantage, we require authorization for these medications for all outpatient sites of care when you bill the medications as a professional service or as an outpatient facility service and you bill in one of the following ways:

- Electronically through an 837P transaction or on a professional CMS-1500 claim form
- Electronically through an 837I transaction or using a UB04 claim form for a hospital outpatient type of bill 013x

Important reminder

Depending on the medication, you can quickly submit authorization requests through NovoLogix or through AIM.

- **NovoLogix:** You can access NovoLogix through Provider Secured Services. It offers real-time status checks and immediate approvals for certain medications. Also note:
 - For Medicare Plus Blue, if you have a Type 1 (individual) NPI and you checked the Medical Drug PA box when you completed the *Provider Secured Access Application* form, you already have access to NovoLogix. If you didn't check that box, complete an **Addendum P** form to request access to NovoLogix and fax it to the number on the form.
 - For BCN Advantage, if you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix.

If you need to request access to Provider Secured Services, complete the **Provider Secured Access Application** form and fax it to the number on the form.

- **AIM:** You can submit authorizations through the **AIM ProviderPortal** or by calling AIM at 1-844-377-1278. For information about registering for and accessing the AIM *ProviderPortal*, see the **Frequently asked questions** page on the AIM Specialty Health website.

List of requirements

For a list of requirements related to drugs covered under the medical benefit, see the **Medical Drug and Step Therapy Prior Authorization List**.

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Learn more about health concerns addressed in Medicare Health Outcomes Survey

According to the National Committee for Quality Assurance:

- Falls are the leading cause of death by injury in people age 65 and older; each year, 1 in 4 older adults falls.
- Urinary incontinence is significantly underreported and underdiagnosed.
- Any amount of physical activity reduces the risk of developing certain chronic conditions and increases quality of life.

The Medicare Health Outcomes Survey, or HOS, measures patient-reported outcomes to help address these serious health concerns. The survey runs from April to July and asks Medicare Advantage members about how their health care providers talk to them about these important topics:

- Fall risk management
- Management of urinary incontinence in older adults
- Physical activity in older adults

Review the HOS tip sheet to see sample survey questions and learn how you can address care opportunities with patients.



We're clarifying how to submit authorization requests for Medicare Part B medical specialty drugs Prolia and Xgeva

Although Part B specialty drugs Prolia® and Xgeva® have the same generic name, denosumab, and HCPCS code, J0897, the system through which you request authorization differs. Both drugs require authorization for Medicare Plus BlueSM PPO and BCN AdvantageSM members.

See complete article on **Page 31** for details.

Providers should bill 99422 for telemedicine service for BCN Advantage members

Providers should bill *99422 for telemedicine services for BCN AdvantageSM members. The previous code was retired, effective Jan. 1, 2020.

* CPT codes, descriptions and two-digit numeric modifiers only are copyright 2019 American Medical Association. All rights reserved.

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What you need to know about Medicare fraud, waste and abuse

BCN AdvantageSM uses Medicare funds to pay doctors, hospitals, pharmacies, clinics and other health care providers to provide care to patients eligible for Medicare benefits. Sometimes, providers and patients misuse Medicare resources, leaving less money to help people who need care. This misuse falls in the following categories: fraud, waste, or abuse.

Definition of fraud

Fraud is intentional deceit or misrepresentation of the truth that results in some extra cost to the health care system. Fraud schemes range from those committed by individuals acting alone to broad-based activities by institutions or groups of individuals. Seldom do these schemes target only one insurer or the public or private sector exclusively. Most are simultaneously defrauding several private and public-sector victims, including Medicare and Medicaid.

Health care fraud is defined in Title 18, United States Code (U.S.C.) § 1347, as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

This definition applies to health care programs such as Medicare and Medicaid.

Definition of abuse

Abuse occurs when a provider or a patient behaves in a way that is inconsistent with sound business or medical practices, resulting in an unnecessary cost to the Medicare program. Abusive practices can involve payment for services that aren't medically necessary or that fail to meet professionally recognized standards for health care.

Differences between fraud and abuse

Fraud is distinguished from abuse in that there is clear evidence that fraudulent acts were committed knowingly and intentionally. Abusive practices, on the other hand,

may not be intentional or it may be impossible to show that intent existed. Although these types of practices may initially be classified as abusive, they may develop into fraud if there is evidence that the provider or patient was intentionally conducting an abusive practice.

Definition of waste

Waste describes the outcome from practices that result in unnecessary costs to the health care system, but generally do not involve intentional or criminally negligent actions.

Waste can result from poor or inefficient billing or treatment methods, for example.

Minimizing fraud, waste and abuse means the federal government, through contracted insurers such as BCN Advantage, can provide more care to more people and make the Medicare program stronger. Together, all of us can work to find, report and investigate fraud, waste and abuse.

Fraud, waste and abuse prevention

See our policy and applicable laws on web-DENIS under *BCN Provider Publications and Resources*. Click on *Policies and Information* and then *Detection and Prevention of Fraud, Waste and Abuse Policy*. Information on fraud, waste and abuse can also be found in the *BCN Provider Manual*.

BCN Advantage HMO-POSSM and BCN Advantage HMOSM providers and members can report fraud and abuse to the anti-fraud hotline for Blue Cross Blue Shield of Michigan at 1-888-650-8136.

You may also contact the Office of Health Services Inspector General one of the following ways:

Phone: 1-800-HHS-TIPS (1-800-447-8477)

Online: [Medicare.gov/fraud](https://www.medicare.gov/fraud).

Mail: Office of Inspector General
Attention: OIG Hotline Operations
P.O. Box 23489
Washington, D.C. 20026

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Correction: Annual visits for Medicare Advantage patients

We ran an **article** in the January-February 2020 issue of *BCN Provider News* (Page 9) titled, "Get ready for annual visits for your Medicare Advantage patients."

We included some examples of preventive visits that require clarification. The corrected information appears below:

- Osteoporosis screening
 - Bone mineral density testing for women over age 65 and men over age 70
 - Recommended every 2 to 10 years, depending on risk factors
 - Medicare pays for the screening every two years; more often if medically necessary
- Comprehensive diabetes care
 - A1c blood sugar screening to diagnose diabetes — every three years if test is normal; once diagnosed, 2 to 4 times per year to monitor treatment response
 - Urine microalbumin screening — yearly
 - Retinal eye exam — every other year if negative or every year if positive

Correction: Here's the link to the star measure tip sheet on BMI

We ran an article in the January-February issue of *BCN Provider News* (Page 12) about documenting BMI in the primary care setting. There was supposed to be a link to a star measure tip sheet. Click on the PDF below for the correct tip sheet.

We apologize for the error.



Update: Blue Cross, BCN support providers who offer comprehensive opioid treatment

In the January-February 2020 BCN Provider News, we published an article on this topic. We have updated the article with some additional information and clarifications. Please use the following as your reference for information about the Centers for Medicare & Medicaid Services program that encourages providers to offer the comprehensive range of opioid treatment services that many patients need.

We've implemented the CMS program that encourages providers to offer the comprehensive range of opioid treatment services that many patients need. **See Page 17** for the updated article.

Authorization requirements changing for home health, TPN and IDPN services for BCN members

We're changing authorization requirements for home health, total parenteral nutrition and intradialytic parenteral nutrition services for Blue Care Network members.

See full article on **Page 36** for details.

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Consider an ASC as site of care option
for low-risk patients

By Dr. Marc Keshishian



If your patient is in good health with no chronic conditions and has never had an adverse reaction to anesthesia, consider choosing an ambulatory surgical center for routine outpatient procedures instead of the hospital. Outpatient procedures increasingly done in ASCs include:

- Lens and cataract procedures
- Colonoscopy and biopsy
- Upper gastrointestinal endoscopy and biopsy
- Hip and knee arthroplasty

What's in it for you?

Choosing an ASC can give you more control over surgical practices, more flexible scheduling and lower facility fees. Additionally, the list of covered surgical procedures at ASCs is growing each year. According to **Becker's ASC Review**, six coronary intervention procedures, including cardiac stenting, may be added to that list in 2020, as proposed by the Centers for Medicare & Medicaid Services.

What's in it for your patients?

With ASCs, patients benefit from more convenient locations, shorter waiting times for scheduling procedures, a **lower chance of post-operative** infections and lower cost shares than outpatient surgery in a hospital, contributing to higher overall patient satisfaction. Procedures typically take less time than those done at hospital outpatient departments, so patients are under anesthesia for a shorter period of time, leading to **fewer complications**.

Economic impact

The **number of ASCs** in the U.S. increased 1% from 2012 to 2016; however, the number went up 2.4% from 2016 to 2017. As of 2018, **CMS data** shows Michigan has about 100 ASCs. Nationally, the care that ASCs provide saves money, according to the **Ambulatory Surgery Center Association**. Procedures performed in ASCs save the Medicare program and its beneficiaries more than \$2.6 billion on average each year because the rates for procedures performed in ASCs are much less than those same procedures performed in hospitals.

Choosing an ASC versus a hospital outpatient department for your patient is your decision. And, if it's appropriate for your patient, the benefits to providers, patients and Medicare show choosing an ASC is a win-win-win situation.

Dr. Keshishian is senior vice president and chief medical officer, Blue Care Network and vice president, Health and Clinical Affairs, Blue Cross Blue Shield of Michigan

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Criteria corner

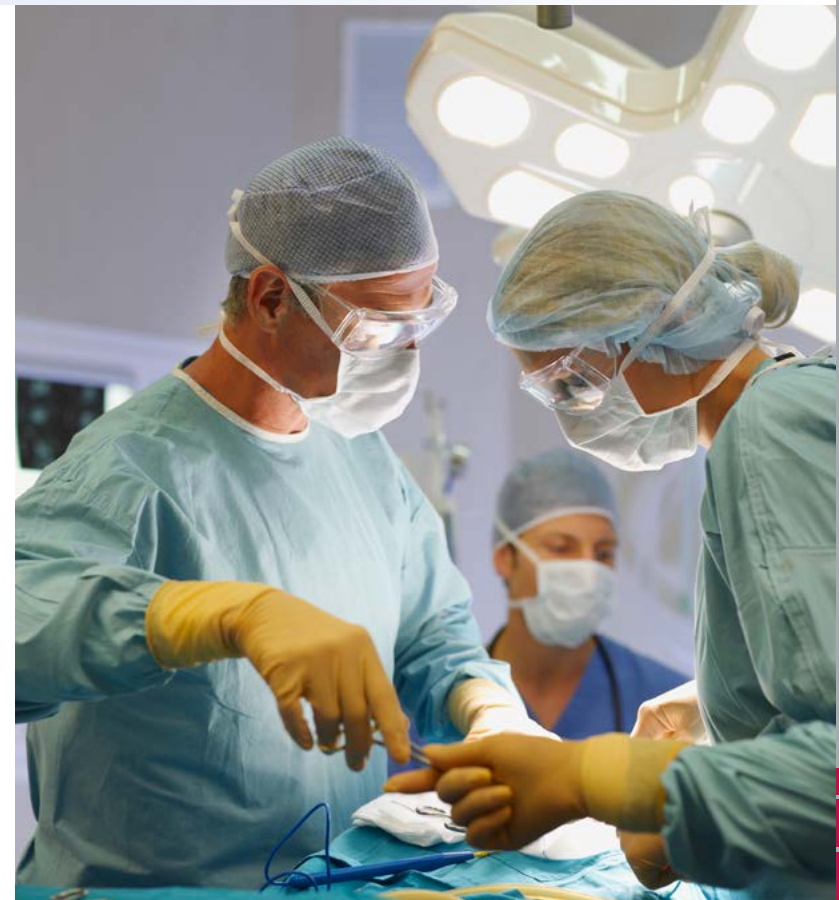
Blue Care Network uses Change Healthcare's InterQual Level of Care when conducting admission and concurrent review activities for acute care hospitals. To ensure that providers and health plans understand the application of the criteria and local rules, BCN provides clarification from Change Healthcare on various topics.

Question:

Using the 2019 Inpatient List, please confirm that an open prostatectomy is appropriate for the inpatient setting, and that an open radical prostatectomy has an asterisk which would mean it can be either inpatient or outpatient.

Answer:

The asterisk for Prostatectomy, Radical indicates that due to variations in practice (for example, open, laparoscopic, laparoscopically assisted, robotic-assisted), this procedure can be performed in the inpatient or outpatient setting. The Prostatectomy, Open is strictly an open approach with no minimally invasive surgery techniques offered and is usually performed on a large prostate (> 80 grams). Therefore, it's done in the inpatient setting only. We'll continue researching criteria for future updates of the content.



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Know member rights and responsibilities

Blue Care Network members have certain rights and responsibilities. Providers should be aware of these rights.

Members have a right to:

- Receive information about BCN and BCN AdvantageSM services, practitioners or providers, and member rights and responsibilities
- Be treated with respect and recognition of their dignity and their right to privacy
- Participate with practitioners in making decisions about their health care
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Voice complaints or appeals about BCN and BCN Advantage, or the care provided
- Make recommendations regarding BCN and BCN Advantage member rights and responsibilities policy

Members have a responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need to provide care
- Follow plans and instructions for care that they have agreed to with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

A complete list of these rights and responsibilities is available on our [website](#).

Medical policy updates

Blue Care Network's medical policy updates are posted on Provider Secured Services. Go to *BCN Provider Publications and Resources* and click on *Medical Policy Manual*. Recent updates to the medical policies include

Noncovered services

- Surface electromyography
- Surgery for groin pain in athletes

Covered services

- Ground ambulance services
- Genetic testing — molecular analysis for targeted therapy of non-small-cell lung cancer
- Cochlear implant
- Implantable bone-conduction and bone-anchored hearing devices
- Charged-particle (proton or helium ion) radiotherapy for neoplastic conditions
- Skin and tissue substitutes
- Closure devices for patent foramen ovale and atrial septal devices
- Magnetic resonance-guided focused ultrasound
- Drug testing in pain management and substance use disorders treatment



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Update: Blue Cross, BCN supports providers who offer comprehensive opioid treatment

In the January-February 2020 BCN Provider News, we published an article on this topic. We have updated the article with some additional information and clarifications. Please use the following as your reference for information about the Centers for Medicare & Medicaid Services program that encourages providers to offer the comprehensive range of opioid treatment services that many patients need.

Blue Cross Blue Shield of Michigan and Blue Care Network have implemented the CMS program that encourages providers to offer the comprehensive range of opioid treatment services that many patients need. You can view the CMS final rule on this program, which was published in the **Federal Register**.

What this means

Starting Jan. 1, 2020, Medicare Plus BlueSM PPO and BCN AdvantageSM are using bundled rates to reimburse providers who offer certified opioid treatment programs, or OTPs. The bundled payment includes both drug and non-drug components and may allow for intensity add-on codes to be used when needed.

Only providers who are certified through the Substance Abuse and Mental Health Services Administration, or SAMHSA, to provide OTP services are eligible to receive bundled reimbursement.

Additional information you need to know

- This applies to Medicare Plus Blue and BCN Advantage members only — not to our commercial members (BCN HMOSM and Blue Cross' PPO).
- Member cost-sharing applies for these services.
- The bundled OTP reimbursement is for professional services only:
 - For Medicare Plus Blue, payment is based on the Medicare physician fee schedule.

- For BCN Advantage, payment is based on the flat rates for non-drug costs released in December 2019 by CMS in **Opioid Treatment Programs (OTPs) Medicare Billing and Payment Fact Sheet** (MLN 8296732).
- HCPCS codes G2067 through G2080 must be billed with place of service 58.
- The reimbursement does not include drug costs. You'll need to bill these as pharmaceutical services using standard billing practices.

What's an OTP?

OTPs provide medication-assisted treatment along with counseling and other services for people diagnosed with an opioid use disorder. The treatment of opioid dependence with medications is governed by the Certification of Opioid Treatment Programs, 42 Code of Federal Regulations 8. This regulation created a system to accredit and certify opioid treatment programs.

SAMHSA's Division of Pharmacologic Therapies is responsible for overseeing the certification of OTPs.

For information on how to obtain OTP certification, visit **SAMHSA's Certification of Opioid Treatment Programs** webpage.

About the CMS program

Section 2005 of the SUPPORT for Patients and Communities Act established a new Medicare Part B benefit for opioid use disorder, or OUD, treatment services. The OUD treatment services include medications for medication-assisted treatment furnished by opioid treatment programs.

To meet this statutory requirement, CMS has finalized the following:

- Definitions of OTP and OUD treatment services
- Enrollment policies for OTPs

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Update, continued from Page 17

- Methodology and estimated bundled payment rates for OTPs that vary by the medication used to treat OUD and service intensity, and by full and partial weeks
- Adjustments to the bundled payment rates for geography and annual updates
- Flexibility to deliver the counseling and therapy services described in the bundled payments via two-way interactive audio-video communication technology as clinically appropriate
- Zero beneficiary copayment for a time-limited duration

Blue Cross and BCN have implemented this program beginning Jan. 1, 2020, as required by the Substance Use-

Disorder Prevention that Promotes Opioid Recovery and Treatment, or SUPPORT, for Patients and Communities Act. However, for Blue Cross and BCN members, applicable member cost-sharing amounts apply.

What's next?

In the future, we may offer bundled rates to reimburse OTP services for our commercial members, in addition to our Medicare Advantage members.

Look for updates on this and on related topics in future issues of *The Record* and *BCN Provider News*, as well as web-DENIS messages and news items on our ereferrals.bcsbm.com website.

Tell your patients about the risks of medication noncompliance

In the United States, 3.8 billion prescriptions are written annually, with only one in five new prescriptions filled, according to the Centers for Disease Control and Prevention. Among those filled, the CDC estimates, 50% are taken incorrectly because of issues related to timing, dosage, frequency and duration.

As most physicians know, patients often don't understand the damage or consequences of noncompliance. This is especially true for those who have high blood pressure, high cholesterol, asthma or diabetes.

To encourage your patients to take medication compliance seriously, consider sharing these statistics with them:

- Patients with hypertension who aren't taking high blood pressure medication correctly are three to seven times more likely to suffer a stroke, according to the American College of Cardiology.
- More than 12% of adults in the U.S. ages 20 and older had total cholesterol higher than 240 mg per dl, the CDC found. But only 55% of adults who could benefit from statin medication are currently taking it.

- Of U.S. adults diagnosed with asthma, 61.9% don't have their asthma controlled and are five times more likely than children to die from asthma, according to the CDC.
- Patients with Type 2 diabetes who are noncompliant with their diabetes medication are more likely to be hospitalized or visit the emergency room than patients who are compliant, according to the National Center for Biotechnology Information.

Suggestions

To help ensure your patients take their medication appropriately, suggest they do the following:

- Print the American Heart Association's [medicine chart](#) to write down when and how to take medication.
- Use pill organizers.
- Use sticky notes, a white board or a calendar to keep track of medications and when to take them.
- Use a smartphone to set reminders.

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Additional free waiver training opportunities offered

Battling the opioid epidemic



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We've added information on some new training sessions since we communicated about this topic in the January-February BCN Provider News.

The Michigan Center for Clinical Systems Improvement, known as Mi-CCSI, and Blue Cross Blue Shield of Michigan are hosting the American Society of Addiction Medicine Treatment of Opioid Use Disorder course at various Michigan locations this year. Each course will provide the required eight educational hours to obtain the medication-assisted treatment waiver to prescribe buprenorphine in an office setting for patients with opioid use disorder.

The first two sessions, both hosted by Mi-CCSI, include a financial incentive. They're flagged with two asterisks after the date and time, with an associated footnote at the bottom of the article.

Date and time	Location and registration link
March 2 from 8 a.m. to 5 p.m.**	Muskegon Community College Stevenson Center, Room 2318 221 S. Quarterline Road Muskegon To register, click here :
April 27 from 8 a.m. to 5 p.m.	Hagerty Center 715 E. Front St. Room A and B Traverse City To register, click here :

Date and time	Location and registration link
May 28 from 8 a.m. to 5 p.m.	Upper Peninsula Health Group Conference Room 853 W. Washington St. Marquette To register, click here :
June 5 from 8 a.m. to 5 p.m.	Thunder Bay National Marine Sanctuary 500 W Fletcher St. Alpena To register, click here :
Sept. 21 from 8 a.m. to 5 p.m.	Kent County Health Department 700 Fuller Ave. NE. Grand Rapids To register, click here :

These courses fill up quickly, so we encourage you to register early.

**The first 15 providers attending the full eight hours will be paid for the day as follows:

- Physicians (M.D.s and D.O.s) — \$500
- Advanced practice providers (nurse practitioners and physician assistants) — \$250

This incentive is only for the March 2 session.

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Behavioral health providers may discuss decisions with BCN physician reviewers

Blue Care Network is committed to a fair and thorough process of determining utilization by working collaboratively with its participating behavioral health practitioners.

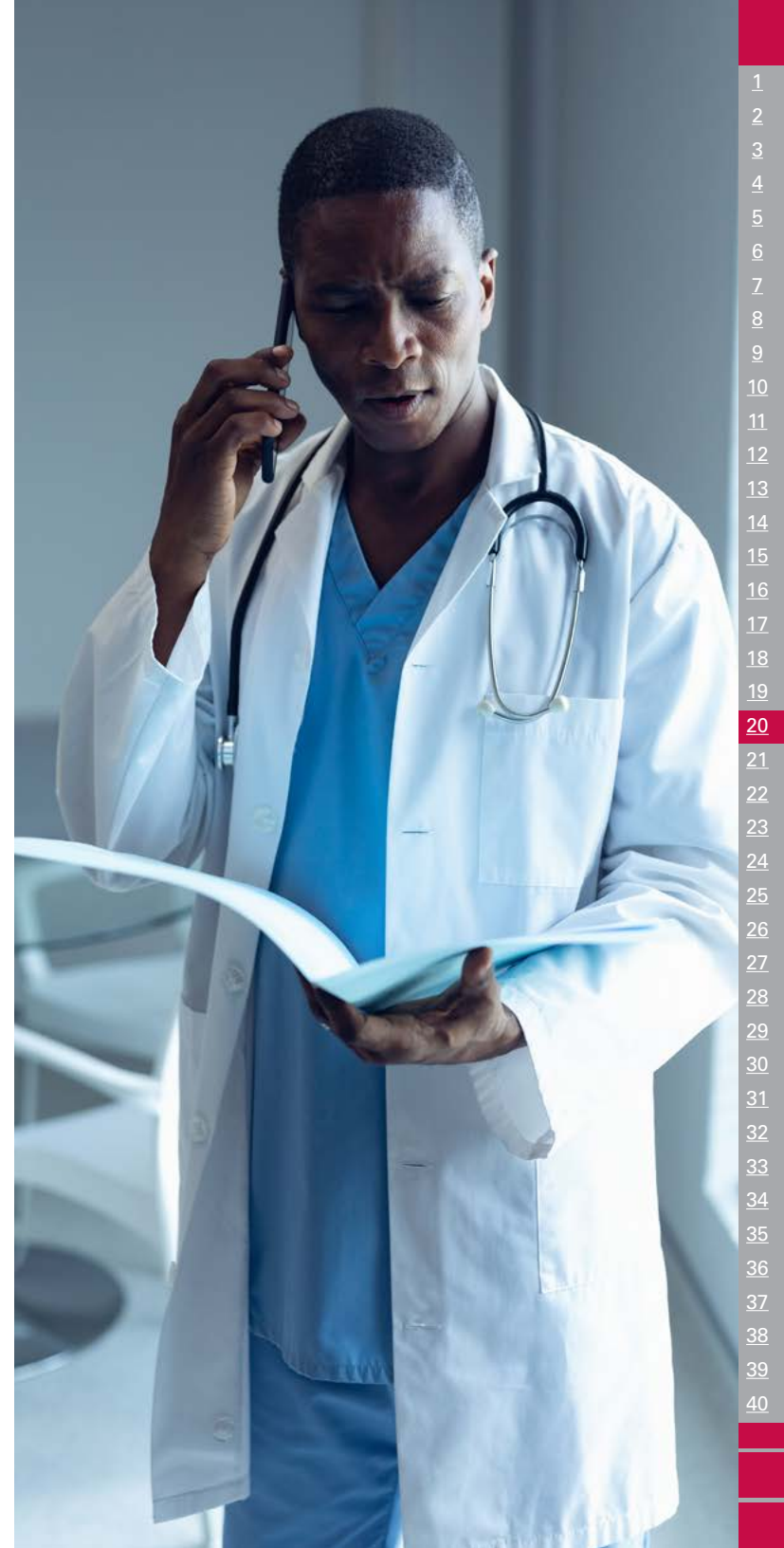
BCN's behavioral health physician reviewers may contact practitioners for additional information about their patients during their review of all levels of care, patient admissions, additional hospital days and requests for services that require medical policy and benefit interpretations.

When BCN doesn't approve a service request, we send written notification to the requesting practitioner. The notification includes the reason the service wasn't approved and a phone number for BCN's behavioral health physician.

Practitioners may discuss any decision with a BCN behavioral health physician reviewer. Call Behavioral Health at 1-877-293-2788 Monday through Friday, from 8 a.m. to 5 p.m. To discuss an urgent case after normal business hours with one of our behavioral health physician reviewers, call 1-800-482-5982.

How to obtain a copy of behavioral health criteria

Upon practitioner request, BCN will provide you with the behavioral health criteria used in our decision-making process. Call 1-877-293-2788 to request a copy.



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Reminder: We've updated the 2020 BCN behavioral health fee schedule

We've updated the 2020 BCN Behavioral Health Fee Schedule to add or revise fees for these services:

- Long-acting drugs billed with these HCPCS codes: J0400, J0401, J1631, J2062, J2315, J2358, J2426, J2680, J2794 and J3486 (when directly purchased)
- Administration of a long-acting drug billed with CPT code *96372
- Spravato™ (esketamine) billed with the not-otherwise-classified code J3490
- Observation period after administration of Spravato: Use codes *99415 and *99416, as appropriate

We also added this important information:

For BCN HMOSM (commercial) claims only

- We'll reimburse the J codes for professional claims (HCFA 1500) based on the BCN professional NDC fee schedule, with fees configured as discounts from the average wholesale price.
- You should bill using the appropriate National Drug Code, NDC units and NDC unit of measure. For information on this, refer to the Pharmacy chapter of the *BCN Provider Manual*. Look in the section titled "Drugs covered under the medical benefit." Scroll through that section to find the information about billing with NDCs.
- We'll reimburse professional claims submitted without the NDC information according to the HCPCS code and units billed based on the fee published in the BCN Behavioral Health Fee Schedule.

For BCN AdvantageSM claims only

- We'll reimburse facility (UB04) claims submitted according to the HCPCS code and units billed based on the fee published in the BCN Behavioral Health Fee Schedule.
- Sequestration may apply, for BCN Advantage pricing.

For both BCN HMO and BCN Advantage claims

- We'll reimburse the *96372 administration code according to the published fee in the BCN Behavioral Health Fee Schedule; you must include the appropriate modifier.
- Spravato claims billed with NOC code J3490 require the NDC, NDC units and NDC unit of measure. We'll reimburse the 50458 0028 02 and 50458 0028 03 NDCs for both professional and facility claims based on the BCN professional NDC fee schedule.
- Spravato claims billed with CPT codes *99415 and *99416 must include the appropriate modifier and can include nonphysician staff time used to monitor. We'll reimburse these claims according to the published fee in the BCN Behavioral Health Fee Schedule.

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Non-medical behavioral health practitioners can be reimbursed for prolonged psychotherapy services starting Feb. 1

Non-medical behavioral health practitioners are eligible for reimbursement of services associated with procedure codes *99354 and *99355 for dates of service on or after Feb. 1, 2020.

These codes apply to evaluation and management-related psychotherapy services in the office or another outpatient setting, when the service is prolonged — that is, when it requires direct patient contact beyond the usual time the service takes:

- Use *99354 to bill the first hour of a prolonged service.
- Use *99355 to bill each additional half hour of a prolonged service.

Here's additional information you need to know:

- Those codes must be billed on the same day and by the same practitioner as the companion evaluation and management or psychotherapy codes.
- You can bill these codes for BCN HMOSM, BCN AdvantageSM or Medicare Plus BlueSM PPO members only. You can't bill them for Blue Cross' PPO members currently but watch for future updates.
- For BCN HMO members, standard referral requirements currently apply. In the near future, no referral will be required.
- These services don't require authorization for any member.

- The following licensed providers can bill these codes for services related to behavioral health:
 - Psychiatrists who are board-eligible or board certified
 - Psychologists who have a doctorate or master's degree and a full or limited license
 - Master's-level social workers and professional counselors who have a master's degree and a full license
 - Marriage and family therapists who have a master's degree and a full license
 - Clinical nurse specialists and nurse practitioners who are certified and licensed
 - Physician assistants who have a master's degree and are licensed
- You must comply with the American Medical Association's billing guidelines.
- The medical record must clearly show the medical necessity for using these codes.
- You should document your intervention and revise the member's treatment plan as needed if the member needs these interventions frequently. You may also request consultation if the member isn't making progress.
- We're reviewing our medical policies to include using these codes for a broader range of services than is currently reflected in those policies.

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Fully licensed psychologists can be reimbursed for ABA services

Blue Cross Blue Shield of Michigan and Blue Care Network can reimburse fully licensed psychologists for applied behavior analysis services if the services are within their education, training and experience.

To qualify to be reimbursed for ABA, the psychologist must:

- Be contracted with Blue Cross or BCN to provide behavioral health services
- Have a doctoral degree in psychology (PhD, EdD or PsyD)
- Have a full license to practice psychology in Michigan
- Have education, training and experience in providing ABA

Submit an attestation form

Psychologists who believe they qualify for ABA reimbursement must complete a form stating that they have educational background, training and experience in providing ABA services.

Access this form as follows:

- On **BCN's Autism webpage** at ereferrals.bcbsm.com. Look under the "Autism provider resource materials" heading.
- On BCN's Autism page within Provider Secured Services.:
 1. Visit bcbsm.com/providers.
 2. Click *Login*.
 3. Log in to Provider Secured Services.
 4. Click *BCN Provider Publications and Resources*, at the right.
 5. Click *Autism*.
 6. Look under the "Autism provider resource materials" heading.

Complete the form and follow the instructions to submit it. We'll let you know by email if you can bill for ABA services.

Additional information

This applies to services for Blue Cross and BCN commercial members (Blue Cross' PPO and BCN HMOSM), since these members typically have autism coverage under their plans.

When billing ABA services, psychologists should use the autism billing codes along with modifier AH.

See the following documents for more information:

- *Applied Behavior Analysis Billing Guidelines and Procedure Codes* — You can access this document on the BCN or Blue Cross Autism web page within Provider Secured Services. Follow the directions given earlier in this article to access that page.
- *BCN Behavioral health fee schedule* — To access this document, log in to Provider Secured Services and click *BCN Provider Publications and Resources* on the right side of the Provider Secured Services welcome page. Click *Behavioral Health* on the left and look under the "General resources" heading.

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Quality corner: Primary care physician contact

Primary care physician contact occurs when the behavioral health provider and the primary care physician reach out to one another to discuss the patient's health. This may occur when the patient has a new evaluation, begins treatment or therapy, starts a new medication, has a significant change in condition or experiences a comorbid issue.

Unfortunately, contact between behavioral health providers and PCPs isn't widespread,¹ especially when compared with other specialties.

Why is it important?

Collaboration is important to improve outcomes, since at least 70% of visits to primary care physicians may be due to psychological issues.² Underlying psychological problems can also complicate and contribute to physical problems, such as obesity, hypertension and chronic pain.³ When

regular contact occurs between behavioral health and primary care doctors, providers can ensure the greatest impact and value for patient health.

Working with the PCPs in your area likely will increase your referrals from that medical group and can lead to more collegial relationships which can decrease burnout.

Meaningful contact

Contact should be meaningful. This includes a behavioral health assessment, rudimentary treatment plan and member-specific recommendations. Sometimes having a "curbside" consult with primary care physicians can enhance your understanding of the interventions they're recommending and help PCPs understand and incorporate the interventions you're attempting with the patient.

References

1. <http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf>
2. <http://www.bhintegration.org/services/primary-care.aspx>
3. <http://www.bhintegration.org/services/primary-care.aspx>

Blue Distinction Specialty Care takes aim at opioid use disorders

Blue Cross has launched another tool in its battle against opioid use disorders — a Blue Distinction® Center designation for substance use treatment and recovery.

The new program focuses on the treatment of substance use disorders, including opioid use disorders, across the spectrum of care delivery. Facilities with residential, inpatient, intensive outpatient, or partial hospitalization services will be considered for designation.

See full article on **Page 1**.

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HEDIS medical record reviews begin in February

Each year from February through May, Blue Care Network conducts Healthcare Effectiveness Data and Information Set, or HEDIS®, medical record reviews for a selected group of members.

For the HEDIS reviews, we look for details that may not have been captured in claims data, such as blood pressure readings, HbA1c lab results, colorectal cancer screenings and body mass index. This information helps us improve health care quality reporting for our members.

Blue Care Network's HEDIS staff will contact you to schedule an appointment for a HEDIS review or request that you fax the necessary records. The HEDIS review also requires proof of service documentation for data collected from a medical record.

If you have questions or concerns, contact us at 1-855-228-8543.

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We're announcing HEDIS quality measure changes

In October, the National Committee for Quality Assurance released value set changes for the following HEDIS® quality measures:

- Comprehensive Diabetes Care, or CDC: HbA1c control
- Comprehensive Diabetes Care, or CDC: Retinal eye exam
- Controlling High Blood Pressure, or CBP

Important changes

- **CDC: HbA1c:** Two new procedure codes (*3051F and *3052F) were added to better capture HbA1c levels. Code *3045F (HbA1c level 7.0-9.0%) should no longer be used. When conducting an HbA1c test in your office, submit the distinct numeric results on the HbA1c claim with the appropriate procedure code:

Procedure code*	Most recent HbA1c level
3044F	<7%
3046F	>9%
3051F	≥7% and <8%
3052F	≥8% and ≤9%

- **CDC: Retinal eye exam:** One new procedure code (*2023F) was added to capture negative eye exam results, which result in two years of compliance for HEDIS®. The code descriptor for *2022F was also revised to indicate its use for a positive eye exam. When results are received from an eye care professional, submit the results on a \$0.01 claim with the appropriate procedure code:

Procedure code*	Retinal eye exam findings
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)

- **CBP:** The measure has been revised to allow for administrative closure through claims. Submit blood pressure procedure codes for each office visit:

Procedure code*	Most recent systolic blood pressure
3074F	<130 mm Hg
3075F	130-139 mm Hg
3077F	≥ 140 mm Hg
Procedure code*	Most recent diastolic blood pressure
3078F	<80 mm Hg
3079F	80-89 mm Hg
3080F	≥ 90 mm Hg

Learn more about the CDC and CBP measures, including information about who's included in the measures, exclusions and useful tips, by accessing the following tip sheets:



Controlling high blood pressure



Comprehensive diabetes care

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MQIC continues to review clinical guidelines for opioid prescribing

The Michigan Quality Improvement Consortium continues to review and update the guideline, **Opioid Prescribing in Adults Excluding Palliative and End-of-Life Care**, first issued in 2017. The guideline is based on the CDC *Guideline for Prescribing Opioids for Chronic Pain*, from the Centers for Disease Control and Prevention.

The MQIC guideline has incorporated some state legislative requirements including mandates for providers to obtain a MAPS report, use the Start Talking form while educating patients and abide by dosing and day limits for prescribing opioids.

Due to these efforts, patients can now opt out of receiving opioids by signing the Non-Opioid Directive.

The guideline also provides information for educating patients and family members on the use of naloxone, and the need for the patient to be seen in an emergency department following its use, due to the short duration of action.

MQIC's evidence-based clinical practice guidelines help ensure that providers in Michigan can conform to one set of

guidelines endorsed by participating health plans. To date, 13 health plans participate.

By implementing the guidelines into practice, providers will be able to meet some of the quality programs benchmarks. Guidelines are issued for preventive services for all age groups as well as several chronic disease conditions, including hypertension and diabetes.

Blue Cross Blue Shield of Michigan and Blue Care Network have been participating in MQIC for more than 20 years. Blue Cross' chief medical officer, Thomas Simmer, M.D., and John "Jack" Billi, M.D., professor of internal medicine and medical director of collaborative quality initiatives at Michigan Medicine, have been co-chairs of the consortium since its inception.

MQIC has issued 31 guidelines; each guideline is reviewed and updated every two years. The organization may update guidelines when new compelling evidence is issued.

Please refer to all **MQIC guidelines** at the MQIC website.

Quality improvement program information available upon request

We provide you with ongoing information about our quality improvement programs and clinical practice guidelines through this newsletter. Approved clinical practice guidelines are available to all Blue Care Network primary care physicians, primary care groups and specialists.

Copies of the complete guidelines are available on our secure provider portal. To access the guidelines:

- Log in to Provider Secured Services.
- Click on *BCN Provider Publications and Resources*.
- Click on *Clinical Practice Guidelines*.

The Michigan Quality Improvement Consortium guidelines are also available on the **MQIC website**. BCN promotes the development, approval, distribution, monitoring

and revision of uniform evidence-based clinical practice guidelines and preventive care guidelines for practitioners. We use MQIC guidelines to support these efforts. These guidelines facilitate the delivery of quality care and the reduction in variability in physician practice and medical care delivery.

Our Quality Improvement Program encourages adherence to MQIC guidelines and offers interventions focusing on improving health outcomes for BCN members. Some examples include member and provider incentives, reminder mailings, telephone reminders, newsletter articles and educational materials. We use medical record reviews and quality studies to monitor compliance with the guidelines.

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We've changed requirements for some commercial medical benefit drugs

Blue Cross Blue Shield of Michigan and Blue Care Network encourage proper utilization of high-cost medications that are covered under the medical benefit. As part of this effort, we maintain a comprehensive list of requirements for both Blue Cross' PPO and BCN HMOSM commercial members.

From July 2019 to December 2019, the following medical drugs had authorization requirement updates, site-of-care updates or both:

HCPSC code	Brand name	Generic name
J0179	Beovu®	brolocizumab-dbl
J0598	Cinryze®	C1 esterase inhibitor
J3111	Evenity™	romosozumab-aqqg
J0641	Fusilev®	levoleucovorin
J0642	Khazory™	levoleucovorin
Various	Immune globulin products	Immune globulin
Q5103	Inflectra®	infliximab-dyyb
J0202	Lemtrada™	alemtuzumab
J1745	Remicade®	infliximab
Q5104	Renflexis®	infliximab-abda
J2350	Ocrevus®	ocrelizumab
J3490**/J3590**	Scenesse®	afamelanotide
J3490**/J3590**	Skyrizi™	risankizumab-rzaa
J2323	Tysabri®	natalizumab
J3490**/J3590**	Zolgensma®	onasemnogene abeparvovec-xioi

**Will become a unique code.

For a detailed list of requirements, see the **Blue Cross and BCN utilization management medical drug list**. You can access this list from the following pages on the **ereerrals.bcbsm.com** website.

- **Blue Cross' Medical Benefit Drugs** – Pharmacy page
- **BCN's Medical Benefit Drugs** – Pharmacy page

Additional notes

Authorization requirements apply only to groups that currently participate in the standard commercial Medical Drug Prior Authorization program for drugs administered under the medical benefit. Refer to the opt-out list for PPO groups that don't require members to participate in the programs.

To access the list:

1. Go to **bcbsm.com/providers**.
2. Log in to Provider Secured Services.
3. Click *BCBSM Provider Publications and Resources*.
4. Click *Newsletters & Resources*.
5. Click *Forms*.
6. Click *Physician administered medications*.
7. Click *BCBSM Medical Drug Prior Authorization Program list of groups that have opted out*.

An authorization approval isn't a guarantee of payment. Health care providers need to verify eligibility and benefits for members.

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Medicare Part B medical specialty drug prior authorization list is changing in March

We're adding medications to the Medicare Plus BlueSM PPO and BCN AdvantageSM Part B medical specialty prior authorization drug list. These specialty medications are administered in outpatient sites of care, such as a physician's office, an outpatient facility or a member's home.

Providers will either need to request authorization through the NovoLogix[®] on line tool or the AIM Specialty Health ProviderPortalSM, depending on the drug. Please see the complete article on **Page 10** for details.

We're adding two medical drugs to the site of care program for Blue Cross and Blue Care Network commercial members starting April 1

We're expanding the site of care program for specialty drugs covered under the medical benefit, starting April 1, 2020. This applies to Blue Cross' PPO (commercial) and BCN HMOSM (commercial) members for the following drugs:

- Hemlibra[®] (emicizumab-kxwh, HCPCS code J7170)
- Onpatro[®] (patisan, HCPCS code J0222)

What to do by April 1

Providers should encourage commercial members to select one of the following infusion locations before April 1, instead of an outpatient hospital facility:

- A doctor's or other health care provider's office
- An ambulatory infusion center
- The member's home (from a home infusion therapy provider)

If members currently receive infusions for these drugs at a hospital outpatient facility, providers must:

- Obtain prior authorization for that location
- Check the directory of participating home infusion therapy providers and infusion centers to see where the member may be able to continue infusion therapy

If the infusion therapy provider can accommodate the member, they'll work with the member and the member's

practitioner to make this change easy. The member may also contact the ordering practitioner directly for help with the change.

More about the authorization requirements

The authorization requirements apply only to groups that are currently participating in the standard commercial Medical Drug Prior Authorization program for drugs administered under the medical benefit. These changes don't apply to members covered by the Federal Employee Program[®] Service Benefit Plan.

Authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.

List of requirements

For a list of requirements related to drugs covered under the medical benefit, please see the **Requirements for drugs covered under the medical benefit – BCN HMO and Blue Cross PPO** document located on our **ereferrals**. **bcbsm.com** website:

- **Blue Cross' Medical Benefit Drugs - Pharmacy webpage**
- **BCN's Medical Benefit Drugs - Pharmacy webpage**

We'll update the requirements list for these drugs before April 1.

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Xanax will have a quantity limit, effective May 1

Effective May 1, 2020, we'll limit Xanax and its generic equivalent alprazolam to four mg per day for *HMO Custom Drug List* and the *HMO Custom Select Drug List*. This change will affect members with new prescriptions on or after May 1, 2020.

Members with a current prescription for Xanax or alprazolam can continue to use them at their current doses.

Long-acting morphine products will have a quantity limit, effective May 1

Effective May 1, 2020, some long-acting morphine products will have new quantity limits. Members who currently have prescriptions for these drugs will be grandfathered. These changes won't affect them.

Members who receive a prescription for these drugs over the new quantity limit on or after May 1, 2020, will need a prior authorization.

The table below lists these long-acting morphine products and their new quantity limits:

Brand name	Generic	HMO daily limit	PPO daily limit
Avinza	Morphine ER capsule 24 hr	30 capsules per month	30 capsules per month
MS Contin	Morphine sulfate tablet ER	120 tablets per 30 days	120 tablets per 30 days
Kadian capsules	Morphine sulfate ER capsules	30 capsules per month	30 capsules per month

We'll no longer cover Soma, Soma compound or Soma compound with codeine

Starting May 1, Blue Cross Blue Shield of Michigan and Blue Care Network will no longer cover the following Soma products:

- Soma and its generic, carisoprodol
- Soma compound and its generic, carisoprodol with aspirin
- Soma compound with codeine and its generic

If members fill a prescription for one of these drugs on or after May 1, 2020, they'll be responsible for the full cost.

We'll cover the following alternatives that have similar effectiveness, quality and safety:

- Flexeril® (cyclobenzaprine)
- Norflex® (orphenadrine)
- Robaxin® (methocarbamol)
- Parafon Forte DSC (chlorzoxazone)
- Zanaflex® (tizanidine)

We'll mail letters to members to notify them of this change and encourage them to talk to their doctors about getting a prescription for one of the covered alternatives.

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We're clarifying how to submit authorization requests for Medicare Part B medical specialty drugs Prolia and Xgeva

Although Part B specialty drugs Prolia® and Xgeva® have the same generic name, denosumab, and HCPCS code, J0897, the system through which you request authorization differs. Both drugs require authorization for Medicare Plus BlueSM PPO and BCN AdvantageSM members.

- If you're administering Prolia, which is used to treat osteoporosis, request authorization through the NovoLogix® online tool.
- If you're administering Xgeva, which is primarily used to treat bone metastases due to solid tumors, request authorization through the AIM ProviderPortalSM.
- Note: Be sure to use the **brand name** when requesting Xgeva through the AIM ProviderPortal so AIM will know you're ordering the correct medication. Using the generic name, denosumab, can cause delays in the prior authorization process.

How to bill

Be sure to enter the following National Drug Code numbers on the claim, along with the HCPCS code J0897, to ensure appropriate and timely reimbursement.

- Prolia — Enter NDC 55513071001
- Xgeva — Enter NDC 55513073001

For Medicare Plus Blue and BCN Advantage, we require authorization for these medications for all outpatient sites of care when you bill the medications as a professional service or as an outpatient facility service and you bill either of the following ways:

- Electronically through an 837P transaction or on a professional CMS-1500 claim form
- Electronically through an 837I transaction or using a UB04 claim form for a hospital outpatient type of bill 013x

Important reminder

You can quickly submit authorization requests through the NovoLogix online tool and through AIM Specialty Health.

- **NovoLogix:** You can access NovoLogix through Provider Secured Services. It offers real-time status checks and immediate approvals for certain medications. Also note:
 - For Medicare Plus Blue, if you have a Type 1 (individual) NPI and you checked the Medical Drug PA box when you completed the *Provider Secured Access Application* form, you already have access to NovoLogix. If you didn't check that box, you can complete an **Addendum P** form to request access to NovoLogix and fax it to the number on the form.
 - For BCN Advantage, if you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix.

If you need to request access to Provider Secured Services, complete the **Provider Secured Access Application** form and fax it to the number on the form.

- **AIM Specialty Health:** You can submit authorizations through the **AIM ProviderPortal** or by calling AIM at 1-844-377-1278.

For information about registering for and accessing the AIM ProviderPortal, see the **Frequently asked questions** page on the AIM Specialty Health website

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Clinical editing billing tips

In most issues, we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that the performed procedure is correctly reported to us.

This issue's tips include:

- Cataracts — reporting post-op care
- Using modifier 50, RT and LT
- Anatomical modifiers
- Screening ultrasounds for abdominal aortic aneurysm



*Clinical editing
billing tips*

Fully licensed psychologists can be reimbursed for ABA services

Blue Cross Blue Shield of Michigan and Blue Care Network can reimburse fully licensed psychologists for applied behavior analysis services if the services are within their education, training, and experience.

See the full article, including information about billing for ABA services, **Page 23**.

Non medical behavioral health practitioners can be reimbursed for prolonged psychotherapy services starting Feb. 1

Non medical behavioral health practitioners are eligible to be reimbursed for services associated with procedure codes *99354 and *99355 for dates of service on or after Feb. 1, 2020.

These codes apply to evaluation and management-related psychotherapy services in the office or in another outpatient setting, when the service is prolonged — that is, when it requires direct patient contact beyond the usual time the service takes:

- Use *99354 to bill the first hour of a prolonged service.
- Use *99355 to bill each additional half hour of a prolonged service.

See the full article on **Page 22** for more information.

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Reminder: We've updated the 2020 BCN behavioral health fee schedule

We've updated the 2020 BCN Behavioral Health Fee Schedule to add or revise fees for these services:

- Long-acting drugs billed with these HCPCS codes: J0400, J0401, J1631, J2062, J2315, J2358, J2426, J2680, J2794 and J3486 (when directly purchased)
- Administration of a long-acting drug billed with CPT code *96372
- Spravato™ (esketamine) billed with the not-otherwise-classified code J3490
- Observation period after administration of Spravato: Use codes *99415 and *99416, as appropriate

See complete article on **Page 21** for additional billing information.

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We're using some new codes for online visits, starting Jan. 1

Effective Dec. 31, 2019, procedure codes *98969 and *99444 were no longer payable for an online visit.

Physicians must now submit their claims using one of these new patient-initiated, digital-communication codes: *99421, *99422 and *99423. For services provided by a nonphysician, use the codes *98970, *98971 or *98972.

*CPT codes, descriptions and two-digit modifiers only are copyright 2019 American Medical Association. All rights reserved.

Billing information for Medicare Part B medical specialty drugs that require prior authorization

We're adding medications to the Medicare Plus BlueSM PPO and BCN AdvantageSM Part B medical specialty prior authorization drug list. These specialty medications are administered in outpatient sites of care, such as a physician's office, an outpatient facility or a member's home.

See article on **Page 10** titled, "Medicare Part B medical special drug prior authorization list is changing in March," for billing information.

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Important information about peer-to-peer reviews and appeals

When we deny your request to authorize an inpatient or outpatient service, you can ask for a peer-to-peer review or you can appeal the denial.

Whether you're requesting a peer-to-peer review or submitting an appeal, there's important information you need to know.

- For Medicare Advantage authorizations denied **before** a service or admission is provided, you can only submit an appeal. You'll be able to talk to a Blue Cross or Blue Care Network medical director during the appeal process:
 - For BCN AdvantageSM, you'll have an opportunity to talk to a medical director during the panel review.
 - For Medicare Plus BlueSM PPO, you can ask to talk to a medical director anytime during the appeal process.
- For Medicare Advantage authorizations denied **during or after** a service or admission is provided, you can either request a peer-to-peer review or submit an appeal.
- For commercial authorizations denied before, during or after a service or admission is provided, you can either request a peer-to-peer review or submit an appeal.

For any denied authorization, if you decide to submit an appeal, follow the appeal process outlined in the denial letter you receive.

Medicare Advantage members are those covered by a Medicare Plus Blue or BCN Advantage plan. Commercial members are those covered by a Blue Cross PPO or BCN HMOSM plan.

Requesting a peer-to-peer review

- **Purpose.** A peer-to-peer review is a conversation between the member's health care provider and a Blue Cross or BCN medical director about the clinical nuances of the member's medical condition and the medical necessity of the services.

- **Process.** The process for submitting a request for a peer-to-peer review is outlined in the document titled **How to request a peer-to-peer review with a Blue Cross or BCN medical director**. The process differs by type of service and line of business.

We can't accept peer-to-peer request forms about more than one member

When you request a peer-to-peer review using the **Physician peer-to-peer request form**, you must submit a separate form for each request.

We can't accept a form that has information about more than one member. We also can't accept a form used as a face sheet with information about different members attached to it.

Here's why. When you fax a form to us, we upload it to the member's case in the e-referral system along with any attachments you've sent with it. If a form uploaded to one member's case has information about other members on it or attached to it, it's a violation of the Health Insurance Portability and Accountability Act.

Don't submit clinical information after an authorization is denied

Submission of clinical information after an authorization request is denied results in the initiation of an appeal. Once that occurs, it's no longer possible to have a peer-to-peer review for most members.

Missed peer-to-peer reviews won't be rescheduled

If you miss a peer-to-peer review that was scheduled with a medical director, you won't be able to reschedule it. You'll have to file an appeal.

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Important information, continued from Page 34

How to file an appeal

When we deny an authorization request you've submitted, you'll receive a letter explaining how to file an appeal.

If you want to appeal our determination, review the letter carefully and follow the directions about filing an appeal.

Additional information

For additional information, you may review the newsletter articles we recently published:

- "We're aligning peer-to-peer review request processes for acute non-behavioral health non-elective inpatient admissions," in the January 2020 issue of **The Record**
- "We're aligning peer-to-peer review request processes for acute non-behavioral health non-elective inpatient admissions," in the January-February 2020 issue of **BCN Provider News**, Page 40

Radiation therapy services for A9590 require authorization starting April 1 for all Blue Cross and BCN members

Services associated with HCPCS code A9590 (iodine i-131, iobenguane, 1 millicurie) require authorization by eviCore healthcare for dates of service on or after April 1, 2020.

This applies to all Blue Cross and Blue Care Network members with plans subject to eviCore healthcare authorization requirements:

- Blue Cross' PPO
- Medicare Plus BlueSM PPO
- BCN HMOSM
- BCN AdvantageSM

We've updated the document titled **Procedures that require clinical review by eviCore healthcare** to reflect this new requirement.

How to submit authorization requests

Submit authorization requests to eviCore in one of these ways:

- Preferred: Use eviCore's provider portal at **www.evicore.com**.
- Alternative: Call eviCore at 1-855-774-1317.
- Alternative: Fax to eviCore at 1-800-540-2406.

Additional information

For more information, refer to the document titled **eviCore Management Program: Frequently Asked Questions**.

You can find this document and other resources on our **ereferrals.bcbsm.com** website:

- The **BCN eviCore-Managed Procedures** web page
- The **Blue Cross eviCore-Managed Procedures** web page

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Authorization requirements changing for home health, TPN and IDPN services for BCN members

We're changing authorization requirements for home health, total parenteral nutrition and intradialytic parenteral nutrition services for Blue Care Network members. We first communicated about these changes in January 2020 in a web-DENIS message and in a news item on our [ereferrals.bcbsm.com](#) website.

Here's what's changing.

Home health services

For traditional home health care, including services such as nursing visits and physical, occupational and speech therapy, the following changes are occurring:

- For BCN HMOSM (commercial) and BCN AdvantageSM members covered through the UAW Retiree Medical Benefits Trust, home health no longer requires authorization. This was effective in December 2019 and applies to both contracted and noncontracted providers.
- For BCN HMO and BCN Advantage members not covered through the UAW Retiree Medical Benefits Trust, home health requires authorization for these providers:
 - *Noncontracted providers.* Call these authorization requests in to BCN Utilization Management at 1-800-392-2512.

- *Providers who are contracted with BCN but who do not belong to the provider network associated with the member's plan.* Submit these authorization requests through the e-referral system.

TPN and IDPN services

TPN and IDPN services no longer require authorization for BCN members. This applies to both contracted and noncontracted home infusion providers and to all BCN HMO and BCN Advantage members.

Additional information

We've updated the **Care Management chapter** of the *BCN Provider Manual* to reflect the changes related to home health, TPN and IDPN. Look in the section titled "Guidelines for transitional care."

We've removed the *Home care form* and the *TPN Nutrition Assessment / Follow-up Form* from our [ereferrals.bcbsm.com](#) website.

These changes don't affect enteral nutrition services, which continue to require authorization. Submit authorization requests for enteral nutrition through the e-referral system and complete the questionnaire that opens.

We're adding two medical drugs to the site of care program for Blue Cross and Blue Care Network commercial members starting April 1

We're expanding the site of care program for specialty drugs covered under the medical benefit, starting April 1, 2020. This applies to Blue Cross' PPO (commercial) and BCN HMOSM (commercial) members for the following drugs:

- Hemlibra® (emicizumab-kxwh, HCPCS code J7170)
- Onpattro® (patisiran, HCPCS code J0222)

See full article on [Page 29](#).

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TurningPoint begins managing authorizations for musculoskeletal surgical procedures with dates of service on or after June 1

In the last issue of **BCN Provider News**, Page 43, we told you that providers will need to submit authorization requests through TurningPoint Healthcare Solutions, LLC, for inpatient and outpatient musculoskeletal surgical procedures for BCN HMOSM (commercial), BCN AdvantageSM and Medicare Plus BlueSM PPO members.

Here's some important information you need to know:

- Providers should submit authorization requests for all surgical procedures related to musculoskeletal conditions scheduled to occur on or after June 1, 2020, to TurningPoint starting May 1.
- This pertains to procedures currently managed by Blue Cross Blue Shield of Michigan or BCN.
- These changes don't apply to Blue Cross PPO (commercial) plans.
- eviCore healthcare® will continue to manage lumbar spinal fusion surgeries for Medicare Plus Blue members throughout 2020. You can find the codes for these procedures in the "Lumbar spinal fusion surgery procedures requiring authorization by eviCore" table in the *Procedures that require authorization by eviCore healthcare* document; you can find this document on the ereferrals.bcbsm.com website by clicking Blue Cross and then clicking eviCore-Managed Procedures.

You can find procedure codes for orthopedic and spinal procedures managed by TurningPoint on ereferrals.bcbsm.com. The links are below:

- **Orthopedic**
- **Spinal**

For more information, refer to our frequently-asked-questions document on ereferrals.bcbsm.com.

Webinar training and portal registration

Provider offices can register for the TurningPoint portal as follows:

- Visit bcbsm.com/providers and log in to Provider Secured Services.
- Click *Musculoskeletal Service Authorizations through TurningPoint* and enter your NPI.

If you're having trouble accessing the TurningPoint provider portal using this process, contact the Blue Cross Web Support Help Desk at 1-877-258-3932.

Note: Out-of-state providers. Log in to your home plan's website and select an ID card prefix from Michigan. This will take you to the Blue Cross Blue Shield of Michigan website.

To register directly on the TurningPoint portal, go to their [website](#) and click *Register for access* under the *Login Now* button. You'll need to complete a form and submit the request to TurningPoint.

We'll offer webinar training about the program and how to use the TurningPoint portal for professional providers and facilities in April. Use the links below to register.

Professional providers can register for training [here](#).

Facility providers can register for training [here](#).

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Submit requests for swallow services to BCN, not to eviCore healthcare

We're clarifying where to submit requests for outpatient swallow services and speech therapy.

- BCN Utilization Management manages authorizations for outpatient swallow services for BCN HMOSM (commercial) and BCN AdvantageSM members
- Swallow services are handled separately from speech therapy, which is managed by eviCore healthcare

Here's what you need to know.

Submit requests for swallow services to BCN

Requests for outpatient swallow services must be submitted to BCN Utilization Management through the e-referral system or by calling 1-800-392-2912.

Here are the requirements for these services:

- Swallow evaluations (procedure code *92610) and swallow studies (procedure codes *92611 through *92617) require plan notification.
- Swallow therapy (procedure code *92526) requires authorization. We make determinations based on medical necessity review. You must submit clinical information along with the authorization request.

Refer to the [e-referral User Guide](#) for instructions on how to submit plan notifications and authorization requests using the e-referral system.

Submit requests for speech therapy to eviCore

Swallow evaluations, studies and therapy are handled separately from speech therapy, which is managed by eviCore healthcare.

Submit authorization requests for outpatient speech therapy to eviCore in one of the following ways:

- Recommended: Use the eviCore healthcare provider portal at www.evicore.com.
- Alternatives: Call eviCore at 1-855-774-1317 or fax to eviCore at 1-800-540-2406.

We've updated our documents

We've updated the following documents to clarify the requirements for swallow services:

- [BCN Referral and Authorization Requirements](#)
- [Procedure codes that require authorization by BCN](#)

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2019 American Medical Association. All rights reserved.

We've changed requirements for some commercial medical benefit drugs

Blue Cross Blue Shield of Michigan and Blue Care Network encourage proper utilization of high-cost medications that are covered under the medical benefit. As part of this effort, we maintain a comprehensive list of requirements for both Blue Cross' PPO and BCN HMOSM commercial members.

See complete article on [Page 28](#).

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Updated e-referral system questionnaires released for BCN and Medicare Plus Blue in February

In the **January-February issue** of BCN Provider News (page 41), we listed the questionnaires that we expected to release in the e-referral system by Jan. 26, 2020.

Most of the questionnaires listed in the articles were updated on Dec. 8, 2019. However, we had to postpone the release of the following questionnaires to Feb. 2:

- Breast reduction — We combined the *Breast reduction, adult* and the *Breast reduction, adolescent* questionnaires for BCN HMOSM and BCN AdvantageSM members into a single questionnaire for both adult and adolescent BCN HMO and BCN Advantage members.
- Spinal cord stimulator or epidural or intrathecal catheter (trial or permanent placement) — We replaced this questionnaire with the following three questionnaires:
 - Spinal cord stimulator — For BCN HMO members
 - Spinal cord stimulator — For Medicare Plus BlueSM and BCN Advantage members
 - Intrathecal catheter — For Medicare Plus Blue, BCN HMO and BCN Advantage members

In addition, we updated the following questionnaire on Feb. 2:

- Sleep studies — Opens only for BCN HMO and BCN Advantage members

Here's some additional information you need to know:

- We updated the preview questionnaires, authorization criteria and medical policies on the ereferrals.bcbsm.com website for the questionnaire updates.
- We use our authorization criteria and medical policies and your answers to the questionnaires when making utilization management determinations on your authorization requests.
- For all these services, you can access preview questionnaires at ereferrals.bcbsm.com. The preview questionnaires can help you prepare your answers ahead of time. To find the preview questionnaires:
 - For BCN: Click *BCN* and then click **Authorization Requirements & Criteria**. Scroll down and look under the "Authorization criteria and preview questionnaires" heading.
 - For Medicare Plus Blue: Click *Blue Cross* and then click **Authorization Requirements & Criteria**. In the "Medicare Plus Blue PPO members" section, look under the "Authorization criteria and preview questionnaires — Medicare Plus Blue PPO" heading.

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