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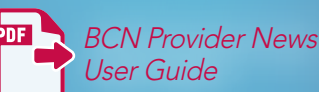
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New secure provider website coming in 2021

We reported the **results of a provider survey** conducted by Blue Cross Blue Shield of Michigan and Blue Care Network in our March-April issue. In this survey, you told us some things you like about our current online tools and pointed out what you'd like to see improved. Since then, we've been working to address many of the concerns you raised while keeping features you like.

We're pleased to announce that we'll introduce a new secure provider website in 2021 with additional online tools and functionality designed to make it easier for you to do business with us. The new site will still provide access to many of the tools you currently use, but it will have a simple, fresh look, updated search features and improved performance.

New site will be operated by Availity

Our new secure provider website will be operated by Availity. Availity is a multi-payer website that offers easy-to-use online tools for health care providers. This means that you'll be able to log in and request information for your patients that have coverage with several different health plans, including Blue Cross Blue Shield of Michigan and Blue Care Network.

Watch for more information in future issues of this newsletter.

We've changed preventive screenings to a calendar year schedule

We've changed the frequency for preventive screenings to a calendar year for BCN HMOSM members to align with Blue Cross PPO plans and to allow members who deferred their screenings due to COVID-19, to have more flexibility in future scheduling.

This means members can schedule their routine screenings at any time during the year regardless of when they had the screening in the previous year. This applies to preventive screenings that members schedule annually, such as mammograms.

Most screenings included in HEDIS measures are not recommended on an annual basis. For high-risk patients, however, providers may continue to recommend annual screenings for cervical cancer or certain diabetic screenings, such as retinal eye exams, for example.

Please see
[Preventive screenings](#), continued on Page 2

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Preventive screenings, continued from Page 1

Annual physical reminder

As a reminder, providers can schedule a physical exam for BCN members any time throughout the year. There are no limits to the frequency of physical exams for HMO patients.

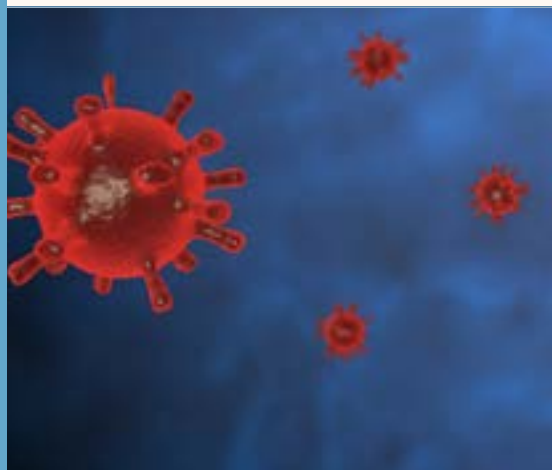
Healthy Blue LivingSM HMO members are required to visit their primary care physician for an exam within 90 days of enrollment or renewal. Providers can schedule this physical exam any time. If last year's physical was in March, for example, the member can get a physical in January.

BCN encourages each Healthy Blue Living HMO member to see his or her PCP well before the deadline and will accept a qualification form from an office visit occurring up to 180 days prior to the member's renewal date. See the complete article in the **January-February issue**, Page 3, for details.

This year, we extended the deadlines for Healthy Blue Living members. See the article on Page 5 of the **July-August issue** for details.

Preventive screenings for BCN Advantage follow Medicare guidelines

BCN AdvantageSM and Medicare Plus BlueSM PPO follow guidelines set by the Centers for Medicare & Medicaid Services. Those rules have not changed. More information on the frequency of Medicare screenings is available at [cms.gov](https://www.cms.gov).



Checking the status of temporary measures for COVID-19

In June, some of the temporary measures we put in place for the COVID-19 crisis have concluded.

You can find information about this on our coronavirus webpage, which is available through Provider Secured Services and on our public website at bcbsm.com/coronavirus.

Also, refer to the article on **Page 29** for more information.

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BCN extends rate increases for in-person home health care and home infusion nursing visits in response to COVID-19

In response to the continuing COVID-19 pandemic, Blue Care Network is extending changes to reimbursement for certain services through Dec. 1, 2020. We're extending these increases to support providers caring for our BCN HMOSM and BCN AdvantageSM members during this crisis.

What's changing

For dates of service from April 1, through Dec. 31, 2020, BCN will increase rates by 25% for services delivered in person in a member's home and not through telemedicine.

Note: On June 5, we had announced that the increases would be applied through Aug. 31, 2020.

These services are:

- All types of care covered through a provider's home health care contract
- Nursing visits covered under home infusion therapy

To find the rates for these services, log in to Provider Secured Services and look for the web-DENIS alert that was posted on July 13. The same information is also on our COVID-19 pages within Provider Secured Services.

Some groups extend COVID-19 cost share waivers

Effective July 1, 2020, the Michigan Public School Employees' Retirement System, or MPSERS, and State of Michigan Blue Cross retiree groups are extending member cost share waivers for COVID-19 treatments. The cost share waivers that were in place through June 30, 2020, are now effective until Sept. 30, 2020.

This includes telehealth for medical and behavioral health services, primary care and behavioral health office visits, as well as in-office diagnostic X-ray and labs. These groups will continue to cover COVID-19 related services such as physician and hospital evaluation test administration and lab tests, as mandated by the government.

As we previously announced, some other self-funded commercial groups are continuing to waive member cost share for telehealth for dates of service March 16 through Dec. 31, 2020.

We're encouraging providers to submit claims to Blue Cross Blue Shield of Michigan and Blue Care Network and wait for the remittance advice before charging the member cost share, if applicable.

More information is available at bcbsm.com/coronavirus or through Provider Secured Services.

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We're revising our policy on hypofractionation for breast and prostate cancer as part of our radiation oncology program managed by eviCore healthcare

Blue Cross Blue Shield of Michigan and Blue Care Network have revised the radiation oncology program managed through eviCore healthcare to limit coverage to hypofractionation (a shorter, equally effective regimen) for many breast and prostate cancers, effective for requests submitted on or after Sept. 21. The changes align with evidence-based guidelines including the National Comprehensive Cancer Network, or NCCN.

This new policy applies to Blue Cross' PPO, Medicare Plus BlueSM PPO, BCN HMOSM and BCN AdvantageSM. It doesn't apply to Blue Cross' PPO self-funded groups.

We've made the change to align with NCCN. The change will result in less frequent visits for patients.

For **breast cancer patients**, the policy change means that hypofractionation will be covered in cases where the regional lymph nodes are not included in the treatment.

IORT and APBI will continue to be allowed in accordance with policy.

For external beam radiation, both hypofractionation (three to four weeks) and standard fractionation (six weeks) are currently allowed. Effective Sept. 21, only hypofractionation (the shorter regimen) will be allowed, though exceptions to this will be made on a case-by-case basis.

For **prostate cancer patients**, both hypofractionation (four to five weeks) and standard fractionation (nine weeks) are currently allowed. Effective Sept. 21, only hypofractionation (the shorter regimen) will be allowed. Exceptions will be made on a case-by-case basis.

In addition, the prostate cancer policy has been updated to now allow SBRT for high-risk patients, in alignment with NCCN.

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
 - BCN/BCN Advantage: 1-855-774-1317
 - Blue Cross PPO/ Medicare Plus Blue: 1-877-917-2583
- Alternative: Fax to eviCore at 1-800-540-2406

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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Blue Cross recognized by J.D. Power for highest member satisfaction among commercial health plans in Michigan

Putting members first is a hallmark of our work at Blue Cross Blue Shield of Michigan. That's why we're honored to receive the J.D. Power Award for highest member satisfaction among commercial health plans in Michigan for the second time in three years.

We want to thank our health care providers for the role they've played in helping us achieve this honor. The experience members have in provider practices and hospitals influences their impression of Blue Cross.

This award is given to the Michigan health plan that ranks first place overall in the J.D. Power 2020 Commercial Member Health Plan study. It recognizes our efforts at Blue Cross to make sure our members are taken care of with the right care at the right time.



Blue Cross Blue Shield of Michigan received the highest score in Michigan in the J.D. Power 2020 U.S. Member Health Plan Study of customers' satisfaction with their commercial health plan. Visit [jdpower.com/awards](https://www.jdpower.com/awards).

Improving the experience for members has been the focus of many Blue Cross initiatives throughout the past few years. They include:

- Making health care more affordable through Value-Based Contracting and Blueprint for Affordability
- Working closely with providers to improve health care quality through our Physicians Group Incentive Program and collaborative quality initiatives
- Launching programs to support care management and diabetes management
- Improving access to health care through the Blue Cross Online Visits app
- Enhancing our Blue Cross mobile app and **bcbsm.com** with the new MIBlue Virtual Assistant chat feature, which enables members to get answers to their health plan questions 24/7

We appreciate the care you give your patients — our members — and your ongoing efforts to improve health care quality and affordability.

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Blue Care Network program helps members understand surgery options

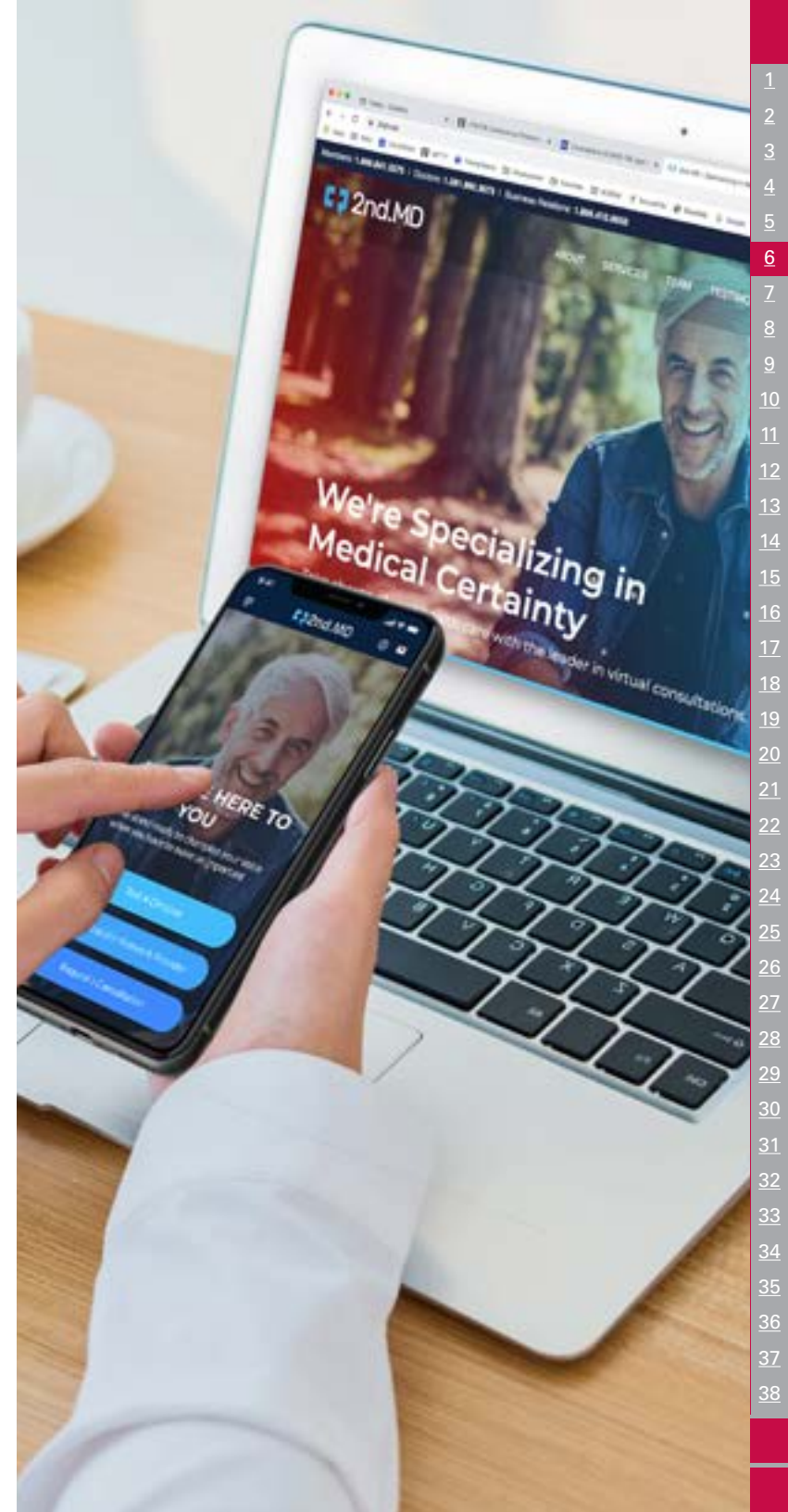
Blue Care Network is expanding a **program** we started last October to help members understand and make decisions about high cost, high-risk conditions.

Our agreement with 2nd.MD gives some commercial members access to personalized second opinions and treatment options (by video or phone) from medical specialists at top institutions.

This service can help patients make better decisions and understand alternatives to surgery, if appropriate. 2nd.MD can also help members find a high-quality, in-network local physician who is experienced with the member's specific condition.

The program is available to self-insured BCN and Blue Cross Blue Shield of Michigan members and will be expanded to fully insured groups in mid-2021.

A member's current treating provider may opt to consult with the 2nd.MD expert. Providers may also be asked to share a patient's medical records with 2nd.MD.



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Online Training

On-demand training available

Provider Experience is continuing to offer training resources for health care providers and staff.

We've posted recordings of webinars previously delivered this year. In addition, video and eLearning modules are available on specific topics. The on-demand courses are designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

You can find them on the *Learning opportunities* and *Provider Training* pages. Here's how to find the links:

For Blue Cross

- Log in to Provider Secured Services.
- Go to *BCBSM Newsletters and Resources*.
- Click on *Provider Training* under Popular links.
- Find the most recent webinar links under 2020 Provider Training webinars in the Featured Links section.
- To find video and eLearning modules, click on the *E-Learning (Online training, presentations and videos)* link under Quick access at the top of the page.

For BCN

- Log in to Provider Secured Services.
- Go to *BCN Provider Publications and Resources*.
- Click on *Learning opportunities* under Other Resources.
- Find the most recent links under 2020 Provider Training Webinars.

As additional training webinars become available, we'll communicate about them through this newsletter.

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Providers find *Blues Brief* helpful and easy to read

Earlier this year, we conducted an online survey to determine your satisfaction with the monthly professional, quarterly facility and specialty versions of *Blues Brief*. *Blues Brief* is a two-page newsletter that offers a quick summary of several key articles in *The Record* and *BCN Provider News*.

Most survey respondents were subscribers to the monthly professional version of *Blues Brief*. Some of the comments we received indicated that the newsletter was helpful and easy to read. Other findings:

- Seventy-six percent received *Blues Brief* in the last 12 months.
- Fifty-eight percent prefer to read *Blues Brief* through their email subscription which takes them directly to the articles online.
- Eighty-one percent read every publication of *Blues Brief*.
- Ninety-six percent said there's the right amount of detail included in the publication.




Blues Brief helps you stay on top of important news if you happen to miss an issue of *The Record* or *BCN Provider News*. And it will always link back to the original article in either of those newsletters.

If you miss an issue of any of our publications and you can't find your email, visit the archives pages:

- [BCN Provider News](#)
- [The Record](#)
- [Blues Brief](#)

Keep in mind that *Blues Brief* isn't intended to be a replacement for *The Record* or *BCN Provider News*. It's important to review both publications regularly to make sure you have all the information you need to do business with us.

As a reminder, you can subscribe to our newsletters and *Blues Brief* two ways:

1. Click the *Manage Subscriptions* link at the bottom of your email version of *The Record* or *BCN Provider News*. Once you make changes to your subscriptions, simply click on *Update* and we'll process the changes. Our system doesn't automatically acknowledge your changes, but we'll add you to the distribution list.
2. Visit our [subscription page](#) to choose your preferred *Blues Brief* versions.

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Medication reconciliation post-discharge is critical to patient safety and care coordination efforts

Collaboration is a key component of medication reconciliation. Communication between medical, nursing, ambulatory and pharmacy staff involved in the patient's care and the patient, their caregiver or family members is vital for its success.

Medication reconciliation is about obtaining the most accurate list of patient medicines, allergies and adverse drug reactions and comparing them with the medications, documented allergies and adverse drug reactions listed in the outpatient medical record. Any discrepancies are then documented and reconciled.

View the Medication Reconciliation Post-Discharge tip sheet to learn more about when the process should be completed, information to include in a patient's record, Current Procedural Terminology codes* that should be included in claims and tips for talking with patients about this important topic.



Medication Reconciliation Post-Discharge tip sheet

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

Medical specialty drug prior authorization lists are changing in September for BCN HMO, Medicare Plus Blue PPO and BCN Advantage members

We're adding authorization requirements for three specialty drugs covered under the medical benefit for BCN HMOSM, Medicare Plus BlueSM and BCN AdvantageSM members.

For dates of service on or after Sept. 25, 2020, the following drugs will require authorization through AIM Specialty Health[®]:

- Zepzelca[™] (lurbinectedin), HCPCS codes J3490, J3590, J9999
- Phesgo[™] (pertuzumab/trastuzumab/hyaluronidase-zzxf), HCPCS codes J3490, J3590, J9999
- Nyvepria[™] (pegfilgrastim-apgf), HCPCS codes J3490, J3590, J9999

See full article on **Page 25** for details and how to submit authorization requests.

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Medicare Part B medical specialty drug prior authorization list is changing

We're making changes to the Medical Drug and Step Therapy Prior Authorization List for Medicare Plus BlueSM PPO and BCN AdvantageSM 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 (place of service 11, 12, 19, 22 or 24).

New authorization requirements

For dates of service on or after July 9, 2020, the following medication for wet age-related macular degeneration will require authorization through the **NovoLogix**[®] online tool:

- J3590*, abicipar pegol

For dates of service on or after Aug. 21, 2020, the following medications will require authorization through NovoLogix:

- A gene therapy for hemophilia A
 - Roctavian[™] (valoctocogene roxaparvovec, HCPCS code J3590)
- Other medications
 - Uplizna[™] (inebilizumab-cdon, HCPCS code J3590)
 - Avsola[™] (infliximab-axxq, HCPCS code Q5121)

Note: On March 16, 2020, we published a web-DENIS message and a news item on the **ereferrals.bcbsm.com** website stating that Avsola doesn't require authorization. However, for dates of service on or after Aug. 21, 2020, Avsola will require authorization

For dates of service on or after Sept. 28, 2020, the following medications will require prior authorization through NovoLogix:

- Illaris[®] (canakinumab, HCPCS code J0638)
- Cutaquig[®] (immune globulin subcutaneous [human] – hipp, HCPCS code J1599)
- Xembify[®] (immune globulin subcutaneous [human] – klhw, HCPCS code J1558)

Authorization requirement removed

For dates of service on or after Aug. 1, 2020, the following medications for osteoporosis and other diagnoses involving bone health will no longer require authorization:

- Boniva[®] (ibandronate), HCPCS code J1740
- Aredia[®] (pamidronate), HCPCS code J2430

How to bill

For Medicare Plus Blue and BCN Advantage, we require authorization for the places of service referenced above when you bill these medications as follows:

- Electronically through an 837P transaction or on a professional CMS-1500 claim form
- Electronically through an 837I transaction or by using the UB-04 claim form for a hospital outpatient type of bill 013x

Important reminder

Submit authorization requests through NovoLogix. It offers real-time status checks and immediate approvals for certain medications. For Medicare Plus Blue and 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.

For a list of requirements related to drugs covered under the medical benefit, please see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**.

*J3590 is a code is used for unclassified biologics

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IVIG dosing strategy is changing for the Medicare Part B medical specialty drug program, starting Dec. 7

Blue Cross Blue Shield of Michigan and Blue Care Network require authorization for immune globulin products covered under the medical benefit for Medicare Plus BlueSM PPO and BCN AdvantageSM members.

As part of the authorization process, we're updating our dosing strategy for intravenous and subcutaneous immune globulin therapy to minimize drug waste, reduce unnecessary drug exposure and decrease the risk of adverse events.

Effective Dec. 7, 2020, we'll calculate doses using adjusted body weight for members when:

- The member's body mass index is 30 kg/m² or greater
- The member's actual body weight is 20% higher than their ideal body weight

This applies to all Medicare Plus Blue and BCN Advantage members who start therapy on or after Dec. 7, 2020, when the therapy is 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 (places of service 11, 12, 19, 22 and 24).

Members who currently receive immune globulin will continue to receive their current dose until their authorizations expire.

Important reminder

Submit authorization requests for these drugs through the NovoLogix[®] online tool. It offers real-time status checks and immediate approvals for certain medications.

For Medicare Plus Blue and 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.

For a list of requirements related to drugs covered under the medical benefit, please see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**.

Pharmacy-benefit drugs: News about electronic prior authorization

Starting Aug. 3, you can use CoverMyMeds[®] and other free ePA tools, such as Surescripts[®] and ExpressPath[®] to submit requests for most pharmacy-benefit drugs for our Medicare Advantage members. These are members who have coverage through Medicare Plus BlueSM PPO or BCN AdvantageSM plans.

You can already submit ePA requests for our commercial members (Blue Cross' PPO and BCN HMOSM).

See the article on **Page 22** for more information about ePA tools.

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Talk with your patients about osteoporosis

Many people don't know they have osteoporosis until they suffer a fracture. That's why it's important to maintain ongoing conversations with your older patients about the risks of falls and the benefits of osteoporosis screening.

Starting the conversation

Proactively evaluate the risk of falls with older patients at each office visit: Ask your patients if they've fallen or had issues with balance and walking.

As appropriate, suggest:

- A cane or walker
- An exercise program
- Vision testing

Assess the potential causes, such as medications. And consider the need for vitamin D supplementation.

For women age 65 and older, reinforce the importance of screening for osteoporosis with bone mineral density testing. This test is the only one that can diagnose osteoporosis.

For women age 67 and older who've already incurred a fracture, order a bone mineral density test and prescribe an osteoporosis medication within six months of the fracture. Do this unless BMD testing was done within two years of the fracture or osteoporosis treatment has occurred 12 months before the fracture.

Checking on osteoporosis care

HEDIS® star measures, including the Health Outcomes Survey, evaluate osteoporosis care and the risk of falls.

HEDIS measures

The *Osteoporosis Management in Women Who Had a Fracture* measure assesses the percentage of women age 67 and older who had a bone mineral density test or treatment for osteoporosis within six months of a fracture. Patients who had bone mineral density testing two years prior to a fracture or osteoporosis treatment 12 months before the fracture are excluded.

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

The *Risk of Falls* measure assesses the percentage of members 65 and older who:

- Were seen by a practitioner in the past 12 months
- Discussed falls or problems with balance or walking with their current provider

The Health Outcomes Survey asks patients:

- Have you ever had a bone mineral density test to check for osteoporosis?
- Has your doctor discussed the risk of falls, how to prevent falls or how to treat problems with balance or walking?

For more information

The U.S. Preventive Services Task Force [webpage on osteoporosis](#) indicates that doctors should screen all women age 65 and older for osteoporosis.

The American College of Physicians published evidence-based [osteoporosis treatment guidelines](#) in the *Annals of Internal Medicine* on May 9, 2017. The group recommends that doctors offer pharmacologic therapy to reduce the risk for hip and vertebral fractures in women with known osteoporosis.

You can also check out the Centers for Disease Control and Prevention's [Older Adult Falls](#) webpage.



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Isolation and economic uncertainty puts children and adults at increased risk for domestic violence

The COVID-19 pandemic had a largely unexpected result — an increase in domestic violence coupled with a reduction in calls to report domestic abuse. This phenomenon has affected both children and adults.

Keeping children safe

Due to the closure of schools and the stay-at-home orders, there's been a significant reduction in calls to child welfare agencies about possible abuse. Children were simply not in regular contact with teachers, social workers, doctors and others who could help them if they faced violence in a home environment. Other key factors:

- Home visits to at-risk families have been reduced and are now done virtually in many cases.
- Child-parent visitations and family reunification efforts have been reduced or have ceased entirely due to COVID-19.
- Court hearings about family reunification have been delayed.
- Other vital parts of the child welfare system, including home-based parenting programs, were brought to a near standstill.



William Beecroft, M.D.



Kristyn Gregory, D.O.

We expect that data will show an uptick in overall cases of reported child abuse once stay-at-home orders are lifted. The extended period of isolation, in conjunction with financial and economic stresses, has exacerbated the domestic violence crisis across the country. As the Brookings Institution reported at [brookings.edu](https://www.brookings.edu) on April 30, "COVID-19 has created a perfect storm of factors that will almost certainly lead to a sharp increase in unreported cases of child abuse and neglect, as children are cut off from interactions with professionals and teachers, confined at home with caregivers and relatives, and families are feeling the stress of job loss and economic uncertainty."

Brookings went on to say that the country's system of detecting abuse and neglect, which is heavily dependent on reports by teachers, doctors and other professionals, is rendered almost completely powerless in this new situation as in-person and face-to-face interactions between children and professionals were minimized by the stay-at-home orders.

William Beecroft, M.D., and Kristyn Gregory, D.O., are medical directors for Blue Cross Blue Shield of Michigan.

Please see [From the medical director](#), continued on Page 14

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From the medical director, continued from Page 13

In response to this situation, some states are calling on the general public to be extra diligent during this time and report suspected child maltreatment to Child Protective Services. However, it's been found that reports from the general public were less likely to be substantiated as accurate than reports from professional mandated reporters.

Adults at risk

In addition to children, adults — particularly women and LGBTQ+ individuals — are at an increased risk of domestic violence due to the lockdowns that were instituted to contain COVID-19, according to an article from the **Council on Foreign Relations**. Some high- and middle-income countries, including the U.S., Australia, France, Germany and South Africa, have reported increases in domestic violence since the COVID-19 outbreak.

Here are some of the ways that COVID-19 is affecting intimate partner violence survivors, according to the National Domestic Violence Hotline:

- Abusive partners may withhold necessary items, such as hand sanitizer or disinfectants.
- Abusive partners may share misinformation about the pandemic to control or frighten survivors, or to prevent them from seeking appropriate medical attention if they have symptoms.
- Abusive partners may withhold insurance cards, threaten to cancel insurance, or prevent survivors from seeking medical attention.
- Programs that serve survivors may be significantly affected. Shelters may be full or may even stop intakes altogether. Survivors may also fear entering a shelter because of being in close quarters with groups of people.
- Survivors who are older or have chronic heart or lung conditions may be at increased risk in public places where they would typically get support, such as shelters, counseling centers or courthouses.
- Travel restrictions may affect a survivor's escape or safety plan. It may not be safe for them to use public transportation or to fly.
- An abusive partner may feel more justified and escalate their isolation tactics.

The National Domestic Violence Hotline offers some suggestions for survivors on their website at **thehotline.org**. Their suggestions focus on three key areas:

- Create a safety plan.
- Practice self-care.
- Reach out.

We encourage you to share the following information about the National Domestic Violence Hotline with your patients:

- Victims and survivors who need support can call 1-800-799-7233 or 1-800-787-3224 for TTY.
- Those who are unable to speak safely can log onto **thehotline.org** or text LOVEIS to 22522.

It's important that we all remain extra vigilant to signs of domestic abuse among our patients, friends and neighbors during these challenging times.



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Medication reconciliation post-discharge is critical to patient safety and care coordination efforts

Collaboration is a key component of medication reconciliation. Communication between medical, nursing, ambulatory and pharmacy staff involved in the patient's care and the patient, their caregiver or family members is vital for its success.

See full article on [Page 9](#).

Important notice about pediatric feeding programs

For dates of service on or after Sept. 1, authorization is required for pediatric feeding services (S0317) for BCN HMOSM members. Look for more information in the web-DENIS message posted Aug. 5.

BCN has a medical policy on pediatric feeding programs. Blue Care Network's medical policy updates are posted on Provider Secured Services. Go to *BCN Provider Publications and Resources* and click *Medical Policy Manual*.



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

- Coblation®, radiofrequency ablation for musculoskeletal conditions
- Peroral endoscopic myotomy for treatment of esophageal achalasia or gastroparesis

Covered services

- Reconstructive breast surgery / Management of implants
- Reduction mammoplasty
- BMT— hematopoietic cell transplantation for autoimmune diseases
- Bone marrow transplant- hematopoietic cell transplantation for myelodysplastic syndromes and myeloproliferative neoplasms, allogeneic
- Circulating tumor DNA for management of non-small-cell lung cancer (liquid biopsy)
- Endoscopic radiofrequency ablation or cryoablation for Barrett's esophagus
- Frenum surgery (frenulum surgery, frenulectomy, frenulectomy, frenotomy, frenotomy)
- Hyperbaric oxygen therapy
- Noninvasive techniques for the evaluation and monitoring of patients with chronic liver disease
- Microprocessor-controlled prostheses and orthoses for the lower limb



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Blue Cross demonstrates ongoing commitment to members' behavioral health needs

By Dr. Amy McKenzie

Across the country, we've seen an increased focus on mental health over the past few years and a realization of the many ways that mental health affects physical health.

The need for mental health services has become even more apparent as the country struggles to address the COVID-19 pandemic. We've witnessed an increased number of calls to crisis lines and rising rates of substance use disorder, suicide and domestic violence. (See column on **Page 13** by Drs. William Beecroft and Kristyn Gregory.)

That's why Blue Cross Blue Shield of Michigan took swift action at the start of the pandemic to put in place a range of initiatives to help our members seek care during the crisis and make it easier for our health care providers to care for them. Many of our actions have centered around telemedicine.

We introduced incentives to help providers fund the adoption of telemedicine. Over a four-week period beginning in mid-March, the percentage of primary care physicians and behavioral health providers who

are providing telemedicine services grew to more than more than 80% from less than 10%—a truly phenomenal increase.

While some of the initiatives we wrote about in the **May-June issue** of *BCN Provider News* concluded June 30, many other initiatives for battling the COVID-19 pandemic remain. For example, for our Medicare Advantage members, we'll be waiving cost share for common medical and behavioral health services through Dec. 31, 2020, for both in-office and telemedicine visits. And we'll continue to waive cost share for COVID-19-related treatment for Medicare Advantage members through Dec. 31, 2020. This includes COVID-19-related treatment delivered through telemedicine.

I'm extremely proud of all that Blue Cross has done to help battle the pandemic and related mental health issues, as well as the efforts of all the health professionals who have worked on the front lines to save lives and slow the rate of COVID 19. And our efforts to address mental health issues won't stop when the pandemic winds down.

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Commitment, continued from Page 16

We're keeping our focus on programs designed to address common barriers to receiving behavioral health care, including access, mental health stigma, behavioral health integration, cost of care and member education. Here's a brief overview:

- We're continuing to develop and expand our Psychiatric Consultant Collaborative Care Model. This model incorporates a psychiatric consultant and a behavioral health care manager (who may be a social worker or psychologist) into the patient's care team. It provides care for a patient's mental health concerns within a patient-centered medical home setting. Training on this model will begin in September.
- We launched the myStrength program, an online tool offered through Livongo®, an independent company that works closely with Blue Cross Blue and Blue Care Network. It provides stress management strategies, parenting tips and emotional support tools, including a module for coping with COVID-19. All members have access to the program at no cost through Dec. 31, 2020. You can let your patients who

are Blue Cross or BCN members know they can go to bh.mystrength.com/bcbsmcvd19 and create a free myStrength account.

- We're in the initial stages of developing a pilot program that will help primary care physicians identify patients who have mental health needs and refer them to psychologists in their area.

Blue Cross is committed to offering our members — your patients — a continuum of programs to address their mental health needs. With the support and leadership of our health care providers, we want Blue Cross to be the market leader in delivering innovative, holistic solutions focused on the integration of behavioral and physical health.

If you have any thoughts on how we can do a better job of integrating behavioral and physical health, email me at AMcKenzie@bcbsm.com.

Amy McKenzie, M.D., is the medical director for Provider Engagement.

Isolation and economic uncertainty put children and adults at increased risk for domestic violence

The COVID-19 pandemic had a largely unexpected result — an increase in domestic violence coupled with a reduction in calls to report domestic abuse. This phenomenon has affected both children and adults.

See the medical director column on **Page 13** to read the full article.



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We're temporarily allowing direct-line ABA interventions to be performed by telemedicine

During the COVID-19 crisis and until further notice, we're temporarily allowing providers to perform direct-line ABA interventions (*97153) through telemedicine, for dates of service on or after Aug. 3, 2020.

See the new **Guidelines for ABA services delivered via telemedicine** document for guidance on determining which members can benefit from direct-line ABA interventions performed by telemedicine.

We updated the following documents to reflect this change:

- *Telehealth for behavioral health providers*
- *Telehealth procedure codes for COVID-19*
- *Temporary changes due to the COVID-19 pandemic*

You can find these documents on our public website at bcbsm.com/coronavirus and through Provider Secured Services.

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

To check whether a member has an autism benefit, follow the instructions on these documents:

- **Checking Blue Cross eligibility and autism benefits.** Log in to Provider Secured Services, click *Blue Cross Provider Publications and Resources*, click *Clinical Criteria & Resources*, and click *Autism* (in the Resources section). Finally, click to open the document.
- **Checking BCN eligibility and autism benefits on web-DENIS.** Log in to Provider Secured Services, click *BCN Provider Publications and Resources* and click *Autism*. Finally, click to open the document.

For authorization requirements related to autism services for various lines of business, refer to the **Summary of utilization management programs for Michigan providers.**



Duane DiFranco, XXX



William Beecroft, M.D.

Drs. DiFranco and Beecroft earn new roles in the Michigan Psychiatric Society

Dr. Duane DiFranco, vice president, Medicare Stars and Clinical Management, was named president of the **Michigan Psychiatric Society** from May 2020 to May 2021. He has been a member of the society since he began his career as a resident doctor and has previously served as president-elect, secretary/treasurer and councilor.

Dr. William Beecroft, Blue Care Network medical director, has been named a councilor for MPS for the 2020-2021 term.

"Folks with mental illness face tremendous battles that are made much worse during this time of COVID-19. To be able to lend my voice and to be able to steer the direction of our professional society as they deal with these issues on the frontlines is a tremendous opportunity," said Dr. DiFranco.

The Michigan Psychiatric Society represents the interests and professional needs of psychiatric physicians in Michigan while striving to ensure quality care for people with mental disorders and their families through promotion of education, research and advocacy.

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Quality corner: Initiation and engagement of alcohol and other drug dependence treatment

What does this measure focus on?

Initiation and engagement of alcohol and other drug dependence treatment is a HEDIS® measure. It looks at the percentage of patients ages 13 or older with a new episode of alcohol or other drug abuse or dependence.

Two parts are examined:

- Initiation of AOD treatment — Treatment must be initiated within 14 days of the diagnosis. Treatment can be initiated through:
 - An inpatient alcohol or other drug admission
 - An outpatient visit
 - An intensive outpatient encounter
 - A partial hospitalization
 - Telehealth (including telephone visits, e-visits, virtual check-ins)
 - Medication treatment (also known as medication-assisted treatment, or MAT)
- Engagement of AOD treatment — Considered complete if the first bullet and one of the other two are completed.
 - Member initiated treatment (above)
 - Member whose initiation of AOD treatment was not a medication treatment: Member received two or more AOD engagement visits or one medication treatment event 34 days after the initiation treatment
 - Member whose initiation of AOD treatment was a medication treatment: Two or more AOD engagement events (only one can be a medication treatment event) within 34 days after the initiation event

Why is this important?

Higher morbidity and mortality rates are associated with substance use disorders more than any other preventable health problem. The treatment costs of health conditions caused by a substance use disorder are a strain on the health care system, totaling more than \$165 billion each year in health care expenditures alone.

While treating alcohol and other drug dependence leads to improved health and productivity, only 10% of the 23.1 million Americans who need treatment receive it, according to a 2012 estimate from the National Institute on Drug Abuse.

Ensuring patients get care and it counts

Many providers administer the care, but HEDIS looks at specific timeframes and circumstances to ensure the best quality. Providers need to keep timing in mind.

- If you diagnose a patient with AOD dependence, schedule a visit at your own practice or refer the patient to a behavioral health provider as soon as possible so treatment can be started within 14 days of the diagnosis.
- Schedule engagement events within 34 days of the initiation event. HEDIS also specifies certain stipulations when looking at what does and doesn't count. These two important tips can affect whether the service is considered complete by HEDIS standards:
 - The date of an eligible AOD diagnosis and the initiation visit can be on the same day, but must be with two different providers, unless the provider is offering medication treatment
 - The patient can complete more than one engagement visit on the same day, but the visits must be with different providers. Engagement visit and engagement medication treatment can be on the same date with the same provider.

Note: For members in the "other drug abuse or dependence" cohort (for example, members with an AOD diagnosis unrelated to alcohol or opioids), medication treatment does not meet the criteria for either initiation or engagement.

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Remind your eligible patients to get mammograms every two years

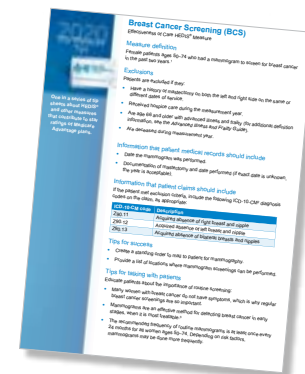
One in eight women in the United States will be diagnosed with breast cancer in her lifetime, making it the second most common cancer in women. You play an integral role in early detection by recommending regular screenings to your patients. Early detection through regular screening is key to a better outcome.

The Healthcare Effectiveness Data and Information Set breast cancer screening star rating measure is used by the Centers for Medicare & Medicaid Services to drive improvements in patient health. CMS and HEDIS® recommend routine mammogram screenings every 24 months for women ages 50 to 74.

The National Committee for Quality Assurance now allows patients to be excluded from the Breast Cancer Screening HEDIS star quality measure due to advanced illness and frailty. They acknowledge that measured services most likely would not benefit patients who are in declining health.

Please review the Breast Cancer Screening tip sheet to learn more about this HEDIS measure, including information that should be documented in a patient's medical record and included in claims along with tips for talking with patients.

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



Breast Cancer Screening tip sheet

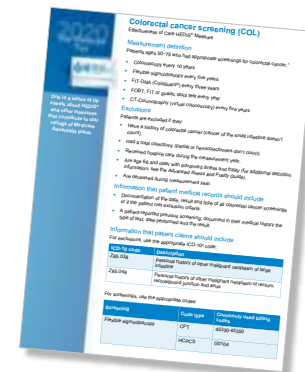
Remind your patients of the importance of colorectal cancer screening

Colorectal cancer is the third most common cancer diagnosed in both men and women in the United States, according to the American Cancer Society. Your patients may assume that a colonoscopy is the only way to test for colorectal cancer, but there are many types of screenings available. Talk to your patients about the importance of early detection and the tests available, including those that are noninvasive.

It's important for providers to document the type of screening performed, or any exclusions, in the patient's medical record. Exclusions for this measure have changed to include advanced illness and frailty of the patient.

Providers should make sure they order the most appropriate colorectal screening, based on the patient's status.

View the Colorectal Cancer Screening tip sheet to learn more about the measure, such as information to include in a patient's record, CPT codes that should be included in claims and tips for talking with patients.



Colorectal Cancer Screening tip sheet

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Help improve diabetic patient health while reducing medical record review requests

The Healthcare Effectiveness Data and Information Set Comprehensive Diabetes Care measure provides a comprehensive picture of the clinical management of patients with diabetes. It's a star rating measure used for HEDIS® reporting, which is used by the Centers for Medicare & Medicaid Services to drive improvements in patient health.

Patients who have diabetes require consistent medical care and monitoring to reduce the risk of severe complications and improve outcomes. Interventions to improve diabetes outcomes go beyond glycemic control, as diabetes affects the entire body. That's why the diabetes care measure includes HbA1c control, retinal eye exams, medical attention for nephropathy and blood pressure control.

View the tip sheet to learn more about the measure, new exclusions (including advanced illness and frailty of the patient) and ways you can close gaps in care for patients who have diabetes. The tip sheet also covers required medical record documentation and claim coding, which, if adhered to, can reduce the need for medical record reviews.

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Here's new information about electronic prior authorization for drugs covered under pharmacy benefits

Starting Aug. 3, you can use CoverMyMeds® and other free ePA tools such as Surescripts® and ExpressPAth® to submit requests for most pharmacy-benefit drugs for our Medicare Advantage members. These are members who have coverage through Medicare Plus BlueSM or BCN AdvantageSM plans.

You can continue to submit ePA requests for members who have Blue Cross Blue Shield of Michigan or Blue Care Network commercial coverage.

New feature in CoverMyMeds

For those who use CoverMyMeds to submit ePA requests, there's a new feature that helps ensure you're identifying the correct insurance plan.

In the Plan or PBM Name field, you can now enter the bank identification number, or RxBIN, and the RxGroup found on the member's ID card.

To locate the correct plan for one of our members:

- Enter 610014 as the RxBIN for both Blue Cross Blue Shield of Michigan and BCN.
- Enter one of these RxGroups:
 - Blue Cross' commercial: BCBSMRX1 or BCBSMAN
 - BCN commercial: MiBCNRX
 - Medicare Plus Blue: BCBSMAN
 - BCN Advantage: BCNRXPD

Remember to look for the RxBIN and RxGroup on the member's ID card.

Please see [Electronic prior authorization](#), continued on Page 23

Benefits of using ePA

Using CoverMyMeds or other ePA tools instead of submitting requests by fax or phone allows you to spend less time on administrative tasks and more time on patient care.

Other benefits of using ePA tools include:

- Automatic approvals for select drugs and improved turnaround time for review and decisions
- Easy use by prescribers, nurses and office staff
- All documentation and requests kept conveniently in one place

Here are some answers to frequently asked questions about ePA.

- **Why should I use ePA?** You'll save time. You can send 11 ePAs in the time it takes to fax just one (based on Comcast and Verizon broadband rates and a fax speed of 33.6 kbps) and patients can receive medications faster.

The process is intuitive. Providers and their authorized personnel can log in online, submit requests and access determinations.

- **What about ePA tools within the electronic health record?**

Using an ePA tool within your electronic health record makes it even easier to submit electronic requests and gives you:

- Clear direction on clinical requirements
- The ability to attach required documentation
- Secure and efficient authorization administration all in one place
- The capability of renewing existing authorizations proactively, up to 60 days before they expire
- Streamlined questions that are specific to the prior authorization request you're submitting

Typically, an ePA tool can be integrated into your current EHR workflow. Check with your vendor to ensure you have software that accommodates an ePA tool.

If an ePA tool isn't available within the EHR you use, you can always create a free online account through CoverMyMeds or other ePA tools such as Surescripts® and ExpressPAth® to submit requests. Registration takes only a few minutes.

If you have questions, call the Pharmacy Clinical Help Desk at 1-800-437-3803.

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Electronic prior authorization, continued from Page 22

Submitting ePA requests using CoverMyMeds

To complete an ePA request using your CoverMyMeds online accounts:

1. Go to covermymeds.com/epa/express-scripts.
(Create a free account if you don't already have one.)
2. Start a prior authorization request:
 - Click *New Request* and select *Michigan* in the *Patient Insurance State* field.
 - **New:** In the *Plan or PBM Name* field, enter the RxBIN and the RxGroup found on the patient's member ID card.
 - Enter the medication, select the appropriate form and click *Start Request*.
3. Complete the request:
 - Complete all information fields marked *Required* and click *Send to Plan*.
 - CoverMyMeds displays a list of patient-specific, clinical questions. Answer all questions that are marked *Required*.
4. Confirm the request:
 - Click *Send to Plan* again to confirm that you've submitted the request.

After Blue Cross or BCN has reviewed your prior authorization request, the determination will appear in your CoverMyMeds account.

CoverMyMeds often returns approval decisions within minutes of submission depending on the complexity of the request or the need for additional review.

IVIG dosing strategy is changing for the Medicare Part B medical specialty drug program, starting Dec. 7

Blue Cross Blue Shield of Michigan and Blue Care Network require authorization for immune globulin products covered under the medical benefit for Medicare Plus BlueSM PPO and BCN AdvantageSM members.

As part of the authorization process, we're updating our dosing strategy for intravenous and subcutaneous immune globulin therapy to minimize drug waste, reduce unnecessary drug exposure and decrease the risk of adverse events.

Effective Dec. 7, 2020, we'll calculate doses using adjusted body weight for members when:

- The member's body mass index is 30 kg/m² or greater
- The member's actual body weight is 20% higher than their ideal body weight

For more information, see the article on [Page 11](#).

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Effective Oct. 1, Nivestym and Zarxio are the preferred filgrastim products for all Blue Cross and BCN commercial and Medicare Advantage members

For dates of service on or after Oct. 1, 2020, the preferred filgrastim products for all Blue Cross and Blue Care Network commercial and Medicare Advantage members will be:

- Nivestym® (filgrastim-aafi; HCPCS code Q5110)
- Zarxio® (filgrastim-sndz; HCPCS code Q5101)

For commercial members, these requirements apply only to groups currently participating in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit. They don't apply to non-Medicare members covered through the UAW Retiree Medical Benefits Trust. They also don't apply to members covered by the Federal Employee Program® Service Benefit Plan.

Patients should take the preferred drugs when possible. Here's what to keep in mind about the members who are prescribed these drugs:

- Members starting treatment on or after Oct. 1 should use a preferred filgrastim product.
- Members currently receiving one of the filgrastim products listed below should transition to Nivestym or Zarxio:
 - Neupogen® (filgrastim; HCPCS code J1442)
 - Granix® (tbo-filgrastim; HCPCS code J1447)

We'll notify commercial members currently taking the nonpreferred drugs and encourage them to discuss treatment options with you.

Here are the authorization requirements for members starting or transitioning to the preferred drugs:

- For Blue Cross' PPO members, the preferred drugs don't require authorization.
- For BCN HMOSM, Medicare Plus BlueSM PPO and BCN AdvantageSM members, the preferred drugs require authorization through AIM Specialty Health®.

Request authorization for patients who must take the nonpreferred drugs

Here are the requirements for members you feel need to take Neupogen or Granix rather than Nivestym and Zarxio:

- For Blue Cross' PPO members, authorization is required. Submit the authorization request through the NovoLogix® online tool.
- For BCN HMO, Medicare Plus Blue and BCN Advantage members, both step therapy and authorization are required. Submit the authorization request through AIM Specialty Health®.

More about the authorization requirements

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

For additional information on requirements related to drugs covered under the medical benefit, see:

- **Blue Cross' PPO and BCN HMO: [Blue Cross and BCN utilization management medical drug list](#)**
- **Medicare Advantage: [Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members](#)**

We'll update the requirements lists with the new information before Oct. 1.

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Medical specialty drug prior authorization lists are changing in September for BCN HMO, Medicare Plus Blue PPO and BCN Advantage members

We're adding authorization requirements for three specialty drugs covered under the medical benefit for BCN HMOSM, Medicare Plus BlueSM and BCN AdvantageSM members.

For dates of service on or after Sept. 25, 2020, the following drugs will require authorization through AIM Specialty Health®:

- Zepzelca™ (lurbinectedin), HCPCS codes J3490, J3590, J9999
- Phesgo™ (pertuzumab/trastuzumab/hyaluronidase-zzxf), HCPCS codes J3490, J3590, J9999
- Nyvepria™ (pegfilgrastim-apgf), HCPCS codes J3490, J3590, J9999

How to submit authorization requests

Submit authorization requests to AIM using one of the following methods:

- Through the **AIM provider portal**
- By calling the AIM Contact Center at 1-844-377-1278

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

More about the authorization requirements

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

For additional information on requirements related to drugs covered under the medical benefit, see:

- **BCN HMO: Blue Cross and BCN utilization management medical drug list and the Medical Oncology Program** list
- **Medicare Advantage: Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**

We'll update these lists with the new information about these drugs before the effective dates.

Praluent and Repatha are no longer designated as specialty drugs

Starting July 1, 2020, the PCSK9 inhibitor drugs Repatha® and Praluent® are no longer designated as specialty drugs.

Specialty drugs require special handling, administration or monitoring. Some can only be filled by a specialty pharmacy.

On or after July 1, 2020, members can fill prescriptions for Repatha and Praluent at any retail pharmacy in our network. Members can fill a 90-day supply of these drugs if their prescription drug benefit allows it.

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Quarterly update: Requirements changed for some medical benefit drugs for BCN HMO members

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 (commercial) and BCN HMOSM (commercial) members.

During April, May and June 2020, the following medical drugs had authorization requirement updates, site-of-care updates or both for BCN HMO members. We updated the list of requirements to reflect these changes.

HCP code	Brand name	Generic name
C9053**	Adakveo®	crizanlizumab-tmca
Q5121**	Avsola™	infliximab-axxq
C9056**	Givlaari®	givosiran
J7170	Hemlibra®	emicizumab-kxwh
J0202	Lemtrada®	alemtuzumab
J0222	Onpattro®	patisiran
J3590*	Palforzia™	Peanut (Arachis hypogaea) allergen powder-dnfp
J0896**	Reblozyl®	luspatercept-aamt
C9061**	Tepezza™	teprotumumab-trbw
J2323	Tysabri®	natalizumab
C9063**	Vyepti™	eptinezumab-jjmr

*Will become a unique code

**Received a unique code on July 1, 2020. Prior to July 1, 2020, this drug was assigned to a not-otherwise-classified (NOC) code.

For a detailed list of requirements, see the **BCN Drugs Covered Under the Medical Benefit** page of the [ereferrals.bcbsm.com](https://www.ereferrals.bcbsm.com) website.

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.

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



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Blue Cross and BCN will have preferred hereditary angioedema medications for our commercial members, effective Nov. 1

Currently, all hereditary angioedema medications require prior authorization for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members. Effective Nov. 1, 2020, Blue Cross and BCN will have preferred medications for HAE therapy for those members.

- We'll require our commercial members to use preferred HAE drugs for acute treatment and for preventive therapy that begins on or after Nov. 1, 2020.
- For commercial members currently receiving a nonpreferred HAE drug:
 - These members are authorized to continue their current therapy until through Oct. 31, 2020.
 - We've proactively authorized therapy with the preferred medications from Nov. 1, 2020, through Oct. 31, 2021, to avoid any interruptions in care.
 - We encourage you to discuss any concerns members may have as they transition to the preferred medications.

We'll be mailing letters to affected members to notify them of these changes.

These changes apply to all Blue Cross' PPO and BCN HMOSM members.

For HAE therapy covered under the medical benefit, the requirements outlined in this article apply only to groups that are currently participating in the standard commercial Medical Drug Prior Authorization Program. Proactive authorizations for preferred therapy on the pharmacy benefit apply to members who have their pharmacy benefit with Blue Cross Blue Shield of Michigan or Blue Care Network.

Which medications are preferred?

For acute HAE treatment

- Preferred medication: Icatibant (HCPCS code J1744)
- Nonpreferred medications:
 - Firazyr® (brand icatibant, HCPCS code J1744)
 - Berinert® (c1 esterase inhibitor, human, HCPCS code J0597)
 - Kalbitor® (ecallantide, HCPCS code J1290)
 - Ruconest® (c1 esterase inhibitor, recombinant, HCPCS code J0596)

For HAE prevention

- Preferred medications:
 - Haegarda® (c1 esterase inhibitor, human)
 - Takhzyro® (lanadelumab-flyo)
- Nonpreferred medication: Cinryze® (c1 esterase inhibitor, human, HCPCS code J0598)

For additional information on requirements related to drugs for our commercial members, see:

- **Requirements for drugs covered under the medical benefit**
- **Requirements for drugs covered under the pharmacy benefit**

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Use our online resources to understand billing guidelines

Blue Care Network provides an array of clinical editing and billing resources to help providers bill to avoid clinical edits or denials. Online resources can help you understand how a claim may process.

Our clinical editing involves moving a claim through multiple rules and logic as well as application of payment rules. Claims have different rules applied based on multiple criteria, including provider specialty, location, frequency of the service, medical policies and benefits.

Log in to Provider Secured Services. Then go to *BCN Provider Publications and Resources* to find the following:

- The link to the Billing/Claims page is listed under the Popular links heading. On that page, you'll find clinical editing resources.
- A link to the Claims chapter of the *BCN Provider Manual* is on the Billing/Claims page.
- You can also click to open the *Medical Policy Manual*, *Clinical Practice Guidelines* and *Clinical Quality Corner* pages. Those links are found under the Other resources heading in the left navigation.

BCN extends rate increases for in-person home health care and home infusion nursing visits in response to COVID-19

In response to the continuing COVID-19 pandemic, Blue Care Network is extending changes to reimbursement for certain services through Dec. 31, 2020. We're extending these increases to support providers caring for our BCN HMOSM and BCN AdvantageSM members during this crisis.

See the article on **Page 3** for details.

Clinical editing billing tips

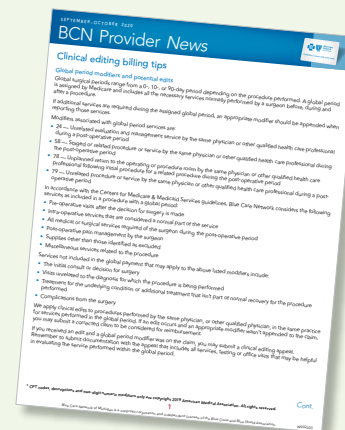
In most issues, we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that the performed procedure is correctly reported to us.

This issue's tips include:

- Global period modifiers and potential edits
- Using modifier 50, LT and RT
- Tips for submitting clinical editing appeals



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We're extending global referrals through at least Dec. 31 for BCN HMO members

Blue Care Network is implementing another utilization management change aimed at supporting our providers during the COVID-19 emergency.

Change in the duration of global referrals for elective and non-urgent services

Here's what's changing for global referrals submitted for BCN HMOSM (commercial) members on or after March 13, 2020:

- For referrals with end dates in 2020, the end date will automatically be extended to Dec. 31, 2020.
- For referrals with end dates after Dec. 31, 2020, the end date specified in the e-referral system will apply.

This applies to global referrals submitted by both in-state and out-of-state providers.

This doesn't apply to BCN AdvantageSM, Medicare Plus BlueSM PPO or Blue Cross' PPO members, because global referrals are not required for those members.

We've added this information to the **COVID-19 utilization management changes** document on our **ereferrals.bcbsm.com** website, on the **Blue Cross Authorization Requirements & Criteria** page and the **BCN Authorization Requirements & Criteria** page.

You can also find this document on our public website at **bcbsm.com/coronavirus** and through Provider Secured Services.

Checking the status of temporary measures for COVID-19

In June, some of the temporary measures we put in place for the COVID-19 crisis have concluded.

We'll continue to waive member cost share for COVID 19 treatment through Dec. 31, 2020.

For the latest status of all temporary measures — including those related to utilization management, telehealth, billing and more — see the *Temporary changes due to the COVID-19 pandemic* document, which shows the start and end dates for each measure.

You can find this and related documents on our coronavirus webpage, which is available through Provider Secured Services and on our public website at **bcbsm.com/coronavirus**.

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eviCore has updated corePath for physical and occupational therapy authorizations

Effective immediately, eviCore healthcare® has made changes to the corePathSM therapy authorization model for first authorization requests for new episodes of treatment. This change applies to:

- Physical therapy providers in categories B and C
- Occupational therapists in category B

Here's what changed

For providers in categories B and C: When initial authorization requests meet certain conditions, eviCore is approving a greater number of visits over a longer authorization duration period. The logic in eviCore's corePath model determines the number of visits and authorization duration based on the patient's condition and complexity.

For more information about how this affects occupational therapy providers, see eviCore's **Physical Therapy Practitioner Performance Summary and Provider Category FAQs** document. See the question titled "How does my category impact my authorization requirements for occupational therapy?"

Note: There haven't been any changes to the number of visits granted or the authorization duration period for providers in category A.

Additional information

To learn more about category assignments, see eviCore's Physical Therapy Practitioner Performance Summary and Provider Category FAQs document referenced above.

You can find additional information on the [ereferrals.bcbssm.com](https://www.bcbssm.com/ereferrals) website:

- On BCN's **Outpatient PT, OT, ST page**
- On the **Blue Cross eviCore-Managed Procedures page**. Look in the "Medicare Plus Blue PPO members" section.

As a reminder, eviCore manages physical and occupational therapy services for non-autism diagnoses for Medicare Plus BlueSM PPO, BCN HMOSM (commercial) and BCN AdvantageSM members. eviCore also manages physical and occupational therapy services for adult BCN HMO members ages 19 and older with autism diagnoses.



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eviCore simplifies authorization process for radiation oncology

eviCore healthcare® has simplified the authorization process for radiation oncology by asking Clinical Decision Support questions, rather than its traditional clinical questions. This applies to authorizations for breast, prostate and non-small-cell lung cancer. It was effective July 1.

As a result, you'll need to answer far fewer clinical questions when submitting these authorization requests.

What you need to do

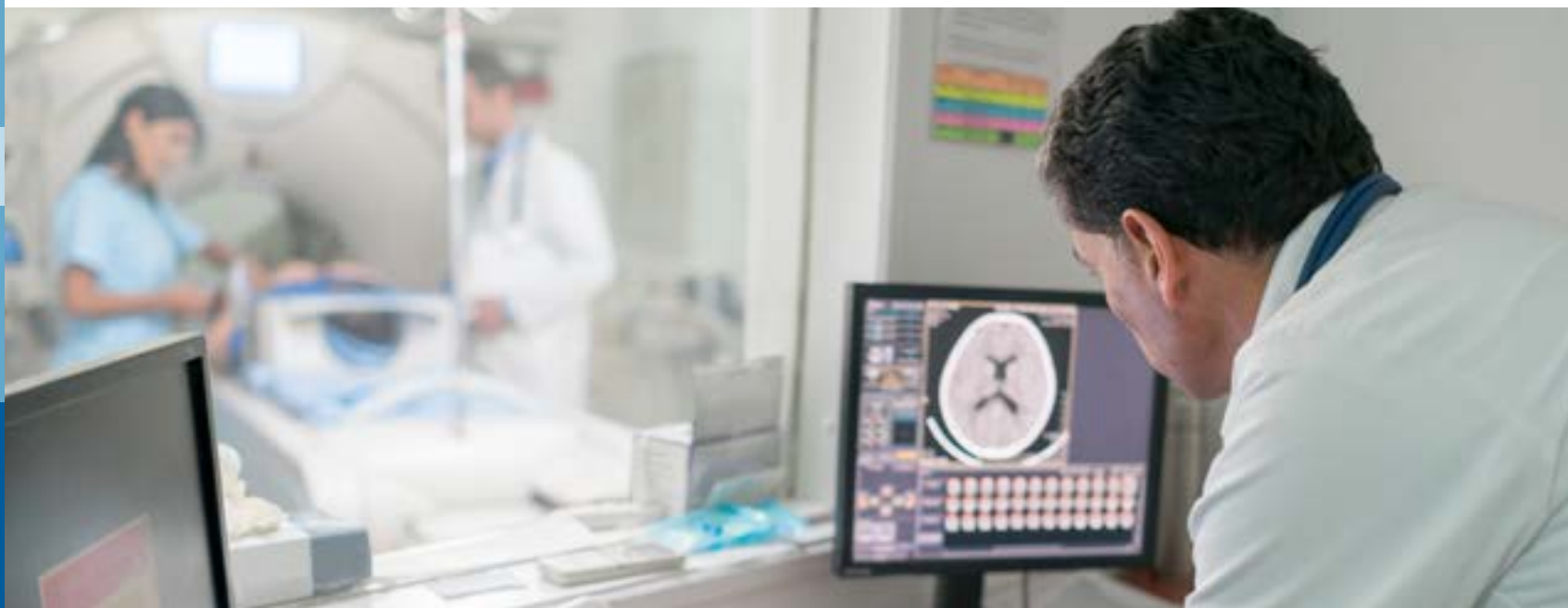
The steps to submit authorization requests to eviCore won't change. You'll follow the typical process of logging in to the eviCore portal at www.evicore.com, initiating a request for Clinical Certification for Radiation Therapy and entering information about the member.

For breast, prostate and non-small-cell lung cancer, the system will prompt you to answer the CDS clinical questions. After answering the questions, you'll be presented with a list of treatment regimens. There's also an option to enter a custom treatment regimen.

eviCore manages authorizations for radiation oncology for most Blue Cross' PPO fully insured groups and for Medicare Plus BlueSM PPO, BCN HMOSM and BCN AdvantageSM members.

For more information, see the [Blue Cross eviCore-Managed Procedures](#) or the [BCN eviCore-Managed Procedures](#) pages of the ereferrals.bcbsm.com website.

See related article on [Page 4](#) titled, "We're revising our policy on hypofractionation for breast and prostate cancer as part of our radiation oncology program managed by eviCore healthcare."



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New and updated questionnaires available in the e-referral system

In June, new and updated questionnaires started opening in the e-referral system for certain procedures. We added and updated preview questionnaires on the ereferrals.bcbsm.com website as they were released.

We use our authorization criteria and medical policies and your answers to the questionnaires when making utilization management determinations on your authorization requests.

New questionnaires

On June 14, 2020, we replaced the *Pregnancy termination 1 — Medically necessary or elective* questionnaire with the following two questionnaires for adult BCN HMOSM members:

- *Pregnancy termination 1 — Medically necessary.*
Applicable procedure codes are: *01966, *59100, *59840, *59841, *59850, *59851, *59852, *59855, *59856, *59857, *59866, S0190, S0191, S0199, S2260, S2265, S2266 and S2267.
- *Pregnancy termination 3 — Elective.*
Applicable procedure codes are: *01966, *59100, *59840, *59841, *59850, *59851, *59852, *59855, *59856, *59857, *59866, S0190, S0191, S0199, S2260, S2265, S2266 and S2267.

Updated questionnaire

On June 28, 2020, we updated the *Vascular embolization or occlusion (TACE/RFA)* questionnaire for BCN HMOSM, BCN AdvantageSM and Medicare Plus BlueSM PPO members.

Preview questionnaires

For all these services, you can access preview questionnaires at ereferrals.bcbsm.com. The preview questionnaires show the questions you'll need to answer in the e-referral system so you can 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.

Authorization criteria and medical policies

The pertinent authorization criteria and medical policies are also available on the Authorization Requirements & Criteria pages.

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TurningPoint musculoskeletal authorization program to expand in January

We'll add Blue Cross Blue Shield of Michigan commercial members to the TurningPoint Healthcare Solutions, LCC musculoskeletal program for spine, pain management and joint replacement surgeries and related procedures for dates of service on or after Jan. 1, 2021. At that time, the program will also expand to include pain management procedures for Blue Care Network commercial, BCN AdvantageSM and Medicare Plus BlueSM members.

In addition, spinal procedures for Medicare Plus Blue members will transition from being managed by eviCore healthcare® to being managed by TurningPoint.

Providers can submit authorization requests for the expanded procedures starting Dec. 1, 2020, for dates of service on or after Jan. 1, 2021.

Background

As reported in the May-June *BCN Provider News*, health care providers should submit authorization requests through TurningPoint for musculoskeletal surgical procedures with a date of service on or after July 1, 2020, for BCN commercial, Medicare Plus Blue and BCN Advantage members. This includes spine and joint replacement surgeries and related procedures.

However, lumbar spinal fusion surgeries for Medicare Plus Blue members will continue to be managed by eviCore through 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. The document is located at [ereferrals.bcbcm.com](https://www.bcbcm.com/ereferrals). Click on *Blue Cross* and then on *eviCore-Managed Procedures*.

For more information

- See the Musculoskeletal Services webpages for **Blue Cross** and **BCN** on the [ereferrals.bcbcm.com](https://www.bcbcm.com/ereferrals) website.
- Find procedure codes for orthopedic, pain management and spinal procedures managed by TurningPoint on [ereferrals.bcbcm.com](https://www.bcbcm.com/ereferrals) as follows:
 - **Orthopedic**
 - **Pain management**
 - **Spinal**
- Refer to the *Frequently asked questions for providers* document on our [ereferrals.bcbcm.com](https://www.bcbcm.com/ereferrals) website.

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Musculoskeletal, continued from Page 33

Register for webinars

We're offering webinar training for providers and facilities for musculoskeletal services managed by TurningPoint.

Use the links below to register.

Provider training

Date	Time	Registration
Nov. 10, 2020	10 to 11:30 a.m.	Click here to register
Nov. 10, 2020	12 to 1:30 p.m.	Click here to register
Nov. 12, 2020	2 to 3:30 p.m.	Click here to register
Nov. 17, 2020	2 to 3:30 p.m.	Click here to register
Nov. 18, 2020	10 to 11:30 a.m.	Click here to register
Dec. 2, 2020	10 to 11:30 a.m.	Click here to register
Dec. 3, 2020	2 to 3:30 p.m.	Click here to register
Dec. 8, 2020	12 to 1:30 p.m.	Click here to register
Dec. 10, 2020	10 to 11:30 a.m.	Click here to register
Dec. 16, 2020	12 to 1:30 p.m.	Click here to register
Jan. 5, 2021	10 to 11:30 a.m.	Click here to register
Jan. 6, 2021	12 to 1:30 p.m.	Click here to register
Jan. 14, 2021	2 to 3:30 p.m.	Click here to register

Facility training

Date	Time	Registration
Nov. 10, 2020	2 to 3:30 p.m.	Click here to register
Nov. 12, 2020	12 to 1:30 p.m.	Click here to register
Nov. 18, 2020	2 to 3:30 p.m.	Click here to register
Dec. 3, 2020	10 to 11:30 a.m.	Click here to register
Dec. 9, 2020	12 to 1:30 p.m.	Click here to register
Dec. 15, 2020	2 to 3:30 p.m.	Click here to register
Jan. 5, 2021	2 to 3:30 p.m.	Click here to register
Jan. 12, 2021	12 to 1:30 p.m.	Click here to register

Portal training

Date	Time	Registration
Jan. 7, 2021	10 to 11 a.m.	Click here to register
Jan. 13, 2021	2 to 3 p.m.	Click here to register

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Determinations on requests for inpatient acute care admissions are based on InterQual criteria, not on the two-midnight rule

The Utilization Management department for Blue Cross and Blue Care Network makes determinations on authorization requests for inpatient acute care admissions based on InterQual® criteria, not on the two-midnight rule.

This applies to admissions of members covered by all our lines of business.

We're clarifying this because we recently received some questions from providers about the two-midnight rule.

Providers should do the following:

- Refer to the InterQual criteria for the type of admission and to the associated Blue Cross and BCN Local Rules.
Note: The Local Rules are available on the ereferrals.bcbsm.com website, on the **Blue Cross Authorization Requirements & Criteria** page and the **BCN Authorization Requirements & Criteria** page.
- Disregard any information about the two-midnight rule that we may have published in past communications.

We're updating the provider manuals to include a statement clarifying that we do not use the two-midnight rule in making determinations on authorization requests for inpatient acute care admissions.

Reminder: 1-866-527-1326 fax number out of service as of Oct. 1

The fax number 1-866-527-1326 will be taken out of service starting Oct. 1, 2020.

Currently, some providers are using that fax number to submit authorization requests for acute inpatient admissions for BCN Advantage members.

If you're using the 1-866-527-1326 fax number, stop faxing these requests now and instead submit them using these methods:

- **Michigan providers:** Submit these requests via the e-referral system. When the e-referral system is not available, do one of these:
 - For non-urgent requests, wait for the system to become available again.
 - For urgent requests, call BCN Utilization Management at 1-800-392-2512 (during business hours) or 1-800-851-3904 (after business hours).
- **Non-Michigan providers without access to the e-referral system:** Call these requests in to BCN Utilization Management at 1-800-392-2512 (during business hours) or 1-800-851-3904 (after business hours).

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Commercial SNF authorization requests to be submitted through the e-referral system starting later this year

Later this year, we'll require skilled nursing facilities to submit authorization requests for our commercial members through the e-referral system and not by fax. This requirement will apply to requests for admissions and requests for additional SNF days.

Sign up now to use the e-referral system

To prepare for this change, it's important that SNFs sign up **now** for access to the e-referral system. Don't wait to sign up, as it may take some time to get access.

You'll also need to learn how to use the e-referral system so you're comfortable with it when this change goes into effect.

Everything you need to know is on our **ereferrals.bcbsm.com** website:

- To sign up for the e-referral system: Follow the instructions on the **Sign Up or Change a User** page.
- To learn how to use the e-referral system: Refer to the **Training Tools** page, where you'll find the **e-referral User Guide** and **Online self-paced learning modules**.

More information about the change

Currently, SNFs are completing a form and submitting it by fax. When the new requirement goes into effect later this year, you'll still need to complete the form, but you'll attach it to the request in the e-referral system instead of faxing it.

This is for members covered by our commercial plans:

- Blue Cross' PPO
- BCN HMOSM

Watch for more news about this change

We'll communicate more details about this change in the coming weeks. Watch for web-DENIS messages as well as news items on our **ereferrals.bcbsm.com** website.

We're revising our policy on hypofractionation for breast and prostate cancer as part of our radiation oncology program managed by eviCore healthcare

Blue Cross Blue Shield of Michigan and Blue Care Network have revised the radiation oncology program managed through eviCore healthcare to limit coverage to hypofractionation (a shorter, equally effective regimen) for many breast and prostate cancers, effective for requests submitted on or after Sept. 21. The changes align with evidence-based guidelines including the National Comprehensive Cancer Network, or NCCN.

See full article on **Page 4** for details.

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What to do when the e-referral system is down

We take the e-referral system out of operation on a monthly basis while we perform maintenance. During those times, you won't be able to use it to submit referrals or authorization requests, to upload clinical documentation, to check the status of an authorization request or to do anything else you typically do in the e-referral system.

When e-referral is down for maintenance, follow these instructions:

- **For non-urgent authorization requests:** Please wait and submit these when the e-referral system is available again.
- **For urgent requests** that need to be processed within 24 hours, call or fax as outlined below.

Service	Line of business	What to do
Acute inpatient admissions	Blue Cross' PPO (commercial)	Fax to 1-800-482-1713 anytime. Note: Faxes received after business hours will be processed the next business day. After business hours: Call 1-800-851-3904
	Medicare Plus Blue SM PPO	Fax to 1-866-464-8223 anytime. Note: Faxes received after business hours will be processed the next business day. After business hours: Call 1-800-851-3904
	BCN HMO SM (commercial) BCN Advantage	During business hours: Call 1-800-392-2512. After business hours: Call 1-800-851-3904
Post-acute admissions and concurrent reviews	BCN HMO SM (commercial)	Fax to 1-866-534-9994 anytime. Note: Faxes received after business hours will be processed the next business day.
Behavioral health services	Medicare Plus Blue SM	Call 1-888-803-4960 anytime.
	BCN HMO SM (commercial)	Call 1-800-482-5982 anytime
	BCN Advantage SM	Call 1-800-431-1059 anytime

You can find this information on our ereferrals.bcbsm.com website. Scroll down the left side of any page on the website and click **e-referral system planned downtimes and what to do**.

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