MAY – JUNE 2020

BCN Provider News

BCN Provider News User Guide

Blue Cross and BCN take action to support providers and protect members during COVID-19 pandemic

Days before the first Michigan cases of COVID-19 were reported, Blue Cross Blue Shield of Michigan and Blue Care Network began taking action to support providers and protect members. Here are some of the temporary actions we've taken:

- Waived authorization requirements and member cost sharing for diagnostic lab testing for COVID-19
- Waived member copays, deductibles and coinsurance for COVID-19 testing and treatment
- Changed clinical review to plan notification for admissions to all Michigan acute care hospitals for all diagnoses and for the first three days of all skilled nursing facility transfers from acute care
- Expanded laboratory testing for COVID-19 to any laboratory provider in Michigan, regardless of network status
- Added influenza testing to physician in-office laboratory testing to rule out flu
- Waived early refill limits on 30-day prescription maintenance medications with the exception of opioids

Please see COVID-19 member support, continued on Page 3

Blue Care Network is extending Healthy *Blue* Living requirements for 90 days

Blue Care Network is extending Healthy *Blue*℠ Living requirements for 90 days for employer groups with renewals from January through March to allow more time for patients to visit primary care physician offices for this purpose during the COVID-19 pandemic.

The extension applies to all members who don't have a health qualification form loaded onto our system as of March 17, 2020. Members with an invalid qualification form (one or more C scores) are not part of this extension.

The extension means that January renewal groups that normally have until the end of April to fulfill Healthy *Blue* Living requirements will have until the end of June. February renewal groups will have until the end of July. March renewal groups will have until the end of August to fulfill requirements.

Please see Healthy *Blue* Living, continued on Page 3

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Inside this issue…

Network Operations

We're working to ensure providers are available to care for our Michigan members

During national emergencies declared by the federal and state government such as COVID-19, Blue Cross Blue Shield of Michigan and Blue Care Network, as directed by the government agencies, allow licensed practitioners to provide services to our members outside of their state of provider licensure. We have temporarily waived the requirement that out-of-state practitioners be licensed in Michigan when they are licensed in another state. In addition, we're relaxing certain requirements for enrollment and credentialing for practitioners joining multiple practice locations as well as practitioners coming out of retirement to assist with care of members.

This is effective until the statewide emergency has been lifted.

Other important information

For in-state providers who plan to work at a different location and bill under a different Type 2 NPI or Tax ID during this pandemic, the group bringing in the temporary physician will need to add him or her to their group through our enrollment self-service tool.

Please follow these guidelines:

- The originating practice should not delete the physician's association with their group, unless this is a permanent change. (This applies to in-state providers making changes through self-service.)
- We recommend practices consider **waiting one week before submitting new claims** associated with the change.
- Be advised that sending in a paper form to execute this process **will take longer** than five business days.

For out-of-state providers

If you're an out-of-state provider with questions about credentialing and enrollment, email Zachary Lucas at zlucas@bcbsm.com.

When you receive confirmation on your submission, we recommend that you wait 10 business days before submitting claims for out-of-state providers. (This applies to out-of-state providers joining in-state groups.)

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Network Operations

COVID-19 member support, *continued from Page 1*

- Facilitated the use of telehealth by revising our policies and creating an incentive for offices to participate in telehealth
- Granted a 90-day extension to claim submission time limits for original claims with submission dates of Jan. 1, 2020, and after until further notice

Expanded use of telehealth

The COVID-19 pandemic brought a spotlight to telehealth as a method to safely provide medical care to patients who are not able to come in for a face-to-face office visit. Blue Cross and BCN have focused efforts on making telehealth easier for both our providers and our members. We have done this by:

- Removing the BCN originating site requirement for telehealth
- Waiving member cost sharing for telehealth services through at least June 30, 2020, on the most common medical office visits, hospitalization follow-up visits and common behavioral health therapy (see **Telehealth procedure codes for COVID-19**)
- Announcing that **all** Blue Cross and BCN members — including all self-funded groups — now have coverage for telemedicine services (those offered by our network providers); most, but not all, members also have access to Blue Cross Online Visits℠ (operated by Amwell)
- Expanding no-cost telehealth services to now include common behavioral health therapy for members with our behavioral health benefits
- Temporarily relaxing HIPAA requirements to allow for alternative channels such as Skype and Apple FaceTime
- Expanding access to our 24-hour nurse hotline for members
- Creating telehealth guides to help providers begin using telehealth
- Introducing incentives through Blue Cross' Physician Group Incentive Program to encourage physician offices to use telehealth, when applicable

If your office is not yet using telehealth, take a few minutes to learn how easy it can be to add a telehealth option. We have two guides that explain telehealth:

- **Telehealth for medical providers**
- **Telehealth for behavioral health providers**

There's also eLearning available on our Coronavirus webpage.

Find more information

To find our telehealth guides and the latest developments on the COVID-19 pandemic, go to our *Coronavirus (COVID-19) information* updates for providers webpage, which is linked from *BCBSM Newsletters and Resources* as well as *BCN Provider Publications and Resources* within our secure provider website at **bcbsm.com**.

While the most comprehensive list of communications is available within our secure provider website, we also have a public webpage for providers who don't have a login and password to our website and for out-of-state providers. This website is available at **bcbsm.com/coronavirus**. Click on ***For Providers***.

Healthy *Blue* Living, *continued from Page 1*

Members currently in standard benefits will remain in standard until they meet the requirements. Members currently in enhanced benefits will stay in enhanced until the extension expires. If they meet the requirement once the extension expires, they'll remain in enhanced.

The 90-day extension includes the following:

- Health qualification form
- Health assessment
- Weight management participation enrollment
- Tobacco coaching enrollment

BCN will send letters to members about the extension. Providers should communicate to patients and reschedule appointments as appropriate.

A note about Weight Watchers

WW® (formerly Weight Watchers) meetings are now virtual. If members can't participate virtually, you can tell them a 90-day extension will apply and that they should resume meetings when in-person meetings start again.

Urgent care centers need to enroll as an urgent care center provider type

Urgent care center providers need to identify themselves as such during the enrollment process. Previously, some providers who offer urgent care services enrolled as group practitioners, most likely because of the hours of operation requirement. We've subsequently relaxed our hours of operation requirement for urgent care providers.

New hours of operation requirements

Blue Cross Blue Shield of Michigan's hours of operation requirements stipulate that an urgent care center must be open to serve members a minimum of 24 morning, evening or weekend hours each week. These hours must be in addition to regular hours of 9 a.m. to 4 p.m. Monday through Friday. This adjustment provides more flexibility for providers to determine their weekly schedule.

Benefits of enrolling as an urgent care center

Benefits include:

- Increasing access to potential patients by being appropriately listed in the urgent care provider directory
- Making sure the correct urgent care benefit is applied to patient claims

If you're an urgent care center, review your enrollment status to make sure you're correctly identified. For current requirements and other details, refer to the provider manual or enrollment form.

J&B needs documentation to replace insulin pumps

Providers can get approval to replace insulin pumps (represented by code E0784) that are more than four but less than five years old when they document in the member's medical record that the warranty has expired and that the pump is malfunctioning.

Providers must submit these requests to J&B Medical Supply, along with the documentation from the patient's medical record. Email documents to ProviderServices@jandbmedical.com or fax them to 1-800-737-0012.

This process change was effective March 1. It applies to BCN HMO℠ and BCN Advantage℠ members.

If you have any questions, contact J&B at 1-888-896-6233.

Network Operations

Medical residents: Here's how you can join our network

Are you completing your medical residency training this summer?

If so, remember to submit your Blue Cross Blue Shield of Michigan or Blue Care Network provider enrollment application **up to 60 days** before the date you complete your training.

It's important to apply within the required time frame; if you apply **prior** to the 60 days, we'll deny your application and you'll have to reapply.

The CAQH ProView application must be completed to begin the credentialing process with Blue Cross and BCN.

To keep Council for Affordable Quality Healthcare® ProView® information current, complete your re-attestation every 120 days and update the Authorize section on CAQH.

Visit the **CAQH ProView™** website for more information on application requirements.

Network Operations

We've renamed two *BCN Provider Manual* chapters

We've renamed two chapters in the *BCN Provider Manual*.

"Health, Well-Being and Coordinated Care" chapter

"Health, Well-Being and Coordinated Care" is the new name for the chapter we previously called "Health Education and Chronic Condition Management." This chapter now offers information on these programs available to members:

- Blue Cross® Health & Well-Being, which includes:
  - Blue Cross Health & Well-Being website, powered by WebMD®* — with an online health assessment, Digital Health Assistant online coaching programs, health trackers, online health tools and multimedia
  - Blue Cross Virtual Well-Being — with online webinars and other downloadable content
  - Tobacco Coaching, powered by WebMD — over-the-phone coaching program
  - 24-hour nurse line
  - Pregnancy assistance
- Blue Cross® Coordinated Care — a program that identifies members with chronic or complex conditions who could benefit from care management. The program includes a custom mobile app that members can use to engage with their care team, find articles and videos about their condition and help with appointment reminders.
- Discounts through Blue365® — offers members savings on health-related products and services from businesses in Michigan and across the United States

To access the "Health, Well-Being and Coordinated Care" chapter:

1. Visit **bcbsm.com/providers**.
2. Click *Login*.
3. Log in to Provider Secured Services.
4. Click *BCN Provider Publications and Resources*, on the right.
5. Click *Provider Manual*, on the left.
6. Scroll down and click *Health, Well-Being and Coordinated Care*.

"Utilization Management" chapter

"Utilization Management" is the new name for the chapter we previously called "Care Management."

We renamed this chapter because everything in it is about referral and authorizations, including those managed by both BCN's Utilization Management and our contracted vendors.

The "Utilization Management" chapter is available on our public **ereferrals.bcbsm.com** website:

1. Visit **ereferrals.bcbsm.com**.
2. Click *BCN*.
3. Click *Provider Manual Chapters*.
4. Click **Utilization Management chapter**.

This chapter is also available on the *Provider Manual* page within *BCN Provider Publications and Resources*.

We'll update references to this chapter in our documents so that they reflect the new name.

*WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing health and well-being services for members.

BCN Advantage

We've made changes to coverage for infliximab biosimilar products for Medicare Advantage members

In April, we removed authorization requirements for certain infliximab biosimilar drugs and designated preferred infliximab biosimilar drugs for Medicare Plus Blue℠ PPO and BCN Advantage℠ members.

Authorization requirements

For dates of service on or after April 3, 2020, we no longer require authorization for the following infliximab biosimilars for Remicade® for Medicare Plus Blue and BCN Advantage members:

- Q5103 Inflectra®
- Q5104 Renflexis®

Preferred biosimilar drugs

Starting April 20, 2020, we've designated the following drugs as preferred infliximab biosimilar products for Medicare Plus Blue and BCN Advantage members:

- J3590 Avsola™
- Q5103 Inflectra
- Q5104 Renflexis

As part of our shared commitment to keeping health care affordable, we encourage you to switch members to one of the preferred infliximab biosimilar products as soon as possible.

Important: Remicade won't be considered a preferred biosimilar and will continue to require authorization for Medicare Plus Blue and BCN Advantage members.

List of requirements

We'll update the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage** members with these changes prior to the effective dates.

The specialty medications on this list are administered in outpatient sites of care, a physician's office, an outpatient facility or a member's home.

We're improving explanation of benefits statements for Medicare Advantage members

BCN Advantage members will receive updated explanation of benefits statements, starting in April.

The new EOBs will include messages on the front page. In case patients ask you about this update, we wanted to provide you with the notice members will receive with their new EOBs:

We've added information to your Explanation of Benefits (EOB).

- *Important messages will now be displayed on the front page.*
- ***Your benefits have not changed.***

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

We're adding medications to the Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue℠ PPO and BCN Advantage℠ members. The specialty medications on this list are administered by a health care professional in a provider office, the member's home, an off-campus outpatient hospital or an ambulatory surgical center (sites of care 11, 12, 19, 22 and 24).

For dates of service on or after June 15, 2020, the following medications will require prior authorization through **NovoLogix®**:

- J1428 Exondys 51®
- J3490 Vyondys 53™
- J3490 Givlaari®
- J3590 Tepezza™
- J3590 Vyepti™

How to bill

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

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

Important reminder

For these drugs, submit authorization requests through the NovoLogix online tool. 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 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.

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 for Medicare Plus Blue PPO and BCN Advantage members**.

BCN Advantage

Advanced illness and frailty exclusions for certain HEDIS star measures

The National Committee for Quality Assurance allows providers to exclude patients from select Medicare Star Rating System measures that are also HEDIS® measures due to advanced illness and frailty. NCQA acknowledges that some measured services won't benefit patients who are in declining health.

You can submit claims with advanced illness and frailty codes to exclude patients who meet the criteria of these measures. Using the appropriate codes also reduces the number of medical record requests you may receive for HEDIS data collection purposes.

For a description of the criteria and a list of HEDIS-approved billing codes, view the *2020 Advanced Illness and Frailty Exclusions Guide* PDF.

2020 Advanced Illness and Frailty Exclusions Guide

HEDIS®, which stands for Healthcare Effectiveness Data and Information Set, is a registered trademark of the National Committee for Quality Assurance.

Home health care moratorium has been lifted

In 2019, the Centers for Medicare & Medicaid Services lifted its home health care moratorium that had prevented new home health agencies from enrolling in Medicare and Medicaid. Blue Cross Blue Shield of Michigan has reviewed the CMS procedures and guidelines for home health agencies and implemented internal procedures to ensure consistency in our review and approval processes for new and existing home health care providers.

Home health care facilities are now eligible to enroll in Traditional, Medicare Plus Blue℠, Blue Care Network and BCN Advantage℠ networks. To submit and review required documentation, enrollment and change forms, visit **bcbsm.com/providers**, scroll down to *Prepare to Enroll* and then click on *Enroll now*.

If you have any questions about the Blue Cross and Blue Care Network enrollment and change process, contact Provider Enrollment at 1-800-822-2761.

Patient Care

Blue Care Network promotes continuity of care in some situations

Continuity of care services are available for the following members:

- Blue Care Network members whose primary care physician, specialist or behavioral health provider voluntarily or involuntarily disaffiliates from BCN
- New Blue Care Network members who require an ongoing course of treatment

Members can't see their current physician if that physician was terminated from BCN for quality reasons. In this instance, the member is required to receive treatment from an in-network provider.

BCN provides continuity of care notification to members at least 30 days prior to the practitioner's termination date.

BCN permits the member to continue treatment in the situations described below provided that the practitioner:

- Continues to accept as payment in full, reimbursement from BCN at rates applicable prior to the termination
- Adheres to BCN standards for maintaining quality health care and provides the necessary medical information related to the care
- Adheres to BCN policies and procedures regarding referral and clinical review requirements

Primary care physicians may offer continuity of care for a member in the situations described in the table below. Specialty providers may offer continuity of care for a member receiving an ongoing course of treatment in the situations described in this table.

Situation	Length of continuity of care
General care	Up to 90 days after the practitioner's termination date.
Pregnancy	Through postpartum care directly related to the pregnancy, if the member is in the second or third trimester of pregnancy at the time of the practitioner's disaffiliation
Terminal illness	For the remainder of the member's life for treatment directly related to the terminal illness, if the member was being treated for the terminal illness prior to the practitioner's disaffiliation

An active course of treatment is defined as:

- An ongoing course of treatment for a life-threatening condition: A disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted
- An ongoing course of treatment for serious acute condition: A disease or condition requiring complex ongoing care, which the covered person is currently receiving, such as chemotherapy, postoperative visits or radiation therapy
- An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes
- The second or third trimester of pregnancy, through the postpartum period

A disaffiliating physician who wishes to offer a member continuity of care in accordance with the conditions of payment and BCN policies must notify BCN and the member who desires approval of continuity of care.

Providers may contact BCN's Care Management department at 1-800-392-2512 to arrange for continuity of care services.

Members should contact Customer Service by calling the number on the back of their member ID card.

A nurse provides written notification of the decision to the member and practitioners.

Newly enrolled members must select a primary care physician before requesting continuity of care services and within the first 90 days of their enrollment.

Patient Care

Blue Care Network promotes coordination of care between practitioners

Blue Care Network has a process to promote continuity and coordination of care among specialists and primary care physicians and behavioral health and primary care physicians.

We collect and analyze data each year to assess the exchange of information between specialists, behavioral health and primary doctors following both inpatient and outpatient consultations. Many studies have identified fragmentation of care as a problem in the medical system.

The information we collect is important as we work to improve continuity and coordination of care within our network.

Patient care that isn't coordinated between providers and across settings confuses members and increases risks to patient safety due to errors and unnecessary costs due to duplicate testing. The collaboration between practitioners can greatly improve both member satisfaction and health outcomes.

Our goal for exchange of information between the specialist and the primary doctor is 100%. This goal can be accomplished by ensuring that the specialist has the correct PCP information at the time of the visit and by forwarding the post visit information to the primary care provider.

We encourage all providers to continue to take steps to enhance the information exchange across the continuum of care.

Medical record guidelines policies require providers to maintain member records

Blue Cross Blue Shield of Michigan and Blue Care Network have a policy to ensure clinical records are maintained for each of our members and organized in a manner that facilitates easy access for reviewing and reporting purposes. The medical record should be stored or electronically secured to comply with HIPAA regulations.

Content of the medical record should include:

- Member demographics
- Health assessment
- Reason for visit
- Diagnosis
- Documentation of discussion about the following: advanced directives, preventive health and health maintenance, patient education, follow-up plan, consultation review and referred services review

Our medical recordkeeping policies support Centers for Medicare & Medicaid Services and National Committee for Quality Assurance standards and contain elements from the Michigan Quality Improvement Consortium guidelines.

Quality management coordinators in our Quality and Population Health Department conduct medical record reviews of our contracted health providers for a variety of reasons including, but not limited to, member complaints, identified deficiencies during a site visit, member surveys, suspicion of fraud, waste or abuse, or random reviews to monitor compliance with established standards for adequacy of medical recordkeeping.

The performance expectation is an overall score of at least 80%.

You can find more information about screening guidelines on the **MQIC** website.

Medical policy updates

We have prioritized communications related to COVID-19, so we haven't included a PDF of all the medical policies mentioned in this article. The PDF below only includes our updated telemedicine services policy.

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

- Genetic testing for corneal dystrophy
- Dry needling of myofascial trigger points
- Measurement of serum antibodies to selected biologic agents
- Intraoperative fluorescence imaging system

Covered services

- Genetic testing for Huntington's disease
- Bone growth stimulation: ultrasound accelerated fracture healing device
- Photodynamic therapy for dermatologic applications
- Cosmetic and reconstructive surgery
- Cranial orthosis (helmet or band therapy) as a treatment of plagiocephaly
- Pediatric feeding programs
- Obstructive sleep apnea and snoring — surgical treatment
- Recombinant and autologous platelet-derived growth factors as a treatment of wound healing and other non-orthopedic conditions
- Transgender services
- Telemedicine services
- Percutaneous tibial nerve stimulation

PDF *Medical Policy Updates*

What you need to know about autism spectrum disorder services and telehealth

We've made changes to our telehealth policy, effective May 1. However, billing an originating site for telehealth services is no longer required, effective in mid-March. An originating site may be used if clinically necessary. Standard member cost-sharing will apply according to the member's benefits.

Please reference the **telehealth basics** and **practice guidelines** pages of the American Telemedicine Association website to determine how to adhere to HIPAA requirements and protect patient confidentiality, as required in your Blue Cross or BCN contract.

The following services for autism spectrum disorder **aren't covered via telehealth**.

- *97151: Assessment, which includes live interaction with the child. This service is critical to the evaluation process and is not covered via telehealth.
- *97153: Applied behavior analysis, which is a direct face-to-face procedure. This service is not covered through telehealth.

The following services for autism spectrum disorder **are covered via telehealth**.

- *97155: Protocol modification, which can use a combination of face-to-face and telehealth services (up to 50% of the time of the services provided) as long as a technician is present face to face.
- *97156: Caregiver training, which can be provided via telehealth services (up to 100% of the time of the services provided).
- *97157: Multi-family group caregiver training, which can be provided via telehealth services (up to 100% of the time of the services provided)
- Submit these codes with a modifier of GT or 95 and place of service 02.

Review the Medical policy updates article on **Page 12** for more information about our updated telehealth policy.

Collaborative care codes now payable with no member cost sharing

Effective July 1, we'll reimburse medical practices who perform collaborative care — with no member cost share. This applies to the following collaborative care codes: *99492, *99493, *99494 and the general behavioral health integration code *99484.

Collaborative care includes mental health, behavioral health and substance abuse services provided in a primary care setting, often with the assistance of psychiatric consultations or social workers. These codes apply to BCN HMO℠, Blue Cross' PPO, BCN Advantage℠ and Medicare Plus Blue PPO.

"These codes allow for reimbursement to the medical practice for behavioral health case management and psychiatric consultation to the practice to coordinate the best holistic care for members' medical and behavioral health needs," says Dr. William Beecroft, Behavioral Health medical director for Blue Cross and BCN.

Collaborative care is designed to improve outcomes and empower patients and their families. This style of practice has been shown to alleviate provider burn out, increase behavioral health access and improve member outcomes for their medical and behavioral health issues, ultimately leading to improvement in members' health and quality of life, says Dr. Beecroft.

As always, remember to check web-DENIS for benefits and eligibility and for specific policy limitations.

Clarifying authorization requirements for PT, OT, ST and physical medicine services for BCN HMO members with autism

For BCN HMO℠ (commercial) members with a diagnosis of autism, it's important to know where to submit authorization requests for physical, occupational and speech therapy by independent therapists and physical medicine services by chiropractors:

- For members 19 years of age or older, eviCore healthcare manages these authorization requests. Submit these requests using the eviCore provider portal.

See more in the article on **Page 25**.

Quality Counts

Changes to the HEDIS measure, Controlling High Blood Pressure, reduces the need for medical record reviews

The Controlling High Blood Pressure Healthcare Effectiveness Data and Information Set measure has been updated to assess patients ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the last reading of the year.

Previous HEDIS® specifications for high blood pressure required medical record reviews to determine if a patient's blood pressure was under control. Now, billing blood pressure CPT Category II codes on each office visit claim can determine compliance. It's not necessary to have a diagnosis of a hypertensive condition when billing the CPT Category II codes.

When you add the correct CPT Category II codes to your claims, medical records will not need to be collected for confirmation. This saves time and lessens the need for medical record review for providers.

To learn more about claims coding to reduce medical record reviews and other measure changes, view the CBP tip sheet below-.

CBP tip sheet


2020
Controlling high blood pressure (CBP)
Effectiveness of Care HEDIS® Measure
Measurement definition
Exclusions
Information that patient medical records should include
Information that patient claims should include

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

Pharmacy News

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

We're adding medications to the Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue℠ PPO and BCN Advantage℠ members. The specialty medications on this list are administered by a health care professional in a provider office, at the member's home, in an off-campus outpatient hospital or in an ambulatory surgical center (sites of care 11, 12, 19, 22 and 24).

For dates of service on or after June 15, 2020, the following medications will require prior authorization through **NovoLogix**®:

- J1428 Exondys 51®
- J3490 Vyondys 53™
- J3490 Givlaari®
- J3590 Tepezza™
- J3590 Vyepti™

See article on **Page 8** for details.

We've made changes to coverage for infliximab biosimilar products for Medicare Advantage members

In April, we removed authorization requirements for certain infliximab biosimilar drugs and designated preferred infliximab biosimilar drugs for Medicare Plus Blue℠ PPO and BCN Advantage℠ members.

Authorization requirements

For dates of service on or after April 3, 2020, we no longer require authorization for the following infliximab biosimilars for Remicade® for Medicare Plus Blue and BCN Advantage members:

- Q5103 Inflectra®
- Q5104 Renflexis®

Preferred biosimilar drugs

Starting April 20, 2020, we've designated the following drugs as preferred infliximab biosimilar products for Medicare Plus Blue and BCN Advantage members:

- J3590 Avsola™
- Q5103 Inflectra
- Q5104 Renflexis

See the full article on **Page 7** for details.

Pharmacy News

We're adding site of care requirements for Lemtrada and Tysabri for commercial members

Starting May 1, 2020, the medical drug site of care program is expanding for Blue Cross' PPO (commercial) and BCN HMO℠ (commercial) members to include:

- Lemtrada® (alemtuzumab, HCPCS code J0202)
- Tysabri® (natalizumab, HCPCS code J2323)

Through April 30th, 2020, members who receive these drugs in one of the following locations are authorized to continue treatment:

- Doctor's office or other health care provider's office
- Ambulatory infusion center
- Hospital outpatient facility

Starting May 1, infusions of Tysabri and Lemtrada may not be covered at hospital outpatient facilities.* Before May 1, members should talk to their doctors to make arrangements to receive infusion services at one of the following locations:

- Doctor's office or other health care provider's office
- Ambulatory infusion center

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.

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:

- The **Blue Cross Medical Benefit Drugs – Pharmacy** webpage
- The **BCN Medical Benefit Drugs – Pharmacy** webpage

We'll update the requirements list for the drugs listed above before May 1.

*Based on Risk Evaluation and Mitigation Strategies program restrictions, administration of Lemtrada and Tysabri are limited to authorized locations. For Lemtrada, we'll restrict transitions to select locations that have safety protocols in place for adverse reactions. To aid in member transition, refer to our **ereferrals.bcbsm.com** website, which contains additional program information and details on available in-state and nationally authorized administration sites.

Quarterly update: Requirements changed 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 PPO and HMO commercial members.

During January, February and March 2020, the following medical drugs had authorization requirement updates, site-of-care updates or both for BCN HMO℠ members:

HCPCS code	Brand name	Generic name
J3590**	Adakveo®	crizanlizumab-tmca
J3490**	Vyondys 53™	golodirsen
J3590**	Avsola™	infliximab-axxqJ
J3490**	Givlaari™	givosiran
J7170	Hemlibra®	emicizumab-kxwh
J0222	Onpattro®	patisiran
J3590**	Reblozyl®	luspatercept-aamt
J3490**	Palforzia™	Peanut (Arachis hypogaea) allergen powder-dnfp
J3590**	Tepezza™	teprotumumab-trbw
J0179	Beovu®	brolucizumab-dbll
J2503	Macugen®	pegaptanib sodium

**Will become a unique code.

For a detailed list of requirements, see the **BCN Drugs Covered Under the Medical Benefit** page of the **ereferrals.bcbsm.com** website.

Additional notes

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

Quantity limits for some migraine medications will change

Starting July 1, 2020, Blue Cross Blue Shield of Michigan and Blue Care Network will have new quantity limits for the migraine medications listed below. The new quantity limits follow U.S. Food and Drug Administration-approved dosing guidelines to help prevent unsafe use.

Drug	Current BCN HMO℠ quantity limit		Current Blue Cross PPO quantity limit		New quantity limit
	Custom Drug List	*Custom Select Drug List*	*Custom, Clinical, Preferred Drug List*	*Custom Select Drug List*	
Amerge® Axert® Frova® Imitrex® Maxalt® Relpax® Zomig®	9 tablets per fill	9 tablets per fill	12 tablets per fill	9 tablets per 30 days	12 tablets per 30 days
Treximet®	9 tablets per fill	Not covered	9 tablets per fill	Not covered	12 tablets per 30 days
Imitrex® Injection	5 injections per fill	5 injections per fill	6 injections per fill	4 injections per 30 days	8 injections/vials per 30 days
Zembrace® injection®	2 injections per fill	Not covered	4 injections per 30 days	Not covered	8 injections per 30 days
Imitrex® nasal spray	6 units per fill	6 units per fill	6 units per fill	6 units per fill	12 units per 30 days
Onzetra™ Xsail® nasal spray	1 dose kit per fill	Not covered	1 dose pack per 30 days	Not covered	1 kit (8 pouches) per 30 days
Zomig® nasal spray	6 units per fill	6 units per fill	6 units per fill	6 units per fill	12 units per 30 days

Members who are currently taking one of these medications may continue to receive their medication, but they'll have to request approval if the use exceeds our quantity limit.

We'll notify affected members of these changes and encourage them to talk with their providers about treatment options.

We'll tell members they should talk to their providers about this change if they:

- Take a greater quantity than those listed
- May need to increase the quantity
- Aren't sure about the quantity they take

Billing Bulletin

CORONAVIRUS
COVID-19

COVID-19 billing guidelines

The Centers for Disease Control and Prevention has introduced a new diagnosis code for confirmed COVID-19 cases, effective April 1, 2020.

Diagnosis codes to use:	Through March 31, 2020:	April 1, 2020, and after:
For confirmed COVID-19	J12.89, J20.9, J22 or J80 in the primary diagnosis field and B97.29 in the secondary diagnosis field	U07.1 as the primary diagnosis
For suspected COVID-19	Z20.828 as the primary diagnosis	

For more information, refer to the **announcement from the CDC about the new ICD-10-CM code**.

For the latest information about COVID-19 coronavirus, including billing tips, go to our *Coronavirus information updates for providers* page. Log in to Provider Secured Services, then click on *BCN Provider Publications and Resources* or *BCBSM Newsletters and Resources*. You can also find information at **bcbsm.com/coronavirus** by clicking on ***For Providers***.

Blue Care Network is ending the 125% multiple surgery reimbursement for certain nerve block procedures

Beginning June 1, 2020, Blue Care Network will no longer apply the 125% multiple surgery reimbursement for hip and knee arthroplasty procedures with nerve block when performed in an outpatient surgical setting. This new reimbursement applies to BCN HMO (commercial) members and aligns with Blue Cross Blue Shield of Michigan reimbursement.

This will apply to hip and knee arthroplasty procedures billed with the following codes:

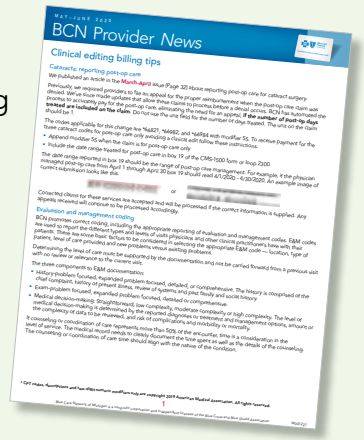
- 27125*
- 27130*
- 27440*
- 27441*
- 27442*
- 27443*
- 27445*
- 27446*
- 27447*

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 tip includes:

- Cataracts — reporting post-op care
- Evaluation and management coding


BCN Provider News
Clinical editing billing tips

Clinical editing billing tips

Use the e-referral system to submit authorization requests and check their status

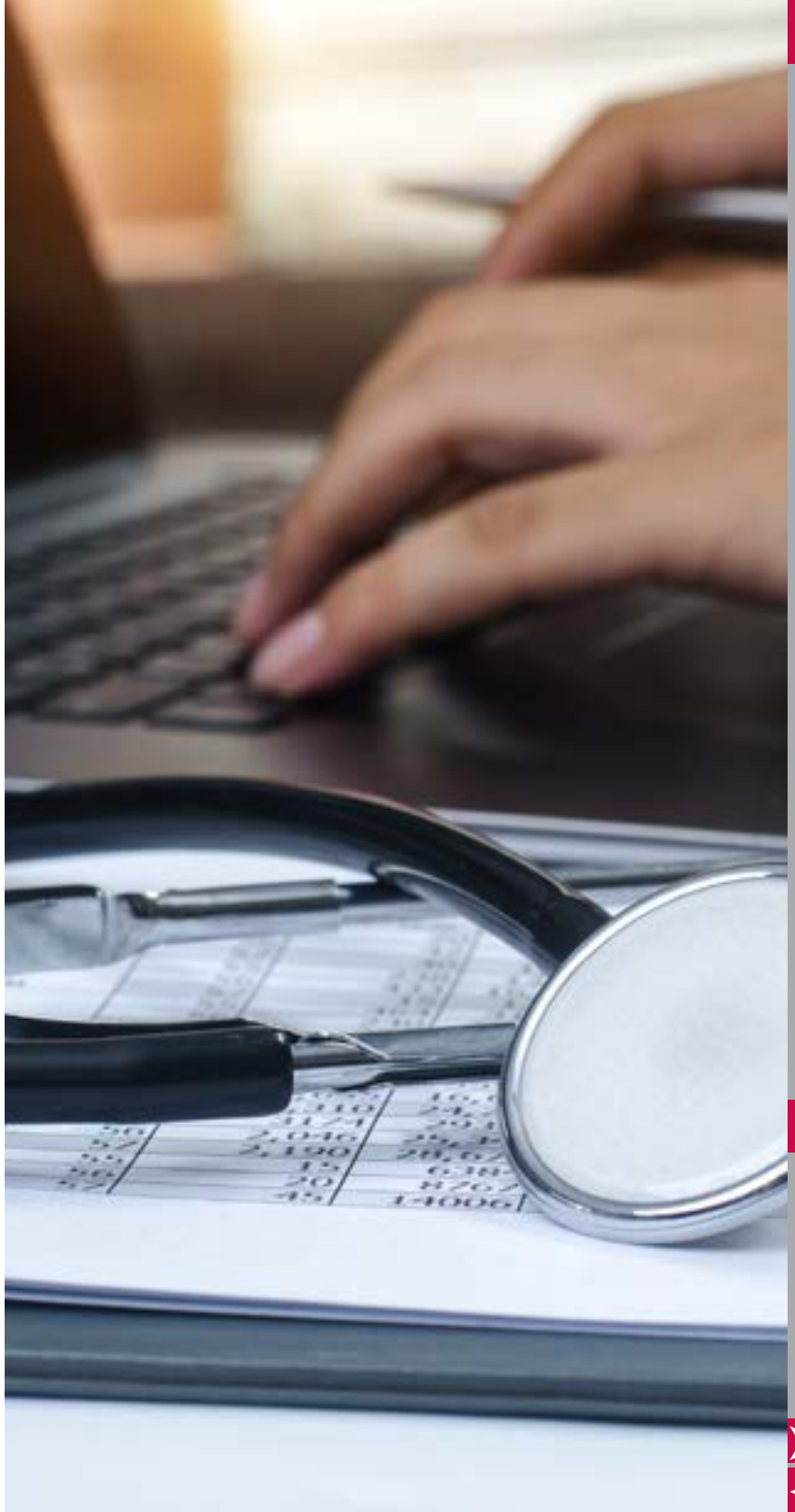
When you need to submit an authorization request to BCN Utilization Management, we encourage you to use the e-referral system.

Using the e-referral system is the most efficient way to handle these requests. Here's why:

- Authorization requests with a questionnaire that meet criteria can be automatically approved through e-referral. This means you'll have your approval right away — no waiting!
- Our phones are busy and using e-referral is the best way to submit your authorization request quickly. Avoid waiting on hold.
- You can use the e-referral system anytime, day or night. It's best to submit authorization requests before you perform the service, but you can submit them anytime using e-referral.
- You can attach required clinical documentation to authorization requests in e-referral. Avoid faxing.
- Using e-referral instead of faxing speeds up these tasks:
  - Requesting extensions of authorization requests that have already been approved
  - Requesting continued stays
  - Submitting discharge dates

Note: Authorization requests for sick or ill newborns must be submitted by fax, since the newborn is not yet a member covered by BCN.

Please see e-referrals, continued on Page 22



e-referrals, *continued from Page 21*

Submit all required clinical information

When authorization requests are not automatically approved, we review the clinical information you've submitted to determine whether the request meets medical necessity criteria.

It's important to submit all pertinent supporting documentation with your request so we can make a decision as quickly as possible. If we haven't received all the required clinical information, we can't complete our review.

When you submit your request through the e-referral system, you can attach all the required clinical information up front and prevent the delays that occur when the case pends for review.

For instructions on how to attach documentation to your request, refer to the **e-referral User Guide**. Search for "Create New (communication)."

Decision time frames

Here are the general time frames for decisions on requests we review for medical necessity:

- Acute inpatient admission requests: Within 24 to 72 hours of receiving the request, depending on the urgency of the request and the receipt of the clinical information

  Note: For BCN Advantage members, the time frame is 72 hours.

- Non-inpatient preservice requests: From 72 hours to 14 days of receiving the request, depending on the urgency of the request and the receipt of the clinical information
- Postservice requests: Within 30 days of receiving the request

For all these requests, BCN may extend the time frame if we don't receive all the required clinical information when the request is first submitted.

Check the status of your request in e-referral

Save time by checking the status of a request using the e-referral system. Again, no waiting on hold.

The status of your request will be one of these:

- Pending decision
- Fully approved
- Partially approved
- Denied
- Voided

You'll see the case status in the dashboard, in the Status column. You'll also see it when you open the case, at the upper left of the screen. For additional information, refer to the **e-referral User Guide**.

Additional information

You'll find more information about submitting authorization requests in the *BCN Provider Manual*, in these locations:

- **Utilization Management chapter** (formerly called the Care Management chapter). Look in the sections titled "Utilization management decisions" and "Guidelines for observations and inpatient hospital admissions."
- **BCN Advantage chapter**. Look in the section titled "BCN Advantage utilization management program."

Reminder: Providers need to submit authorization requests for all surgical procedures related to musculoskeletal conditions to TurningPoint

As we reported in the last two issues, you'll need to submit authorization requests for all surgical procedures related to musculoskeletal conditions to TurningPoint. This is effective for BCN HMO℠ (commercial), BCN Advantage℠ and Medicare Plus Blue℠ PPO members. See the article in the March-April ***BCN Provider News***, Page 37, for detailed information.

Due to the COVID-19 pandemic, we're delaying the date on which TurningPoint will begin managing authorizations. The new date is July 1, 2020.

For information about the duration of authorizations during the COVID-19 pandemic, see the **Changes to authorization durations for elective and non-urgent procedures, including PT, OT and ST, during the COVID-19 pandemic** message that we posted to our public website at **bcbsm.com/coronavirus**.

We'll continue to offer webinar training for providers and facilities.

Use the links below to register for webinars:

- **Training for professional providers**
- **Training for facility providers**

Important information for facilities

Facilities should have an authorization before scheduling surgery.

Facility providers won't be able to access the TurningPoint portal until fourth quarter of 2020 to get a status on authorization requests. In the meantime, we're recommending that the ordering physicians secure the required authorization and provide the authorization numbers to the rendering facilities or providers.

Facilities can look up the status of an authorization request by checking on **ereferrals.bcbsm.com**. The authorization will show in our system one business day after TurningPoint has made a decision. To check the status of an authorization request directly with TurningPoint, call 1-833-217-9670.

Include only procedure codes authorized for musculoskeletal procedures on your claims

For inpatient professional claims, make sure to include only the procedure codes authorized for musculoskeletal procedures on your claim.

On a quarterly basis, Blue Cross and BCN will review paid inpatient claims from professional providers to ensure that the procedure codes on the claims match the procedure codes TurningPoint authorized. If we find overpayments because the claim included codes that TurningPoint didn't authorize, we'll pursue payment recoveries as necessary.

You can request that TurningPoint add procedure codes to an authorization, but you must do this before submitting your claim. For more information about updating procedure codes on an authorization, see the FAQ document referenced below.

Where to find more information

For more information about TurningPoint see the eferrals web page for **BCN** and **Blue Cross**.

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

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

You can also refer to the frequently-asked-questions **document** on our ereferrals.bcbsm.com website.

Interventional pain management services for CPT codes 64451 and 64625 require authorization starting May 1

Interventional pain management services associated with procedure codes *64451 and *64625 require authorization by eviCore healthcare for dates of service on or after May 1.

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

- Blue Cross' PPO
- Medicare Plus Blue℠ PPO
- BCN HMO℠
- BCN Advantage℠

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 webpage**
- **The Blue Cross eviCore-Managed Procedures webpage**

What you should know about authorization requirements for PT, OT, ST and physical medicine services for BCN HMO members with autism

For BCN HMO℠ (commercial) members with a diagnosis of autism, it's important to know where to submit authorization requests for physical, occupational and speech therapy by independent therapists and physical medicine services by chiropractors:

- For members 19 or older, eviCore healthcare manages these authorization requests. Submit these requests using the **eviCore** provider portal.
- For members younger than 19, no authorization is required. Claims for these services pay without a referral or an authorization if they are billed by a BCN-contracted provider with a childhood autism diagnosis code — specifically, for diagnosis codes F84.0, F84.5, F84.8 and F84.9.

We're updating our web pages as well as *BCN Provider Manual* chapters and other documents to include this information.

Additional information

For more information on submitting authorization requests to eviCore healthcare, refer to the **Outpatient rehabilitation services: Frequently asked questions for rehab providers** document.

This document and other resources are available on BCN's **Outpatient PT, OT, ST** page on the ereferrals.bcbsm.com website.

Refer also to eviCore's **Web Portal Presentation** document and **eviCore's BCN implementation** page.

Quarterly update: Requirements changed for some commercial medical benefit drugs

During January, February and March 2020, we've made authorization requirements updates, site-of-care updates or both for certain medical drugs for BCN HMO℠ members.

See the article on **Page 18** for details.

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Feedback

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