NOVEMBER–DECEMBER 2020

BCN Provider News

BCN Provider News User Guide

Blue Care Network to offer 20 individual Marketplace products in 2021

Blue Care Network will offer 20 individual (non-group) Affordable Care Act compliant plans in 2021, including a new statewide bronze HMO product.

The bronze HMO plan includes primary care physician visits, urgent care visits and laboratory services with a copay before the deductible. All individual plans have virtual and telehealth office visit coverage.

Consumers will be able to view 2021 health plans in October on **bcbsm.com** and **healthcare.gov** that are offered in their specific ZIP codes. Enrollment takes place Nov. 1 through Dec. 15.

We're offering:

- 20 plans in three Southeast Michigan counties
- 14 plans in 17 urban counties
- Seven plans in 48 rural lower peninsula counties
- Four plans in 15 Upper Peninsula counties

Please see Products, continued on Page 4

Availity multi-payer provider portal brings advantages to providers

In our **Sept.-Oct. issue** (Page 1), we announced that we're moving to the Availity provider portal in 2021. The Availity provider portal will bring many improvements to your online experience. We're going to focus on different aspects of this transition through a series of articles in this publication and *The Record* over the next year.

This article focuses on the benefits of a multi-payer website.

What is a multi-payer website?

In a multi-payer provider portal, such as Availity, you log in to one website where you can find information for any health plan that uses Availity. This means you only need to learn how to use one system to find information for members associated with multiple health plans. In 2021, in Michigan, Availity will have member information for Blue Cross Blue Shield of Michigan, Blue Care Network, Aetna® and Humana®.

Please see Availity, continued on Page 2

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Network Operations

Availity, *continued from Page 1*

What are the advantages of the Availity multi-payer website?

- **Single login and password** — You'll have fewer logins and passwords to juggle as your Availity login and password will work for multiple payers.
- **Register only once** — You only need to register for Availity once. When you have an Availity account in Michigan, you'll have immediate access to view other Michigan payers who join the Availity provider portal. If you're already an Availity user, you don't need to do anything to access Blue Cross and BCN information once it's available. If you're not an Availity user, watch future issues of this newsletter for registration information.
- **Handle patient coverage tasks using one tool** — With Availity, you can check eligibility and benefits or the status of a claim for patients with coverage from multiple health plans without logging into different systems.
- **Save time with Express Entry** — Availity allows you to set up specific providers in the system so you can click on them from a dropdown menu and have information automatically populate. This means you don't have to retype data, such as NPI numbers or provider names.
- **Easy to use for administrators** — Providers select an administrator who handles Availity access for other users in the office, practice or facility. Adding a user or changing user access is simple with just a few keystrokes by your administrator. Availity also makes user administration easy with training, forums and reports to help manage user access.
- **Learn once and use for many** — Once you learn how to use Availity for one health plan payer, you'll know how it works for other payers as Availity's tools have similar functionality across all participating Availity health plans.
- **Locate specific health plan communications quickly** — Availity offers payer spaces for each participating health plan. So, if you have a question about a specific plan, you can easily click on the Payer Space for that health plan and find the plan's resource materials, news and announcements and tools unique to that health plan. Availity also has a keyword search that helps you find what you need. Blue Cross and BCN will have a payer space site within Availity in 2021.
- **Availity's focus is the provider portal** — Availity's expertise is in building and managing a provider portal with tools that are easy and useful to health care providers. They continually seek provider feedback to improve their website for all users.

Watch for more information about Blue Cross and BCN's move to the Availity provider portal in future issues of this newsletter.

See related article on the next page.

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Network Operations

Many online tools will continue after we move to Availity in 2021

Change can be exciting, but it can be difficult too. While there will be new things to learn in the move to Availity, many of the tools that you're used to will remain. The only change will be how to find those tools.

Once Blue Cross and BCN move to the Availity provider portal next year, you'll log in to Availity rather than logging in to the Blue Cross and BCN Provider Secured Services website. As we get closer to the 2021 launch date, we'll provide you with training and specific step-by-step instructions to make it easy for you to find what you need.

Here's a list of the tools you'll still be able to find once we move to the Availity provider portal. Note that some of these tools may only be available to certain providers based on your access role.

- e-referral (for managing referrals and authorization requests)
- BCBSM Pharmacy Benefit — Medication Prior Authorization
- BCBSM, BCN and Medicare Advantage PPO Medical Benefit — Medication Prior Authorization/NovoLogix
- Health e-Blue℠ (patient data registry and treatment opportunities for primary care physicians and groups)
- Benefit Explainer (benefit detail for PPO commercial members with coverage from employer groups located within Michigan)
- Provider Enrollment and Change Self-Service
- BCBSM Behavioral Health Preservice Review
- Clear Claim Connection™ (for Michigan providers to view claim edits)
- Internet Claims Tool
- BCN Negative Balance Reports
- BCBSM Qualification Form

Many of the resources you use will also continue to be available, including provider publications and resources, provider manuals, the Medical Policy and Pre-Cert/Pre-Auth Router and *Find a Doctor*.

In future issues, we'll provide information on the updated features you'll find in Availity, how to register for Availity and everything you'll need to know to transition to the Availity provider portal for your Blue Cross and BCN patient needs.

Network Operations

Products, *continued from Page 1*

Other changes

- Changing the deductible and out-of-pocket maximum for the majority of plans
- Removing coinsurance on preferred and non-preferred brand-name prescription drugs and moving to a flat-dollar copayment
- Applying a copay before deductible for postnatal visits for Gold, Silver Extra, Silver, Silver Saver, Bronze, Value and Silver Off Marketplace plans.
- Aligning retail health center visits with primary care physician copays
- Maintaining a $0 copay for online visits on all plans except health savings account-eligible plans; they have a $0 copay after a deductible
- Offering virtual and telehealth office visit coverage for all plans

Ask to see the latest member ID card

January is the time when many patients change health care plans. You should always ask to see the latest member ID card and make sure it matches the coverage listed on web-DENIS.

Blue Care Network to offer new, fixed-cost plan in 2021 for small groups

Blue Care Network is offering a new HMO product in 2021 for groups with 50 or fewer employees. The BCN HMO Fixed Cost℠ plan helps members avoid cost uncertainty with a simple copay-only structure. Copays are fixed fees, so members know what they'll pay when they need health care services.

Referrals are required to see a specialist and standard authorization rules apply. Members must select a primary care physician.

The plan features:

- No deductible or coinsurance for medical and pharmacy services
- Copays for certain services instead of a deductible or coinsurance
- Prescription drug coverage
- Preventive care covered at 100%

Price increases are below national projections

Average price increases of 2.5% for Blue Cross' 2021 Marketplace health plans are aligned with **national projections**. Experts estimate rate increases of at least 2% to 4% with some plans already proposing average premium increases of more than 7%

Ongoing rate moderation in Michigan is a result of Blue Cross' long-standing partnerships with physicians and hospitals across the state to deliver more high-quality, cost-efficient care to patients through its **Value Partnerships** programs.

Network Operations

BCN Blue Elect Plus POS plan will offer coverage to out-of-state subscribers

Blue Care Network's Blue Elect Plus Self-Referral Option product has been updated for 2021 to a point of service health care plan, Blue Elect Plus℠ POS. Starting January 1, out-of-state employees who work for an employer with headquarters in Michigan will be eligible to join the plan. With Blue Elect Plus, members will continue to receive covered health care services from in- or out-of-network providers without a referral. Members pay less out of pocket when they seek care from an in-network provider.

Members with a Michigan address must elect a BCN primary care physician. The back of their ID cards will specify that no referrals are required in or out of network in case providers have questions. Members with a non-Michigan address don't need an assigned PCP. They also don't need a referral; they just need to see an out-of-state BlueCard® participating provider for in-network benefits. Out-of-network providers are other providers within the United States that aren't BCN HMO contracted providers or out-of-state BlueCard participating providers.

Even though a referral isn't required, certain in- and out-of-network services will still require prior authorization by BCN to be covered, such as hospitalization, certain radiology services, outpatient therapy and other services.

Note: Most preventive services are covered in network only with the exception of flu vaccine, colonoscopy, mammography and routine prenatal care that are covered in and out of network.

We've developed a short video about the key features of Blue Elect Plus.

Network Operations

Additional laboratory services covered in office during the public health emergency

Until further notice, we're covering additional laboratory services when they're provided in a physician's office. These services are in addition to any laboratory services we already cover when they're performed in a physician's office.

We're doing this to make it easier for our providers to care for our members during the COVID-19 public health emergency.

Here are the codes for the additional laboratory services:

- *0223U
- *0224U
- *86318
- *86328
- *86769
- *87426
- *87635
- U0001
- U0002
- U0003
- U0004

The services listed above can be performed in the physician's office and billed to Blue Cross Blue Shield of Michigan or Blue Care Network, as appropriate.

This applies to all our members covered by products from the lines of business listed below, with an effective date of Feb. 4, 2020:

- Blue Cross' PPO (commercial)
- Medicare Plus Blue℠ PPO
- BCN HMO℠ (commercial)
- BCN Advantage℠

We're adding influenza testing codes to our physician in-office laboratory procedures list

Earlier this year, we added new CPT codes to our physician in-office laboratory procedures list to help physicians rule out influenza during the COVID-19 pandemic.

Here are the CPT codes for influenza tests that can now be performed in a physician's office:

- *87275
- *87276
- *87400
- *87804

Prior to February 2020, Blue Cross Blue Shield of Michigan commercial and Medicare Plus Blue℠ plans already covered CPT code *87804. The other codes were added to the physician in-office laboratory procedures list, with an effective date of Feb. 4, 2020.

All four codes are currently covered for the following lines of business in a physician's office:

- Blue Cross' PPO (commercial)
- Medicare Plus Blue℠ PPO
- BCN HMO℠ (commercial)
- BCN Advantage℠

Blue Cross and BCN clarify guidelines for pre-operative COVID-19 testing

Blue Cross Blue Shield of Michigan and Blue Care Network are offering guidance for pre-operative COVID-19 testing.

Procedures conducted in hospital operating rooms and ambulatory surgical facilities are appropriate for pre-operative COVID-19 testing. In addition, aerosol-generating procedures, regardless of the location performed, such as oral surgery in the office setting, are appropriate for pre-operative COVID-19 testing.

Examples where COVID-19 testing would not be appropriate include a simple wound closure, skin biopsy or routine medical or dental care in an office setting.

Pre-operative COVID-19 testing should support the patient's access to needed medical care and shouldn't become a barrier to receiving care.

The codes for pre-operative testing include:

- Z01.810 – Encounter for preprocedural cardiovascular examination
- Z01.811 – Encounter for preprocedural respiratory examination
- Z01.812 – Encounter for preprocedural laboratory examination
- Z01.818 – Encounter for other preprocedural examination

This pre-op testing guidance is specific to the COVID-19 pandemic.

For more information, see the *Patient testing* section of our COVID-19 webpages on our public website at **bcbsm.com/coronavirus** or within Provider Secured Services by clicking on *Coronavirus (COVID-19)*.

Blue Care Network member handbook goes online in January

Blue Care Network is moving its handbook for members online starting Jan. 1, 2021. Upon enrollment, BCN members will receive a welcome book in the mail. It contains general information about their plan, encourages them to register for a member account to get specific information about their health plan and coverage and tells them how to access their digital handbook.

The digital handbook provides easy access to digital tools, such as benefit documents and Provider Search. Members can download a PDF of their online handbook or call BCN Customer Service to request a print copy.

The digital handbook ensures members have easy access to current benefit information in real time. The digital member handbook is for commercial members only and doesn't include BCN Advantage members or those who purchase their health care plans individually.

How to submit authorization requests during holiday closures

Blue Cross Blue Shield of Michigan and Blue Care Network corporate offices will be closed for the following upcoming holidays.

- Election Day: Tuesday, November 3
- Thanksgiving Day: Thursday, November 26
- Day after Thanksgiving: Friday, November 27
- Christmas Eve: Thursday, December 24
- Christmas Day: Friday, December 25
- New Year's Eve: Thursday, December 31

Refer to the document **Holiday closures: How to submit authorization requests** for instructions on how to submit authorization requests for inpatient admissions during the closure.

You can find this document on the **ereferrals.bcbsm.com** website, on these webpages:

- **Blue Cross Authorization Requirements & Criteria page**
- **BCN Authorization Requirements & Criteria page**

Note: The fax number for BCN Advantage, 1-866-526-1326, will remain in service. We reported in the last issue that we would be discontinuing this number. We apologize for the error.

Network Operations

Sign up for additional training webinars

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

Here's how to register:

Webinar name	Date and time	Registration
Blue Cross 201 – Claims Troubleshooting	Thursday, Nov. 5, 2020 10 to 11 a.m.	**Click here** to register
Blue Cross 201 – Claims Troubleshooting	Thursday, Nov. 5, 2020 2 to 3 p.m.	**Click here** to register
Blue Cross 201 – Claims Troubleshooting	Wednesday, Nov. 11, 2020 10 to 11 a.m.	**Click here** here to register
Blue Cross 201 – Claims Troubleshooting	Wednesday, Nov. 11, 2020 2 to 3 p.m.	**Click here** to register

Blue Cross 201 provides in-depth learning opportunities for providers and builds on information shared in our *Blue Cross 101: Understanding the Basics* webinar. This session reviews the processes and tools available when resolving common issues with claims.

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 web-DENIS, *BCN Provider News* and *The Record.*

Direct reimbursement available to athletic trainers, for physical medicine services on or after Jan. 1

Athletic trainers will have the opportunity to participate in Blue Cross Blue Shield of Michigan's Traditional and TRUST PPO networks as well as BCN HMO℠, starting Jan. 1, 2021.

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

Athletic trainers can find enrollment forms and practitioner agreements on **bcbsm.com/providers**. To find enrollment information, click on *Join Our Network*. Specific qualification requirements are identified within each agreement.

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

Authorization requests must be submitted for BCN members

For BCN HMO members, athletic trainers must submit authorization requests for physical medicine services to eviCore healthcare. There is no authorization required for Blue Cross' PPO members.

For BCN members, authorization requests for both initial and follow-up visits should be submitted to eviCore in one of these ways:

- Through the eviCore provider portal, which you can access:
  - By clicking the *Authorizations and Referrals* button for the member on the web-DENIS Eligibility/Coverage screen
  - By visiting **www.evicore.com**
- By calling eviCore at 1-855-774-1317.

Authorization requests should be submitted before providing services.

For additional information on BCN's utilization management requirements for these services, refer to the **Utilization Management** chapter of the *BCN Provider Manual*. Look in the section titled " Managing PT, OT and ST / Managing physical medicine services." You can access this chapter on the *Provider Manual* chapters **webpage** in the BCN section of our **ereferrals.bcbsm.com** website.

Where to find additional information about requesting authorization

BCN offers additional information in the BCN section of our **ereferrals.bcbsm.com** website about PT, OT, ST, physical medicine services and other procedures managed by eviCore. See the following resources for more information:

- **Procedures managed by eviCore**
- A list of **procedure codes**
- **How to request authorizations through eviCore**
- **Outpatient rehabilitation services: Frequently asked questions** document

The above resources are located on the **ereferrals.bcbsm.com** website.

Important information about PT benefits

Athletic trainers should tell members the physical medicine services they provide count against a member's physical therapy benefits. Because PT benefits are limited during a plan year, the physical medicine services provided by athletic trainers will reduce a member's future benefits for that plan year.

BCN Advantage

New BCN Advantage plans offer member value and flexibility to seek out-of-network-care

Blue Care Network is making some changes to its BCN Advantage products in 2021. We'll being discontinuing four plans (including Basic) and moving members into a new HMO-POS plan called Prime Value. We'll also introduce a new $20 HMO-POS plan called Community Value. We'll also apply point-of-service benefit cost shares when used through Blue Card, toward the maximum out of pocket.

To further enrich our plans, all include $0 PCP and telehealth copays. Some plans have enhanced benefits for over-the-counter items and groceries; personal care assistance; and support for caregivers.

Plans available in 2021

The BCN Advantage plans for 2021.

- BCN Advantage℠ HMO-POS Elements
- BCN Advantage℠ HMO-POS Classic
- BCN Advantage℠ HMO-POS Prestige
- BCN Advantage℠ HMO ConnectedCare
- BCN Advantage℠ HMO-POS Prime Value
- BCN Advantage℠ HMO-POS Community Value

Prime Value

Prime Value will replace these plans: Basic HMO-POS, HealthyValue HMO, HealthySaver HMO and MyChoice Wellness HMO. Prime Value will provide members a high-value plan with the same or better benefits and access to a more comprehensive provider network. The plan has a $0 premium and $0 in-network PCP copayment and offers increased flexibility for members due to the HMO-POS structure. Members in the discontinued plans will be automatically moved into Prime Value. They'll be notified of the changes and won't have to complete enrollment forms

Prime Value features

- No medical deductible in most regions
- Out-of-network services applied to the maximum out-of-pocket amount
- Reduced prescription deductible to $50 on certain tiered drugs
- Added a $100 vision allowance
- Added a $75 allowance per quarter for over-the-counter and food items in most counties
- Caregiver support (see sidebar article on the next page)

Community Value

Community Value is also a new HMO-POS plan available to residents in seven counties in the metro Detroit area. It will have a $20 premium and offer richer benefits, including an allowance for comprehensive dental, vision and hearing aids, a high performance provider network and a leaner formulary.

The HMO-POS format allows members more flexibility to seek out-of-network care.

The plan will be available in Genesee, Livingston, St. Clair, Macomb, Oakland, Wayne and Washtenaw counties.

The member's primary care physician must be part of the BCN Advantage Community Value network. PCPs may refer to specialists and facilities from the full BCN Advantage network for all other services.

Please see BCN Advantage plans, continued on Page 12

BCN Advantage plans, *continued from Page 11*

Other changes

We've made some improvements to four plans:

- Out-of-network services will be applied to the maximum out of pocket for all HMO-POS plans.
- We offer an embedded hearing allowance in all HMO-POS plans.
- A vision allowance is offered for Community Value and Prime Value and will continue to be offered for Classic and Prestige plans.
- Meal benefits are included in all products for members who are post-discharge.
- We reduced the PCP copay to $0 for all HMO plans.
- We added $25 per quarter for the over-the-counter allowance to Elements and ConnectedCare.
- There are adjustments to the pharmacy network for select members.

New supplemental benefits help members with grocery expenses, personal care and caregiver support

Every BCN Advantage individual plan offers a quarterly allowance for members to purchase certain over-the-counter and grocery items. Amounts may differ based on plan and region.

For Prime Value and Community Value, a new in-home support benefit is available for people who live alone and need help to maintain independent living. The services include non-skilled care, such as companionship, light housekeeping and cooking.

Caregiver support is a new benefit for Prime Value members. It offers digital-based support for caregivers. Members are required to be enrolled in a care management program. The program aims to reduce emergency room visits and decrease hospitalization.

BCN Advantage participates in CMS program to make insulin affordable

Our 2021 BCN Advantage individual products (with the exception of Community Value) are participating in a Centers for Medicare & Medicaid services program to help offset the high cost of insulin.

In March 2020, CMS announced the Part D Senior Savings Model, a five-year program that allows participating plans to limit cost-sharing for a 30-day supply of insulin to $35 or less.

BCN will offer select insulins on our formulary from participating manufacturers under this model program. Members who use one of the selected insulins pay a $35 copay for a 30-day supply of insulin through the deductible stage (only Prime Value has a deductible), the initial coverage stage and the coverage gap stage. The program includes both vial and pen dosage forms. The member cost is $70 for a 60-day supply and $105 for a 90-day supply.

Products selected for the Part D Senior Savings Model include:

- Lantus (vials and pens)
- Novolin N, R, 70/30 (vials and pens)
- Novolog and Novolog Mix 70/30 (vials and pens)
- Toujeo pens

BCN Advantage

We're waiving cost share for certain drugs for BCN Advantage Prestige members

We're continuing a program in 2021 to waive cost sharing for certain drugs for eligible members in the BCN Advantage℠ HMO-POS Prestige plan who have been diagnosed with coronary artery disease or congestive heart failure.

The initiative is part of a five-year Value-Based Insurance Design program pilot through the Centers for Medicare & Medicaid Services.

For coronary artery disease, we're waiving the cost share for four drug classes: antiplatelet drugs, statins, ACE/ARBs and beta-blockers for members diagnosed under one of 59 ICD-10 codes. For congestive heart failure, we're waiving the cost share for these drug classes: ACE/ARBs, beta-blockers, diuretics, vasodilators and some other drugs for members diagnosed under one of 24 ICD-10 codes.

We'll identify members for the program based on diagnosis and mail a letter informing members that we've enrolled them in VBID and a care management program. Members can opt out of care management, but they'll still receive their eligible prescriptions with no cost share.

Advanced care planning

We'll also continue to include the Welvie℠ advanced care planning program for 2021 and will expand it to all members enrolled in BCN Advantage Prestige HMO-POS. Prestige members who complete an advanced directive through the online program will receive a $25 gift card. Members can give their completed directives to their health care providers to add to their medical records.

Updates on sequestration and DRG enhancement for Medicare Advantage providers

Earlier this year, the federal CARES Act implemented temporary sequestration relief and inpatient diagnosis-related group enhancement for Original Medicare payments. Blue Cross Blue Shield of Michigan and Blue Care Network applied this financial relief to our Medicare Advantage plans — Medicare Plus Blue℠ PPO and BCN Advantage℠ — for both network and non-network providers. We told you about this in an April web-DENIS alert, a **June *Record*** article and a **July-August *BCN Provider News* article** (Page 10).

Here are updates on those two temporary changes.

Temporary sequestration relief scheduled to end

At the time of this publication, the federal government has scheduled temporary sequestration relief to run through Dec. 31, 2020 dates of service. Blue Cross and BCN will re-implement sequestration in accordance with its provider agreements. This is currently planned to happen Jan. 1, 2021. If the federal government amends the sequestration restoration date, Blue Cross and BCN will also do so to remain in alignment with CMS reimbursement policy.

What this means to you

Given this change in CMS payment method, this means that, for both professional and facility providers, all the Medicare Advantage services that had a 2% reduction in the amount paid prior to May 1, 2020 dates of service due to sequestration will once again have the reduction applied beginning Jan. 1, 2021, or any date after that amended by the federal government. As was our previous practice, the claims payment adjustment will remain consistent with CMS payment methodologies; it will be applied to claims after determining any applicable member deductible, copayment or other member liability.

Durable medical equipment, end-stage renal disease services and lab providers are not affected by sequestration.

DRG enhancements continue until the end of the public health emergency; positive lab test results required beginning Sept. 1

The CARES Act includes a temporary 20% increase in the weighting factor for inpatient DRG payments for Medicare patients diagnosed with COVID-19. This increase applies to discharges occurring on or after the emergency declaration on Jan. 27, 2020, and is expected to continue until the public health emergency ends.

Providers are expected to follow CMS guidance indicating that claims eligible for the temporary increase must have a positive COVID-19 laboratory test in the patient's medical record, effective for admissions on or after Sept. 1, 2020. More information is available in the **MLN Matters® article SE20015 updated Aug. 17, 2020**.

BCN Advantage

We're covering acupuncture for Medicare Advantage members

Retroactive to January 21, 2020, Medicare Plus Blue℠ PPO and BCN Advantage℠ members have coverage for acupuncture for the treatment of chronic low back pain. We cover up to 12 visits in 90 days for qualifying patients if they've had chronic low back pain defined as:

- Lasting 12 weeks or longer
- Nonspecific, in that it has no identifiable systemic cause (not associated with metastatic, inflammatory, infectious disease)
- Not associated with surgery
- Not associated with pregnancy

We'll cover eight additional visits for patients showing improvement, but no more than 20 visits annually. Treatment must be discontinued if the patient isn't improving or is regressing.

Existing network providers can provide this service if they meet all applicable educational and state licensing requirements. For more information on these requirements, refer to the CMS **Decision Memo for Acupuncture for Chronic Low Back Pain**.

This decision is based on the National Coverage Determination for Acupuncture for Chronic Low Back Pain and does not apply to Blue Cross' commercial PPO or BCN HMO members.

Medicare Advantage members transitioning to a new diabetic management program

BCN Advantage℠ and Medicare Plus Blue℠ PPO members currently in the Fit4D diabetes management program managed by Cecilia Health are being transitioned to Livongo for diabetic management services, starting in October. Members enrolled in Fit4D will complete their programs before being offered the new program.

The goal of the diabetic management program is to help patients self-manage their condition, improve medication adherence and reduce unnecessary use of emergency room visits and inpatient admissions.

The target population for the program includes members with diabetes (Type 1 and Type 2) who have one of the following:

- A1C ranges: ≥ 8.0
- Insulin first fill (defined as only one insulin fill in a rolling 12-month period)
- No HbA1C within the last 12 months
- Nonadherent to diabetes medications (CMS star measure)

Our care management area will refer members to the program. We won't ask providers to make recommendations.

Livongo will provide a glucometer and supplies to monitor member glucose readings. Certain readings out of normal range will trigger an alert and follow up by the Livongo clinical team.

Members will have access to an app and web-based support and education. They'll be co-managed by our Care Management department and the vendor.

BCN Advantage

Avoid SNF claim denials for Medicare Advantage by matching PDPM levels on claims to the levels authorized by naviHealth

In November 2020, Blue Cross Blue Shield of Michigan and Blue Care Network will begin denying skilled nursing facility claims for BCN Advantage℠ members when patient-driven payment model levels don't match the levels naviHealth authorized. Facilities can resubmit denied claims with the approved PDPM levels.

This applies to SNF claims for Medicare Plus Blue℠ PPO and BCN Advantage℠ members.

In a future web-DENIS message, we'll let you know the date we'll begin denying claims.

As a reminder, naviHealth:

- Authorizes PDPM levels during the patient's skilled nursing facility stay (from preservice through discharge) for dates of service on or after Oct. 1, 2019
- Works with skilled nursing facilities to ensure billers submit proper PDPM levels for reimbursement

For more information, see **Post-acute care services: Frequently asked questions by providers**.

Medical specialty drug prior authorization lists will change in November for certain members

For dates of service on or after Nov. 20, 2020, we're removing prior authorization requirements for one drug and adding prior authorization requirements for several drugs.

See full article on **Page 40**.

AMC Health remote monitoring program helps manage members with CHF

Blue Cross Blue Shield of Michigan and Blue Care Network are working with AMC Health to offer remote patient monitoring to eligible members living with congestive heart failure. The program, effective Aug. 1, is available to BCN Advantage and Medicare Plus Blue PPO members.

The goal is to reduce avoidable inpatient and outpatient utilization by improving member self-management skills. Using remote monitoring and self-management education provided by the AMC Health team, members will improve medication adherence, reduce gaps in care, improve dietary and other lifestyle factors that affect their conditions and improve communication with their physicians.

The vendor will identify members through a predictive based on diagnosis and claims. Our internal coordinated care department will also refer members to the program.

Patients who agree to participate in this program for up to 12 months will use simple monitoring devices to measure their vital signs (blood pressure, pulse, body weight and glucose level). Results are compared against nationally accepted standards. Care managers follow up with patients with out-of-range trends.

Members' primary care physicians will be able to customize patients' alerts and change parameters to meet the desired goals according to each patient's care treatment plan. AMC Health will send providers a welcome fax informing them of the patient's enrollment in the program.

We're planning to expand the program in the future for members with chronic obstructive pulmonary disorder.

Understanding the link between opioid use and suicide

Over the past two years, I've written columns in our provider newsletters on the topic of suicide prevention and awareness. One dimension that I haven't addressed in previous columns is the link between suicide and opioid use.

In the U.S., the combined number of deaths among Americans from suicide and unintentional overdose increased from 41,364 in 2000 to 110,749 in 2017 — a number that exceeds the number of deaths from diabetes since 2010, according to the Centers for Disease Control and Prevention. An **article** last year in *The New England Journal of Medicine* explores the role that opioid use plays in fueling rates of suicide and unintentional overdose and is worth reading.

William Beecroft, M.D.

Researchers have found that weekly or more frequent opioid use is associated with suicidal ideation, suicide planning and suicide attempts, according to a **flyer** distributed by the U.S. Department of Veterans Affairs. It appears that the risk for suicide increases as the daily dosage of opioids increases. Here are three possible reasons:

- Opioid use influences impulsivity. Those who are intoxicated have difficulty making clear choices or accessing the higher functions of the brain.
- Those who are addicted to opioids are living in reduced social circumstances. Many are unemployed, with a narrow circle of non-using friends. They feel trapped by their addiction and may think suicide is the only way out.
- Opioids alter the perception of pain. While the physical sensation of pain may remain, they don't care as much so are more likely to hurt themselves. Opioids decrease fear and anxiety.

Such negative effects of opioids are among the reasons Blue Cross Blue Shield of Michigan has taken a multipronged approach to battling the opioid epidemic over the past several years. Our efforts include education, advocacy, pharmacy programs and incentives to health care providers who treat patients with opioid use disorder. A 2019 **flyer** outlined our comprehensive strategy. Here are a couple more recent developments:

- Blue Cross supports training sessions throughout Michigan for primary care physicians who want to provide medication-assisted treatment, or MAT, in their offices. MAT includes the use of medications, in combination with counseling and behavioral therapies, to provide a holistic approach to the treatment of substance use disorders. Treatment with buprenorphine, one of the medications used in MAT, has been shown to be beneficial in reducing suicide risk among veterans with depression.
- Working with the **Michigan Opioid Collaborative** and the **Michigan Emergency Department Improvement Collaborative**, we're helping train emergency department doctors to initiate MAT in the hospital. Upon their release from the hospital, we connect patients with outpatient resources and services to support their recovery.

William Beecroft, M.D., is the medical director of behavioral health for Blue Cross Blue Shield of Michigan and Blue Care Network.

Please see From the medical director, continued on Page 18

Patient Care

From the medical director, *continued from Page 17*

Suicide among youth

In addition to the increase in deaths by suicide among adults nationwide, we continue to see an alarming increase in suicide among youths. In Michigan, there's been a 33% increase in death by suicide in the past 20 years among young people ages 10 to 24, according to a **report** on Detroit Public Television. Suicide is the second leading cause of death among our youth.

As I wrote in a **column** on this topic in *Hospital and Physician Update* last year, there are many factors contributing to this increase. Young people are struggling with an increasingly complex, fast-paced world and need tools for coping with feelings of anxiety, depression and low self-esteem.

What can be done

Our schools, health care system and government need to accelerate efforts to curb the rising suicide rate. I currently serve as a subject matter expert on Gov. Gretchen Whitmer's **Suicide Prevention Commission**, which works with state departments, agencies and nonprofits to research the causes and underlying factors contributing to suicide in this state. One area we're looking at is how to use artificial intelligence to identify people at a high risk of suicide so we can reach out to them before they do harm to themselves.

There are also some new medications and therapies that can help address acute depression and suicidal thinking. Esketamine nasal spray can be used for treatment of depressive symptoms in adults with major depressive disorder and acute suicidal ideation. Electroconvulsive therapy has also been shown to be effective for acute depression.

In the primary care setting, doctors are increasingly using screening tools to measure depression in their patients to identify those at risk. If a patient is despondent or sad — especially if they're going through a difficult time, such as divorce — it's important for doctors to ask the question: Have you thought of hurting yourself or taking your own life? It's a myth that asking the question can give someone the idea to commit suicide. The reverse is often the case — once the question is out in the open, patients are more likely to ask for and receive necessary help.

That's why we recommend that doctors keep contact information for area mental health professionals (including psychologists, social workers and psychiatrists) readily available so that they can refer their patients as necessary. Also, members can call the number for mental health services on the back of their member ID card 24 hours a day for help and referrals. If a member doesn't have a specific mental health number, the general number can provide assistance.

Another important resource is the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

As health care professionals, we have a **duty** to get suicidal patients the help they need.

Patient Care

Remind patients to get the flu vaccine

Most people who get the flu experience a mild illness but won't need medical care or antiviral drugs. Most will recover in less than two weeks without treatment. But because of possible complications, the Centers for Disease Control and Prevention recommends flu vaccinations for everyone age 6 months and older, and especially for those at higher risk of complications. This group includes:

- Adults age 65 and older
- Children younger than age 2
- Pregnant women and women up to two weeks after the end of pregnancy
- American Indians and Alaska natives
- People who live in nursing homes and other long-term care facilities

Additionally, certain chronic conditions, such as heart disease, asthma, diabetes and chronic obstructive pulmonary disease, increase a patient's risk of complications due to the flu.

There are also other health conditions that put patients at a higher risk for complications. Some of these include:

- Blood disorders, such as sickle cell disease
- Cystic fibrosis
- Kidney disorders
- Liver disorders
- Patients with a body mass index of 40 or higher
- Patients with a weakened immune system due to a condition or medications
- Neurologic and neurodevelopment conditions

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

- Annular closure devices (for example, Barricaid®, Xclose®, Inclose™)
- Gastric bypass surgery for gastroparesis
- Phrenic nerve stimulation for central sleep apnea

Covered services

- Bone marrow transplant – hematopoietic cell transplantation for Hodgkin's Lymphoma
- Cochlear implant
- Implantable bone-conduction and bone-anchored hearing devices
- Stereotactic radiosurgery and stereotactic body radiotherapy
- Gastric electrical stimulation
- Genetic testing – *JAK2*, MPL and CALR
- Transcranial magnetic stimulation as a treatment of depression and other psychiatric/neurologic disorders
- Telemedicine servies

Medical Policy Updates

Guest column: A provider's perspective on the coordinated care model

By Dr. Jonathan Henry

Dr. Henry is a board-certified community psychiatrist. Dr. Henry initially trained and practiced as a family practitioner and then completed a psychiatric residency. He has been providing the consultant psychiatric component of the CoCare model for two years.

The advent of the coordinated care model, or CoCM, is a blessing to patients and health care system alike. For years, I've listened to primary care colleagues lament the dearth of psychiatric services to help them with the mental health needs of their patients.

With CoCM, primary care physicians work closely with a consulting psychiatrist and a behavioral health care manager to address behavioral health issues. The PCP consults regularly with a consulting psychiatrist and behavioral health care manager to help facilitate the treatment plan. This provides a holistic, or whole-person treatment perspective, program for the patient.

An essential feature is the focus on patient-centered team care. Primary care and behavioral health providers collaborate in such a way the patient receives effective care in a familiar location. This approach fosters increased patient engagement, which can lead to better patient outcomes.

Another core feature is the focus on population-based care. Providers track patients in a registry to monitor progress and to ensure patients are not lost to follow-up. They call patients who aren't improving or who appear to be disengaging to try to improve their treatment trajectory. These features represent a meaningful advance beyond simple curbside consultation or even face-to-face psychiatric referral. Specific treatment goals include measurement-based treatment to target. Routine measurements using evidence-based tools help promote improvement and provide a clear method if patients aren't improving as expected.

To initiate the process, the medical provider identifies a mental health issue in a patient whom he or she feels needs psychiatric help. The provider notifies the care manager, who gathers information about the identified patient and their problems, organizes that information and presents it during a meeting with the CoCM psychiatric consultant. An initial PHQ-9 and GAD-7 are part of the baseline information, as mood and anxiety symptoms are typically at the heart of the patient's complaints. The CoCM psychiatrist analyzes that information, and requests additional information as needed, at which point they provide an opinion and written recommendation.

Please see Guest column, continued on Page 21

Guest column, *continued from Page 20*

The psychiatrist also has access to the practice's medical record, so pertinent information such as the problem list, current medications, laboratory results and the like are available to help formulate the diagnosis and suggest further treatment. The behavioral health care manager then helps to convey the psychiatrist's opinion back to the treating primary care provider for consideration. The psychiatrist doesn't see the patient. The psychiatrist also typically doesn't consult directly with the referring provider. The information flow is bidirectional through the behavioral health care manager.

I typically spend about 30 minutes on evaluating a new patient and about 15 to 20 minutes, depending on the complexity of the case, for established patients. I schedule two hours per week to meet with the care manager for the practice where I work. I conduct all reviews remotely, using a video platform when needed to meet with the care manager. We can simultaneously refer to the patient's chart in the electronic medical record or talk by phone. Treatment goals typically include driving the PHQ-9 and GAD-7 scores to 5 or lower ideally, or at least a 50% reduction in the baseline scores.

When to schedule a consultation

The conditions that trigger a CoCM consultation tend to fall into several general categories. The core problem is insufficient response to the medical provider's initial treatment efforts. So, many consultation replies involve dosage adjustment, medication selection and augmentation efforts.

Another problem is a more complex diagnostic picture. The PHQ-9 and the GAD-7 often serve as the starting point of the evaluation. They often are simply case-finding tools. Comorbidity, as we know all too well, complicates psychiatric diagnosis. Early in my experience, the information that would develop to expose more complicated diagnoses would come in piecemeal fits and starts over time. I find myself relying more on an assortment of measurement-based assessments to increase the efficiency and comprehensiveness of diagnosis. I ask the care manager to also obtain a baseline DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure — Adult to aid this process.

Unidentified bipolar depression is another common issue, so I employ the Mood Disorders Questionnaire, or MDQ, or the Composite International Diagnostic Interview, also known as CIDI, to help explore this possibility. Substance use is another frequent complicating factor that can be assessed using the SBIRT method, also known as Screening, Brief Intervention and Referral to Treatment.

There, screening instruments such as the Alcohol Use Disorders Identification Test, or AUDIT, and the Drug Abuse Screening Test, or DAST, can help begin the process. (Given the explosion in cannabis use, I've started to explore using the Cannabis Use Disorders Identification Test for our growing marijuana-using population).

Please see Guest column, continued on Page 22

Guest column, *continued from Page 21*

Personality disorders can be difficult to identify, especially early in the treatment process. Sometimes, the patient's interactions with front-office or ancillary medical staff provide the first clue. The Zanarini Rating Scale for Borderline Personality Disorder can help with the specific problem of borderline personality. Underlying but under-appreciated trauma is yet another frequently encountered problem. The Adverse Childhood Experiences (ACE) scale is the starting point for this area of difficultly, with the Life Events Checklist, or LEC, and the PTSD checklist as follow-up assessment possibilities. This approach can help to identify a previously missed history of significant traumatic brain injury, which can be another confounding factor.

Suicide, naturally, remains the most feared psychiatric complication, and we know that many suicidal patients can visit their medical providers shortly before a serious attempt. This problem is something that must be kept in mind. Item 9 of the PHQ-9 is one way to screen for this problem, but it may not be sufficient. The Columbia-Suicide Severity Rating Scale, or C-SSRS, is another way to try to get a grip on this issue. Using a specific safety plan is a critical component of managing patients who have more difficulty. The practice's specific approach to identifying and managing suicidal ideation is something worth singling out for attention with its behavioral health care manager and providers.

No matter how sensitive and attuned the providers and the care manager — and how skilled the psychiatric consultant — some problems are clearly beyond the scope of the primary care practice to manage. In such cases, establishing referral procedures to the appropriate level of care is essential. Somatic interventions alone are unlikely to be sufficient for many patients, so it's imperative that effective psychosocial treatment resources are readily available. When primary psychiatric needs clearly exceed the practice's capabilities, then referral processes to psychiatric consultants in the private sector or the community mental health system are required. A practice must identify emergency mental health services needed for acute situations and ensure they're readily accessible.

It's gratifying to help my primary care colleagues provide effective and comprehensive mental health services to their patients in the context of their own practice. It's additionally gratifying to be part of a movement whereby preciously scarce psychiatric resources can be leveraged to identify and treat mild-to-moderately ill patients who previously had no such access to psychiatric expertise.

Resources

- **American Psychiatric Association**
- **AIMS Center at the University of Washington**
- **University of Michigan: Michigan Institute for Care Management and Transformation**

Blue Distinction Centers for Substance Use Treatment and Recovery: the newest BDC designation

As you may have read in our provider publications earlier this year, the Blue Distinction® Specialty Care program added a new Blue Distinction® Center designation for Substance Use Treatment and Recovery, effective January 2020.

Blue Distinction Centers are nationally designated facilities that show a commitment to delivering improved patient safety and better health outcomes, based on objective measures that were developed with input from the community and leading accreditation and quality organizations. The BDC Substance Use Treatment and Recovery program requires designated facilities to deliver coordinated multidisciplinary care to patients and provide timely access to quality medical and psychosocial care in all phases of treatment.

Designated facilities must also offer medication-assisted treatment — a method of treating opioid addiction that includes a medication component as well as behavioral therapies.

Since announcing the new designation, we've added three substance use treatment and recovery facilities in Michigan. Additional Michigan facilities are expected to be added over the next year.

Programs such as this are important as they provide another tool in the fight against the opioid epidemic. According to the Centers for Disease Control and Prevention, 130 Americans die every day from an opioid overdose, a statistic that highlights the seriousness of the opioid crisis and how crucial it is for patients to receive comprehensive care.

In addition to this new designation, the Blue Distinction Specialty Care program is helping people find quality specialty care in the areas of bariatric surgery, cancer care, cardiac care, cellular immunotherapy, fertility care, gene therapy, knee and hip replacements, maternity care, spine surgery and transplants.

For more information about Blue Distinction Specialty Care and to find a Blue Distinction Center for a specific area of specialty care, visit the **Blue Distinction Specialty Care** website.

The new Blue Distinction Center designation was featured in the **MiBluesPerspectives** blog in August.

Behavioral Health

A message from Dr. William Beecroft

Understanding the link between opioid use and suicide

Researchers have found that weekly or more frequent opioid use is associated with suicidal ideation, suicide planning and suicide attempts, according to a **flyer** distributed by the U.S. Department of Veterans Affairs. It appears that the risk for suicide increases as the daily dosage of opioids increases.

See the full column on **Page 17**.

Children on certain antipsychotic medications require routine blood monitoring

The American Academy of Child and Adolescent Psychiatry recommends routine blood monitoring for children on antipsychotic medications with potentially adverse side effects that include weight gain and diabetes. The HEDIS® measure is Metabolic Monitoring for Children and Adolescents on Antipsychotics.

We send reminder letters to physicians and patients about routine blood monitoring. It's important that these patients receive these tests annually:

- At least one test for blood glucose or HbA1c
- At least one test for LDL-C or cholesterol

If you have questions, call BCN Behavioral Health at 1-800-482-5982 from 8 a.m. to 5 p.m. Monday through Friday.

Blue Cross and BCN to offer behavioral health digital tools

Blue Cross and BCN are committed to providing their customers with tools to deal with daily life stressors.

Starting Jan. 1, 2021, Blue Cross and BCN are launching a website and digital application product called myStrength by Livongo.

This product will be available for all fully insured groups with PPO coverage from Blue Cross and all BCN HMO℠ fully insured groups. It will also be available to select self-funded groups with PPO coverage from Blue Cross and select BCN HMO self-funded groups.

With more than 1,600 activities covering more than 30 life topics, myStrength provides content focused on these core areas: depression, anxiety, sleep disorders, substance use disorders, chronic pain, opioid/medication-assisted treatment, stress, mindfulness, balancing emotions, pregnancy and early parenting, nicotine and trauma.

Here's what these members will have access to through myStrength:

- All fully insured groups with PPO coverage from Blue Cross as well as fully insured BCN HMO members will have access to self-guided tools and video modules.
- Select self-funded groups with PPO coverage from Blue Cross and HMO coverage from BCN will have access to self-guided tools, video modules and asynchronous engagement coaching. (Responses to asynchronous engagement coaching may not be immediate or take place in real time.)

Members will be able to call the Customer Service number on the back of their member ID cards to determine whether they have access to the myStrength tools.

To learn more about the myStrength tools, go to **mystrength.com**.

As a reminder, earlier this year and in response to COVID-19, we joined with Livongo to offer a limited release of Livongo's myStrength COVID-19 module to all our members at no cost through Dec. 31, 2020. After Dec. 31, members will no longer have access to this custom module.

Clarification: Commercial and Medicare Advantage members eligible for comprehensive opioid treatment program

In the March-April issue of *BCN Provider News* we ran an article about a Centers for Medicare & Medicaid Services program that encourages providers to offer comprehensive opioid treatment.

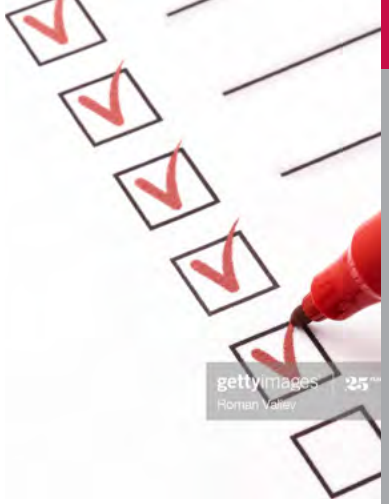
The program now applies to services for our commercial members (Blue Cross' PPO and BCN HMO℠) in addition to our Medicare Advantage members (Medicare Plus Blue℠ PPO and BCN Advantage℠).

Therefore, effective Jan. 1, 2020, Blue Cross and BCN are allowing bundled rates to reimburse providers who offer certified opioid treatment programs per CMS guidelines. There are also bundled payment codes that include both drug and non-drug components and may allow for intensity add-on codes to be used when needed for non-certified opioid treatment programs.

See Page 17 of the **March-April issue** for program details.

Quality Counts

HEDIS 2020 Medicare Advantage star measure changes



In July, the National Committee for Quality Assurance released proposed Healthcare Effectiveness Data and Information Set, or HEDIS®, specification changes for the 2020 measurement year.

The final specifications are expected to be released this month. Although edits to the proposed specifications are possible, fundamental changes are not expected. The following is the available information at press time

Key updates

Controlling high blood pressure

New definition: Hypertensive patients ages 18 to 85 whose blood pressure is adequately controlled (<140/90) during the measurement year. The last BP reading of the year determines compliance.

Important changes

- Patients are now identified for the measure by two outpatient visits with a diagnosis of hypertension from January 1 of the prior year to June 30 of the measure year.
- Blood pressure readings:
  - Blood pressure readings taken by a patient from any *digital* device are acceptable as long as the BP is documented in the patient's legal record by the provider managing the patient's blood pressure.
  - Blood pressure readings taken by the patient using a non-digital device, such as a manual blood pressure cuff and a stethoscope, are not allowed for HEDIS reporting.
  - Patient self-reported blood pressure readings may be obtained during telehealth, telephone, e-visits and virtual check-ins.

Submit claims with BP CPT® II code results even if the blood pressure is not compliant. Including CPT II result codes on the claim alleviates the need for a medical record request.

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

Palliative care exclusion

Patients receiving palliative care are now excluded from the following measures:

- Breast cancer screening
- Colorectal cancer screening
- Controlling high blood pressure
- Comprehensive diabetes care
- Statin therapy for patients with cardiovascular disease
- Osteoporosis management in women who had a fracture

Please see Star measures, continued on Page 27

Learn how HEDIS measures support proper management of musculoskeletal conditions

Musculoskeletal conditions are the second-largest contributor to disability, according to the World Health Organization.

Healthcare Effectiveness Data and Information Set measures related to musculoskeletal conditions include:

- Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis, or ART
- Osteoporosis management in women who had a fracture, or OMW

These measures support appropriate treatment of rheumatoid arthritis and osteoporosis. Proper treatment can help reduce the risk of debilitating complications.

View the ART measure tip sheet and the OMW measure tip sheet to learn more about what's included in these measures, new exclusions (including advanced illness and frailty of the patient) and ways you can close gaps in care for patients with rheumatoid arthritis and osteoporosis. The tip sheets also cover required medical record documentation and claim coding, which may reduce the need for medical record reviews.

Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis (ART)

Osteoporosis management in women with a fracture (OMW)

Star measures, *continued from Page 26*

Advanced illness exclusion

The following measures now allow advanced illness to be captured through telephone and e-visits:

- Breast cancer screening
- Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis
- Colorectal cancer screening
- Controlling high blood pressure
- Comprehensive diabetes care
- Statin therapy for patients with cardiovascular disease
- Osteoporosis management in women who had a fracture

Telephone and e-visit claims with advanced illness diagnoses will exclude patients from the measure if all exclusion requirements are met:

- The patient is 66 or older (67 and older for osteoporosis management)
- Patient had two advanced illness claims in the measurement year or the prior measurement year and a frailty code in the measurement year

Frailty codes are required for the advanced illness exclusion but can't be obtained through telephone or e-visit claim.

Quality improvement program information available upon request

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

- Log into web-DENIS.
- Click on *BCN Provider Publications and Resources*.
- Click on *Clinical Practice Guidelines*.

The **Michigan Quality Improvement Consortium guidelines** are also available on the organization's website.

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

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

Quality Counts

Using telehealth to help close patient gaps in care

Many health care providers are using telehealth to provide care to sick patients. But did you know you can also use telehealth to help meet your patients' preventive care needs and provide treatment for patients with chronic conditions?

To help you understand how telehealth can help you close gaps in your patients' care, we created the *Telehealth Summary of 2020 HEDIS® Measures*.* This document summarizes how you can use telehealth for prevention and screening, care coordination, diabetes care and services for cardiovascular, respiratory, musculoskeletal and behavioral health conditions, among others.

Using this document can help you meet the requirements for HEDIS measures and the Centers for Medicare & Medicaid Services star measures. In addition, the tips offered in this document can help eligible health care providers increase their performance in the Blue Cross Blue Shield of Michigan and Blue Care Network 2020 Quality Rewards program.

Here's how to find the *Telehealth Summary of 2020 HEDIS® Measures*:

1. Log in as a provider at **bcbsm.com/providers**.
2. Click on *BCN Provider Publications and Resources*.
3. Click on *Newsletters & Resources*.
4. Click on *Clinical Quality Corner*.

Other resources

Here are some other helpful resources:

- HEDIS, star and pharmacy measure tip sheets are available on the *Clinical Quality Corner* webpage. Follow the navigation instructions described above.
- The *2020 Quality Measure Description* document is available in the Resources section of Health e-Blue℠.
- The *2020 Quality Rewards Booklet* is available in the Resources section of Health e-Blue℠.
- Learn more about telehealth by clicking on the provider tab at **bcbsm.com/coronavirus** or logging in as a provider at **bcbsm.com** and clicking on Coronavirus (COVID-19).

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

We've added Flumist to the list of vaccines that can be administered by pharmacies for commercial members

Flu season is coming. To help keep our members healthy, we've added Flumist® (allV4) to the list of medical vaccines that can be administered by pharmacies under CPT *90694. Additionally, Flumist will be added to the list of vaccines covered under our members' pharmacy benefits, which can be billed under our claims processor, Express Scripts. These changes apply to Blue Cross Blue Shield of Michigan's PPO (commercial) and Blue Care Network HMO℠ (commercial), non-Medicare members.

Review the complete list of Vaccine Affiliation Program payable vaccine codes

The following vaccines are included:

- Seasonal flu
- Pneumonia
- Shingles
- Human papillomavirus
- Tetanus, diphtheria and pertussis
- Meningitis
- Cholera
- Hepatitis A, B
- Combination vaccines

A complete list of payable codes, including the associated administration codes, are available in the *Vaccine Affiliation Program* payable vaccine codes document below.
Blue Cross and BCN review this document quarterly. Here's how you can find the latest version:

1. Log in at **bcbsm.com** as a provider.
2. Click on *BCN Provider Publications and Resources*.
3. Click on *Newsletters & Resources*.
4. Click on *Health Reform Information* and then click on *List of Vaccine Affiliate Network payable vaccines for non-Medicare patients 2020*.

Update vendor billing software

Pharmacies that administer vaccines paid through the member's medical benefits need to instruct their vendors to update their billing software for our covered codes. If you don't do so, the pharmacy technician may get a front-end rejection and the technician may, in error, tell the member that the vaccine isn't covered.

Reminders on the process for vaccine administration

The process for administering vaccines has not changed. Here are the recommended steps:

1. Pharmacies should bill the Blue Cross and BCN member's pharmacy coverage through our claims processor, Express Scripts. In many cases, vaccine claims will be covered through the pharmacy benefit.
2. If you receive a point-of-sale rejection, you'll need to check the Blue Cross and BCN member's medical eligibility and benefits using the instructions below. Once you've verified the member's immunization benefits, submit your vaccine claim through the medical processes by following the instructions in the Medical Billing section of this document.

   Note: Only pharmacies contracted with Blue Cross and BCN's Vaccine Affiliation Program are eligible to submit claims as medical providers. If you're a Michigan pharmacy that isn't already participating in the Vaccine Affiliation Program, you can sign up. See *How to sign up for the Vaccine Affiliation Program* below.
3. Submit the immunization record to the Michigan Health Information Network, or MIHIN, within three days of administration of vaccines.

PDF *Vaccine affiliation program*

Please see Flumist, continued on Page 31

Flumist, *continued from Page 30*

Checking a member's eligibility and benefits following medical processes

You can check member medical eligibility and benefits by phone or online.

Checking eligibility and benefits by phone:

1. Call 1-800-344-8525.
2. Say *Benefits and eligibility*.
3. Provide your BCBSM PIN or say "I don't have one."
4. Select prompt #9 for "Other."
5. Enter the member's enrollee ID (contract number).
6. Enter the member's date of birth.
7. Say the first five letters of the member's first name.
8. Say "Cost share and benefits."
9. Say "Preventive services" to verify immunization benefits.

Checking eligibility and benefits online:

1. Log in as a provider at **bcbsm.com**.
2. Click *web-DENIS*.
3. Click *Subscriber Info*, then click *Eligibility/Coverage/COB*.
4. Enter the member's enrollee ID (contract number) and click *Enter*.
5. Look up benefits based on the type of coverage:

For PPO members with a national employer group:

6. Select the member and click on *MED* under *Detailed Benefits*.
7. Select your provider type from a dropdown menu (select *All other providers*), then click *GO*.
8. Look under *Immunizations* to see if there are any specific benefit restrictions.

For PPO members with a Michigan employer group:

6. Select the member and click on *MED* under *Detailed Benefits*, then click *Search*.
7. In the Quickview Report tab, scroll down to *Preventive Immunizations*.
8. Click on one of the Immunizations links, then click on *Included Codes* for a list of the codes covered.
9. Click on the code for more information, including Coverage Limitations and Provider Payment Limitations for a list of provider types that can bill for the code.

For BCN HMO members:

6. Click on the patient's name, then click on *Medical Benefits*.
7. Scroll down to Immunizations and look for any restrictions.

Please see Flumist, continued on Page 32

Flumist, *continued from Page 31*

Medical billing

Electronic billing tips for medical claims:

- Use the 837 electronic CMS-1500.
- Include your national provider identifier and immunization practice taxonomy code.
- Report your NPI and your taxonomy code (261QH0100X).
- Use location of service 60.
- Bill the vaccine and the administration on the same claim, but on separate service lines, using the appropriate CPT or HCPCS codes.

Medical reimbursement

Please refer to the list of payable immunizations in the *Vaccine Affiliation Program payable vaccine codes* document and fee schedules available within web-DENIS.

Note: Fee revisions and new codes added after publishing an Entire Fee Schedule are published on web-DENIS.

How to sign up for the Vaccine Affiliation Program

If you are a Michigan pharmacy not participating in the Vaccine Affiliation Program, you can sign up at **bcbsm.com**:

1. Go to **bcbsm.com/providers**.
2. Click on *Join our Network*, scroll down to step 3 and click on ***Enroll now***.
3. Click the button next to *Physicians and Professionals*, then click *Next*.
4. Click the button next to *Enroll a new provider*, then click *Next*.
5. Under "Allied Providers", click the button next to *Vaccine Pharmacy*, then click *Next*.
6. Complete and return the documents on this page.

Where to find help

- **General questions about medical vaccines** —Call Provider Inquiry at 1-800-344-8525 from 8:30 a.m. to 5 p.m. Monday through Friday,
- **Electronic transactions** — For help with electronic transactions, such as the 270/271 eligibility and benefit inquiry transaction, call the Electronic Data Interchange Help Line at **1-800-542-0945** or e-mail EDICustMgmt@bcbsm.com.
- **Issues not resolved** — If you can't get your issue resolved through the above methods, contact Charlie Bono, pharmacy provider consultant for all Michigan pharmacies:

  Charlie Bono
  Email: cbono@bcbsm.com
  Phone: 231-941-6012
  Fax: 855-236-1219

Reminder: Pharmacies can bill for COVID-19 testing

In a provider alert posted Aug. 31, we told you how pharmacies can bill for COVID-19 testing. There's also an article on **Page 33** of this issue.

Here are links to COVID-19 testing documents for pharmacies:

- **For commercial members (Blue Cross PPO and BCN HMO)**
- **For Medicare Advantage members (Medicare Plus Blue℠ and BCN Advantage℠)**

Pharmacy News

Pharmacies can bill us for COVID-19 testing

Pharmacies that participate in the Blue Cross Blue Shield of Michigan and Blue Care Network Vaccine Affiliation Program or have the ability to submit Medicare Part B medical claim forms can bill Blue Cross or BCN for COVID-19 testing services for patients with Blue Cross' PPO℠ or BCN HMO℠ commercial or Medicare Advantage coverage. This change is in accordance with **guidance issued April 8, 2020 by the U.S. Department of Health & Human Services** and **Executive Order 2020-104 issued by Michigan Governor Gretchen Whitmer**. It is in effect until further notice.

Blue Cross and BCN are making it easier for members to get COVID-19 diagnostic and antibody tests by giving them more options on where they can be tested when:

- It's medically necessary.
- The test is ordered by an attending health care provider.

The provider can be a licensed physician, pharmacist or attending clinician operating within the scope of their license.

We posted more information about this change at the end of August on the COVID-19 web page and as a provider alert on web-DENIS. A list of codes that pharmacies can use to bill COVID-19 testing is available on our COVID-19 webpages under the *Patient testing* section.

More information about COVID-19 testing is available on our public website at **bcbsm.com/coronavirus** and through the COVID-19 information page within Provider Secured Services.

We'll change how we cover some drugs, starting Jan. 1

We're making some changes to how we cover some drugs on the Clinical, Custom, Custom Select and Preferred Drug Lists starting Jan. 1, 2021. We'll send letters to affected members and their groups and providers.

The following is a list of these changes:

Changes to the Preferred Drug List

The following are changes to the Preferred Drug List that will be effective January 1, 2021

Drugs on the Preferred Drug List that won't be covered

We'll no longer cover the following brand-name and generic drugs. If a member fills a prescription for one of these drugs on or after Jan. 1, 2021, he or she will be responsible for the full cost. The drugs that won't be covered are listed along with the preferred alternatives that have similar effectiveness, quality and safety. Unless noted, both the brand name and available generic equivalents won't be covered. The example brand-names of preferred alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs that won't be covered	Common use/drug class	Preferred alternatives
Airduo Respiclick®, fluticasone-salmeterol[1] (authorized generic for Airduo Respiclick® by A-S MEDICATION, TEVA)	Bronchospasm	fluticasone/salmeterol (by Prasco, Proficient Rx), Advair HFA®, Breo Ellipta®, Dulera®, Symbicort®
Amitiza®	Constipation	Linzess®, Trulance®
Aptiom®	Anticonvulsants	Tegretol/XR®, Topamax®, Trileptal®, Lyrica, ® Vimpat®
Bunavail®	Opioid use disorder	Suboxone®, Subutex®, Zubsolv®
Calquence®	Cancer	Imbruvica®, Venclexta®
Ciloxan® 0.3% ointment	Ophthalmic anti-infective	Ciloxan® drops, Garamycin®, Ocuflox®, Quixin®, Vigamox®, Zymaxid®
Cimzia®	Autoimmune conditions (such as rheumatoid arthritis, plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, Rinvoq®, Skyrizi®, Stelara® 45mg, 90mg, Taltz®, Tremfya®, Xeljanz/ XR®
Cosentyx®	Autoimmune conditions (such as plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, Skyrizi®, Stelara® 45mg, 90mg, Taltz®, Tremfya®, Xeljanz/ XR®
Crinone® 4%	Progestin	Aygestin®, Megace®, Prometrium®, Provera®
Crinone® 8%	Infertility	Endometrin®
Cutaquig®, Gammaked®, Hizentra® vials	Immune globulin	Gammagard liquid®, Gamunex-C®, Xembify®
Ecoza®, Xolegel®	Topical antifungal	Loprox®, Naftin®, Nizoral®, Oxistat®, Spectazole®
Elestrin®	Estrogen	Divigel®

Please see Drug lists, continued on Page 35

Drug lists, *continued from Page 34*

Drugs that won't be covered	Common use/drug class	Preferred alternatives
Epiduo® Forte	Acne	Amzeeq®, Benzaclin®, Cleocin-T®, clindamycin phosphate 1% gel (NDCs other than 68682046275), erythromycin gel, Retin-A®
Firvanq® (brand)	Anti-infective	Firvanq® (generic), Vancocin®
Humalog Jr Kwikpen® (brand)	Diabetes	insulin lispro junior[1] (nonpreferred brand copay applies)
Inderal XL®, Innopran XL®	Cardiovascular conditions	Inderal®/LA, Inderide®
Intrarosa®	Menopause symptoms	Climara®, Estrace®, Estring®, Premarin® cream, tablets, Vagifem®
Jentadueto®, Jentadueto XR®	Diabetes	metformin (Glucophage®/XR) plus a DPP-4 inhibitor (Januvia®), Janumet®, Janumet® XR
Kevzara®	Rheumatoid arthritis	Enbrel®, Humira®, Rinvoq®, Xeljanz/XR®
Lastacaft®, Pazeo®	Ophthalmic anti-allergy	Elestat®, Opticrom®, Optivar®, Pataday®, Zerviate®
Moviprep®	Bowel preparation	Clenpiq®, Colyte®, Golytely®, Nulytely®, Peg-Prep®, Prepopik®, Suprep®
Mytesi®	Antidiarrheal	Imodium®, Lomotil®
Neulasta®, Udenyca®	Hematopoietic agent	Fulphila®, Ziextenzo®
Nexium® DR packets	Gastrointestinal reflux	Aciphex® tablet, Nexium®, Prevacid®, Prilosec® capsule, Protonix® tablet
Nucynta®	Pain (opioid)	Norco®, morphine sulfate immediate release, oxycodone immediate release, Percocet® , Ultracet®, Ultram®
Nucynta ER®	Pain (opioid)	Butrans®, Duragesic®, Exalgo®, Hysingla ER® (nonpreferred brand copay applies), MS Contin®, Opana ER®, Oxycontin® (nonpreferred brand copay applies)
Otrexup®	Immunosuppressant	Rasuvo®
Praluent®	High cholesterol	Repatha®
ProAir® Respiclick®, Ventolin® HFA, albuterol sulfate HFA[1] (authorized generic for Ventolin HFA® by A-S Medication, Prasco)	Bronchospasm	albuterol sulfate HFA (by Cipla, Par, Perrigo, Proficient Rx, and Teva)
Proctofoam-HC®	Hemorrhoidal preparation	Analpram-HC®, Cortenema®, Pramosone®, Proctocort®
Qtern®	Diabetes	Glyxambi®, Steglujan®
Soma®, Soma® compound with aspirin, Soma® compound with codeine	Muscle relaxant	Flexeril®, Norflex®, Robaxin®, Parafon Forte DSC®, Zanaflex®
Tradjenta®	Diabetes	Januvia®
Zuplenz®	Antiemetic	Kytril®, Zofran®, Zofran® ODT

[1] Represents drugs that are considered brand-name drugs and don't have generic equivalents. These may be considered "authorized generics" which are the same as the brand-name drugs but aren't true generic drugs.

Please see Drug lists, continued on Page 36

Drug lists, *continued from Page 35*

Drugs on the Preferred Drug List that will have a higher copayment

The brand-name drugs that will have a higher copayment are listed along with the preferred alternatives that have similar effectiveness, quality and safety. The example brand names of preferred alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Nonpreferred drugs that will have a higher copayment	Common use/drug class	Preferred alternatives
Alrex®, Bepreve®	Ophthalmic anti-allergy	Elestat®, Opticrom®, Optivar®, Pataday®, Zerviate®
Ilevro®, Prolensa®	Ophthalmic anti-inflammatory	Acular®, Bromday®, Ocufen®, Voltaren® ophthalmic solution
Oracea®	Anti-infective	Adoxa®, Doryx®, Minocin®, tetracycline, Vibramycin®
Qbrexza®	Hyperhidrosis	Antiperspirant products are available over-the-counter

Drugs on the Preferred Drug List that will have quantity limits

These drugs will have changes to the amount that can be filled.

Drug		PPO and HMO	
		Preferred Drug List	New Quantity limit
Oral meds	**Amerge®** (naratriptan) **Axert®** (almotriptan) **Frova®** (frovatriptan) **Imitrex®** (sumatriptan) **Maxalt®** (rizatriptan) **Relpax®** (eletriptan) **Zomig®** (zolmitriptan)	12 tablets per fill	12 tablets per 30 days
	Treximet® (sumatriptan/naproxen)	9 tablets per fill	12 tablets per 30 days
	Emend® 40 mg, 80 mg (aprepitant)	None	4 capsules per 30 days
	Emend® 125 mg (aprepitant)	None	2 capsules per 30 days
	Emend® trifold pack (aprepitant)	None	2 packs (6 capsules) per 30 days
	Kytril® (granisetron)	None	60 tablets per 30 days
	Zofran®/Zofran® ODT (ondansetron)	None	120 tablets per 30 days
Injectable	**Imitrex®** (sumatriptan) Injection	6 injection per fill	12 injections/vials per 30 days
	Zembrace® (sumatriptan) injection	4 injection per 30 days	12 injections per 30 days
Nasal sprays	**Imitrex®** (sumatriptan) nasal spray	6 units per fill	12 units per 30 days
	Onzetra™ Xsail® (sumatriptan) nasal spray	1 dose pack per 30 days	1 kit (8 pouches) per 30 days
	Zomig® (zolmitriptan) nasal spray	6 units per fill	12 units per 30 days

Please see Drug lists, continued on Page 37

Drug lists, *continued from Page 36*

Changes to the Clinical, Custom and Custom Select Drug Lists

The following are changes to the Clinical, Custom and Custom Select Drug Lists that will be effective Jan. 1, 2021.

Drugs on the Clinical and Custom Drug Lists that won't be covered

We'll no longer cover the following brand-name and generic drugs. If a member fills a prescription for one of these drugs on or after Jan. 1, 2021, he or she will be responsible for the full cost. The drugs that won't be covered are listed along with the preferred alternatives that have similar effectiveness, quality and safety. Unless noted, both the brand-name and available generic equivalents won't be covered. The example brand names of preferred alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs that won't be covered	Common use/drug class	Preferred alternatives
Carac®, fluorouracil 0.5% cream[1]	Skin conditions	Aldara®, Efudex®, Tolak®
Cosentyx®	Autoimmune conditions (such as plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, methotrexate, Skyrizi®, Stelara® 45mg, 90mg, Taltz®, Tremfya®
Humalog Jr Kwikpen® (brand)	Diabetes	insulin lispro junior[1] (nonpreferred brand copay applies)
Inderal XL®, Innopran XL®	Cardiovascular conditions	Inderal®/LA, Inderide®
Onexton®	Acne	Duac®, Benzaclin®
ProAir® Respiclick®, Ventolin HFA®, albuterol sulfate HFA[1] (authorized generic for Ventolin HFA®)	Bronchospasm	ProAir HFA®, Proventil HFA®
sodium sulfacetamide, sodium sulfacetamide/sulfur, sodium sulfacetamide/sulfur/urea (Drugs such as: Avar LS®, Plexion®, SSS 10-5®, Sulfacleanse 8-4®, Sumadan®, Sumaxin®, Sumaxin TS®)	Acne	Avar®, Avar-E®, Klaron®, Ovace®, Rosanil®
Soma®, Soma® compound with aspirin, Soma® compound with codeine	Muscle relaxant	Flexeril®, Norflex®, Robaxin®, Parafon Forte DSC®, Zanaflex®
Sprix®, ketorolac nasal spray[1]	Migraine	generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®) generic triptan (such as Amerge®, Imitrex®, Maxalt®, Zomig®)
Zuplenz®	Antiemetic	Kytril®, Zofran®, Zofran® ODT

[1] Represents drugs that are considered brand-name drugs and don't have generic equivalents. These may be considered "authorized generics" which are the same as the brand-name drugs but aren't true generic drugs.

Please see Drug lists, continued on Page 38

Drug lists, *continued from Page 37*

Drugs on the Custom Drug List that will have a higher copayment

The brand-name drugs that will have a higher copayment are listed along with the preferred alternatives that have similar effectiveness, quality and safety. The example brand names of preferred alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Nonpreferred drugs that will have a higher copayment	Common use/drug class	Preferred alternatives
Aldactazide® 50mg/50mg	Hypertension	Aldactazide® 25mg/25mg
Cortisporin® 1% ointment	Topical antibacterial	Bactroban® ointment; gentamicin cream, ointment
Cyclogyl® 1% 5mL (brand)	Eye dilation	Cyclogyl® 1% (generic)
Depo-Testosterone® (brand)	Testosterone replacement	Depo-Testosterone® (generic)
Diuril® suspension	Hypertension	Diuril® tablet
Hyper-Sal®	Lung decongestant/moisturizer	sodium chloride inhalation (generic)
Medrol® 2mg	Steroid	Medrol® (generic strengths)
SSKI®	Thyroid conditions	strong iodine
Tobrex® ointment	Eye anti-infective	Tobrex® drops
Vibramycin® syrup	Anti-infective	Vibramycin® suspension
Zonalon® 30g (brand)	Skin conditions	Zonalon® 45g (generic)

Drugs on the Custom Select Drug List that won't be covered

We'll no longer cover the following brand-name and generic drugs. If a member fills a prescription for one of these drugs on or after Jan. 1, 2021, he or she will be responsible for the full cost. The drugs that won't be covered are listed along with the preferred alternatives that have similar effectiveness, quality and safety. Unless noted, both the brand-name and available generic equivalents won't be covered. The example brand names of preferred alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs that won't be covered	Common use/drug class	Preferred alternatives
Aranesp®, Epogen®	Anemia	Procrit®, Retacrit®
Cosentyx®	Autoimmune conditions (such as plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, methotrexate, Skyrizi®, Stelara® 45mg, 90mg, Taltz®, Tremfya®
Harvoni® tablet, ledipasvir/sofosbuvir tablet[1]	Hepatitis C	Epclusa®, Zepatier®
Humalog Jr Kwikpen® (brand)	Diabetes	insulin lispro junior[1] (nonpreferred brand copay applies)
Praluent®	High cholesterol	Repatha®
ProAir® Respiclick®, Ventolin HFA®, albuterol sulfate HFA[1] (authorized generic for Ventolin HFA®)	Bronchospasm	ProAir HFA®, Proventil HFA®
Soma®	Muscle relaxant	Flexeril®, Norflex®, Robaxin®, Parafon Forte DSC®, Zanaflex®
Sovaldi® tablet	Hepatitis C	Epclusa®, Zepatier®

[1] Represents drugs that are considered brand-name drugs and don't have generic equivalents. These may be considered "authorized generics" which are the same as the brand-name drugs but aren't true generic drugs.

Please see Drug lists, continued on Page 39

Drug lists, *continued from Page 38*

Drugs on the Clinical, Custom and Custom Select Drug Lists that will have quantity limits

These drugs will have changes to the amount that can be filled.

Drug (generic)	BCN HMO current quantity limit		Blue Cross PPO current quantity limit		New quantity limit for all drug lists
	Custom Drug List	Custom Select Drug List	Custom Drug List Clinical Drug List	Custom Select Drug List	
Amerge®(naratriptan) Axert® (almotriptan) Frova® (frovatriptan) Imitrex®(sumatriptan) Maxalt® (rizatriptan) Relpax®(eletriptan) Zomig®(zolmitriptan)	9 tablets per fill	9 tablets per fill	12 tablets per fill	9 tablets per 30 days	12 tablets per 30 days
Treximet® (sumatriptan/naproxen)	9 tablets per fill	Not covered	9 tablets per fill	Not covered	12 tablets per 30 days*
Imitrex® Injection (sumatriptan)	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 (sumatriptan)	2 injections per fill	Not covered	4 injections per 30 days	Not covered	8 injections per 30 days*
Imitrex® nasal spray (sumatriptan)	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 (sumatriptan)	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 (zolmitriptan)	6 units per fill	6 units per fill	6 units per fill	6 units per fill	12 units per 30 days
Emend® (aprepitant) 40mg	None				4 capsules per 30 days
Emend® (aprepitant) 80mg	4 capsules per fill	4 capsules per fill	None		
Emend® (aprepitant) 125mg	2 capsules per fill	2 capsules per fill	None		2 capsules per 30 days
Emend® (aprepitant) trifold pack	2 packs per fill	2 packs per fill	None		2 packs (6 tablets) per 30 days
Kytril® (granisetron)	12 tablets per fill	12 tablets per fill	None		60 tablets per 30 days
Sancuso® (granisetron)	2 patches per fill	2 patches per fill	4 patches per 30 days	4 patches per 30 days	4 patches per 30 days
Zofran® and Zofran® ODT (ondansetron)	None				120 tablets per 30 days

*Doesn't apply to members on the Custom Select Drug List

Medical specialty drug prior authorization lists will change in November for certain members

For dates of service on or after Nov. 20, 2020, we're **removing** prior authorization requirements for one drug and **adding** prior authorization requirements for several drugs.

This affects BCN HMO℠, Medicare Plus Blue℠ PPO, BCN Advantage℠ and UAW Retiree Medical Benefits Trust PPO non-Medicare members.

Drug that will no longer require prior authorization

For dates of service on or after Nov. 20, we'll **no longer require prior authorization** for the following drug for Medicare Plus Blue, BCN Advantage and UAW Retiree Medical Benefits Trust PPO non-Medicare members:

- Lartruvo® (olaratumab), HCPCS code J9285

Drugs that will require prior authorization

For dates of service on or after Nov. 20, we're adding prior authorization requirements for specialty drugs covered under the medical benefit as follows.

- **For BCN HMO, Medicare Plus Blue and BCN Advantage members:** Providers will have to request prior authorization through AIM Specialty Health® for the following drugs:
  - Blenrep (belantamab mafodotin-blmf), HCPCS codes J3490, J3590, J9999, C9399
  - Monjuvi™ (tafasitamab-cxix), HCPCS codes J3490, J3590, J9999, C9399
- **For UAW Retiree Medical Benefits Trust PPO non-Medicare members:** Providers will have to request prior authorization through AIM for the following drugs:
  - Belrapzo™ (bendamustine hcl), HCPCS code J9036
  - Doxil® (doxorubicin liposomal), HCPCS code Q2050
  - Lipodox® (doxorubicin liposomal), HCPCS code Q2049
  - Herceptin® (trastuzumab), HCPCS code J9355
  - Imfinzi® (durvalumab), HCPCS code J9173
  - Imlygic® (talimogene laherparepvec), HCPCS code J9325
  - Mvasi™ (bevacizumab-awwb), HCPCS code Q5107

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 the following documents:

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

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

Blue Cross and BCN further extend authorization end dates on select medical and pharmacy benefit drugs for Medicare Advantage members

In April 2020, we extended the authorization end dates for select medical and pharmacy benefit drugs for Medicare Plus Blue℠ PPO and BCN Advantage℠ members. We did this to support our health care workers during the COVID-19 pandemic and ensure that members' access to medications wasn't disrupted.

We're now further extending the end dates on authorizations for select medical and pharmacy benefit drugs for Medicare Plus Blue and BCN Advantage members.

- **For medical benefit drugs:** For authorizations with end dates from Aug. 1 through Sept. 30, 2020, we've extended the end dates to Dec. 31, 2020.

  Exceptions for medical benefit drugs: Certain treatments aren't eligible for authorization extensions. These include, but aren't limited to, the following drugs:
  - Remicade®
  - Xiaflex®
  - Nonpreferred hyaluronic acid products such as Genvisc® 850 and Hyalgan®
  - IVIG products such as Gammagard® and Gamunex-C®

- **For pharmacy benefit drugs:** We're extending the authorization end dates to Dec. 31, 2020, for all active authorizations with end dates from July 29 through the end of the year for Medicare Plus Blue, Prescription Blue℠ PDP and BCN Advantage members.

  In addition, Medicare Plus Blue, Prescription Blue PDP and BCN Advantage members can refill their pharmacy prescriptions early. We're taking this extra precaution so members will have enough medication to stay healthy.

Consult the *Temporary changes due to the COVID-19 pandemic* document for other changes temporarily put in place for the public health crisis. You can find this document on our public website at **bcbsm.com/coronavirus** and through Provider Secured Services.

Billing Bulletin

Reminder: BCN covers digital breast tomosynthesis

Blue Care Network covers digital breast tomosynthesis, also known as 3-D mammography, and doesn't require a referral or preauthorization when it's done at an in-network facility.

BCN has a medical policy for digital breast tomosynthesis; it was updated in March 2020.

Our medical policy states the following:

Digital breast tomosynthesis (DBT) (3-D mammography) may be considered established for screening when either:

- DBT is used in combination with digital screening mammography in high risk individuals
- A qualified healthcare provider (ordering provider or radiologist) determines that DBT should be the primary mammographic study

Digital breast tomosynthesis may be considered established for screening or diagnostic purposes when digital mammography alone is inadequate or insufficient, in the judgment of the radiologist reviewer, to support clinical decision-making.

How to find medical policies for BCN

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*.

CPT/HCPCS Level II Codes associated with 3-D mammography include the following: *77061, *77062, *77063, G0279 (Medicare only)

The inclusion of a code in this list isn't a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.

Blue Cross and BCN clarify guidelines for pre-operative COVID-19 testing

Blue Cross Blue Shield of Michigan and Blue Care Network are offering guidance for pre-operative COVID-19 testing.

Procedures conducted in hospital operating rooms and ambulatory surgical facilities are appropriate for pre-operative COVID-19 testing. In addition, aerosol-generating procedures, regardless of the location performed, such as oral surgery in the office setting, are appropriate for pre-operative COVID-19 testing.

Codes for pre-operative testing are listed in the article on **Page 7**.

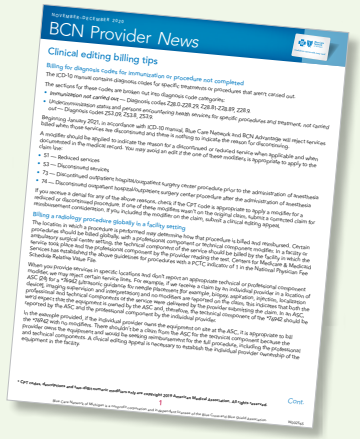
For more information, see the *Patient testing* section of our COVID-19 webpages on our public website at **bcbsm.com/coronavirus** or within Provider Secured Services by clicking on Coronavirus (COVID-19).

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:

- Billing for diagnosis codes for immunization or procedure not completed
- Billing a radiology procedure globally in a facility setting
- Use of modifiers during a global period
- CPT code changes in 2021


BCN Provider News

Clinical editing billing tips

Clinical editing billing tips

Billing Bulletin

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.

We're expanding our cardiology services authorization program with AIM Specialty Health for some members

Starting Jan. 1, 2021, we're adding some cardiology services that will require authorization by AIM Specialty Health® for certain commercial and Medicare Advantage members.

The services include cardiac implantable devices and arterial ultrasound for dates of service on or after Jan. 1, 2021. Please check your patient's plan below to see which services require authorization by AIM.

For Medicare Plus Blue℠ PPO, BCN HMO℠ and BCN Advantage℠ members:

- Cardiac resynchronization therapy, or CRT
- Implantable cardioverter defibrillator, or ICD

For Medicare Plus Blue members only:

- Arterial ultrasound

Authorization requests must be submitted to AIM before the service is performed. You'll be able to submit authorization requests starting Dec. 14, 2020.

Procedure codes

The chart below lists the codes for the additional cardiology services that require authorization.

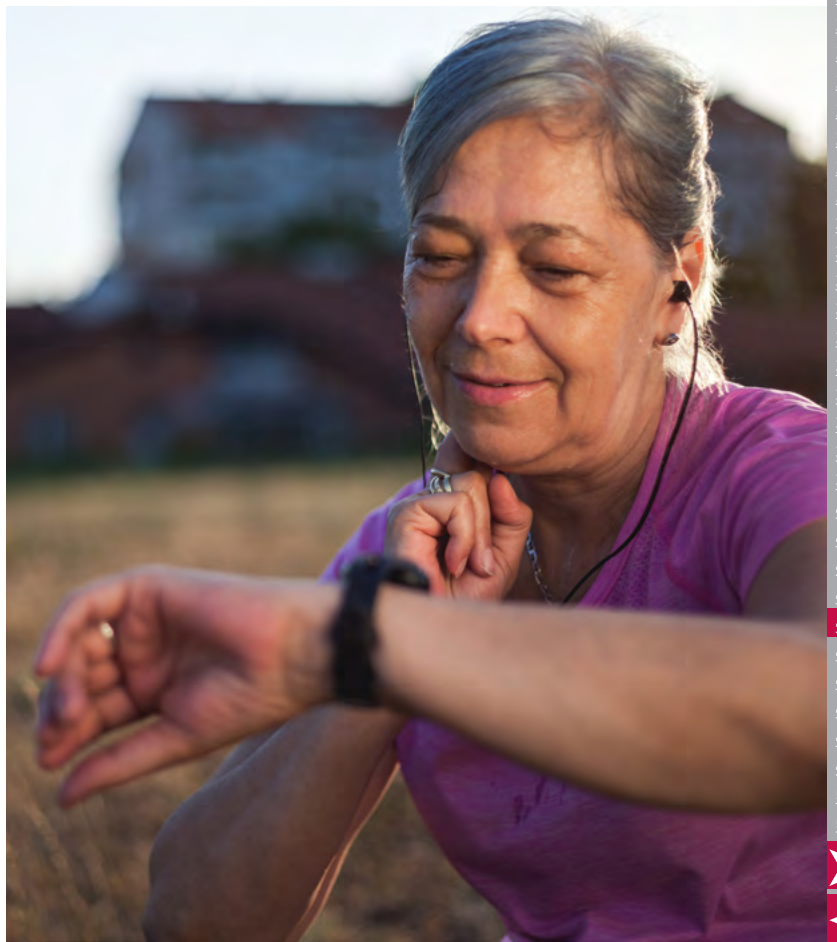
CRT	ICD	Arterial ultrasound
*33208	*0571T	*93880
*33214	*0572T	*93882
*33225	*33215	*93922
*33263	*33216	*93923
*33264	*33218	*93924
	*33240	*93925
	*33241	*93926
	*33249	*93930
	*33262	*93931
	*33270	*93978
	*33272	*93979

Additional information

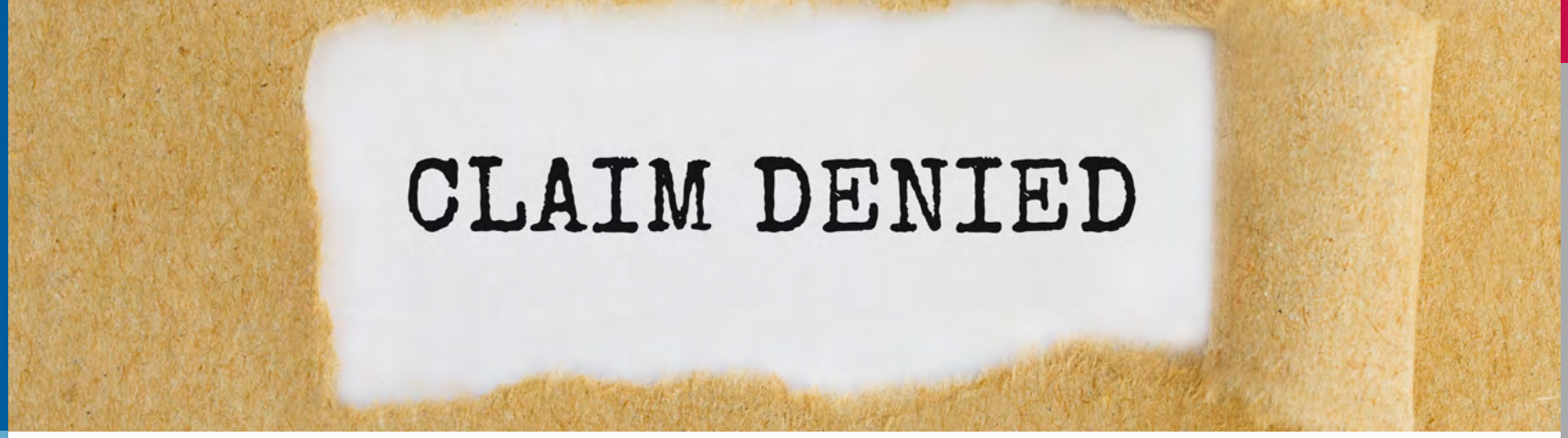
Here's how to request authorization from AIM and register for and use the **AIM ProviderPortal℠**:

- On our **ereferrals.bcbsm.com** website:
  - **Blue Cross AIM-Managed Procedures page**
  - **BCN AIM-Managed Procedures page**
- At **bcbsm.com/providers**, on the **Medicare Plus Blue Preauthorization and Utilization Management** page

We'll update these webpages along with pertinent documents before Jan. 1, to reflect this change.



Referral Roundup



Avoid SNF claim denials for Medicare Advantage by matching PDPM levels on claims to the levels authorized by naviHealth

In November 2020, Blue Cross Blue Shield of Michigan and Blue Care Network will begin denying skilled nursing facility claims when patient-driven payment model levels don't match the levels authorized by naviHealth. Facilities can resubmit denied claims with the approved PDPM levels.

This applies to SNF claims for Medicare Plus Blue℠ PPO and BCN Advantage℠ members.

See the article on **Page 16** for details.

Checking the status of temporary measures for COVID-19

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**.

TurningPoint musculoskeletal authorization program to expand in January

As we communicated in previous issues, TurningPoint Healthcare Solutions LLC is expanding its surgical quality and safety management program for Blue Cross and BCN members.

In this article, we're sharing information about:

- Procedures affected by the TurningPoint program expansion
- How to access the TurningPoint provider portal
- How to submit retrospective authorization requests for procedure codes for which authorization management will transition to TurningPoint from eviCore healthcare® or Medicare Plus Blue Utilization Management
- Registering for webinar training sessions

Procedures affected by the TurningPoint program expansion

Starting Dec. 1, 2020, providers should submit authorization requests for the following procedures to TurningPoint for dates of service on or after Jan. 1, 2021:

- Pain management procedures — For all Blue Cross' PPO fully insured groups, select Blue Cross' PPO administrative service contract groups, all Medicare Plus Blue℠ PPO members, all BCN HMO℠ members and all BCN Advantage℠ members
- Joint replacement surgeries and other related arthroscopic procedures — For all Blue Cross' PPO fully insured groups and select Blue Cross' PPO ASC groups
- Spinal procedures — For all Blue Cross' PPO fully insured groups, select Blue Cross' PPO ASC groups and all Medicare Plus Blue PPO members

TurningPoint provider portal

The most efficient way to submit authorization requests is through the TurningPoint provider portal.

Provider offices can access the TurningPoint provider portal by following these steps:

1. Visit **bcbsm.com/providers** and log in to Provider Secured Services.
2. Click on the *Musculoskeletal Service Authorizations through TurningPoint* link.
3. Enter your NPI.

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

Note for out-of-state providers: Log in to your local plan's website and select an ID card prefix from Michigan. This will take you to the Blue Cross Blue Shield of Michigan website. You can then click the *Musculoskeletal Service Authorizations through TurningPoint* link and enter your NPI. You may need to complete a one-time registration process with TurningPoint. After you register, you'll have access to the *Musculoskeletal service authorization through TurningPoint* link in Provider Secured Services.

In addition, any provider can register for direct access to the TurningPoint provider portal through the TurningPoint website. For more information, see "How do I register for direct access to the TurningPoint Provider Portal?" in the **Musculoskeletal procedure authorizations: Frequently asked questions for providers** document.

Please see TurningPoint, continued on Page 47

TurningPoint, *continued from Page 46*

Submitting retrospective authorization requests

For Blue Cross' PPO fully insured groups and Medicare Plus Blue members, the expansion of the TurningPoint program affects spine procedures managed by eviCore for dates of service prior to Jan. 1, 2021. You'll be able to submit retrospective authorization requests to eviCore through April 30, 2021.

For Medicare Plus Blue members, the expansion of the TurningPoint program also affects some pain management procedures that are managed by Medicare Plus Blue Utilization Management for dates of service before Jan. 1, 2021. In addition, for all Blue Cross' PPO fully insured groups, select Blue Cross' PPO ASC groups, all Medicare Plus Blue members, all BCN HMO members and all BCN Advantage members, the expansion affects pain management procedures managed by eviCore for dates of service before Jan. 1, 2021. For all these services, you'll be able to submit retrospective authorization requests to Medicare Plus Blue Utilization Management through March 31, 2021.

Webinar training sessions

We're offering TurningPoint webinar training sessions. Click a link below to register.

Professional provider training — Includes information about TurningPoint's clinical model and operational changes, along with information about using the TurningPoint provider portal.

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 — Includes information about TurningPoint's clinical model and operational changes and the facility verification process.

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 — Includes information about using the TurningPoint provider portal.

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

Additional information

We recently moved all procedure codes managed by TurningPoint into a single document, titled **Musculoskeletal procedure codes that require authorization by TurningPoint**.

You can also find information about TurningPoint on the Musculoskeletal Services pages on the **ereferrals.bcbsm.com** website:

- **Blue Cross Musculoskeletal Services page**
- **BCN Musculoskeletal Services page**

Update: BCN requires authorization for elective pediatric feeding programs

We're updating an article that ran in the September-October issue to clarify that providers should use S0317 with elective inpatient and outpatient pediatric feeding programs.

For dates of service on or after Sept. 1, 2020, services provided through pediatric feeding programs (S0317) require authorization.

This applies to:

- BCN HMO℠ (commercial) members
- Elective inpatient and elective outpatient programs

Submitting authorization requests

Providers should submit authorization requests through the e-referral system.

- Use S0317 when submitting requests for both inpatient and outpatient programs.
- For elective inpatient requests, don't add the length-of-stay procedure code. Use only the S0317 code when submitting authorization requests.

Claim submission for elective inpatient programs

For inpatient authorization requests that Blue Care Network approves, we'll add the length-of-stay procedure code to the case so that you'll be able to bill a regular inpatient admission for reimbursement purposes. Bill the inpatient admission as you normally would. Don't bill elective inpatient pediatric feeding programs with the S0317 code.

Criteria

The criteria used to make determinations on these authorization requests are included in the **Pediatric Feeding Programs medical policy**, which was effective May 1, 2020.

We referred to this medical policy in the **May-June 2020 issue** of *BCN Provider News*, in an article titled "Medical Policy Updates" (page 12).

Additional information

We're updating the following documents to reflect this new authorization requirement:

- **BCN Referral and Authorization Requirements**
- **Procedures codes that require authorization by BCN**

These documents are available on the **Authorization Requirements & Criteria page** in the BCN section of our **ereferrals.bcbsm.com website**. Look under the "Referral and authorization information" heading.

Skilled nursing facilities must sign up for e-referral to submit authorization requests

We're reminding skilled nursing facilities to sign up for e-referral as soon as possible. SNFs must submit authorization requests for commercial members through the e-referral system, starting Dec. 1, 2020.

This is for members covered by our commercial plans:

- Blue Cross' PPO
- BCN HMO℠

We communicated this information in the **Sept.-Oct. issue** of *BCN Provider News* (Page 36). If you haven't already, sign up now. It may take some time to gain access to the system.

Information on **how to sign up** is on our **ereferrals.bcbsm.com** website.

Currently, SNFs complete a form and submit it by fax. When the new requirement goes into effect in December, 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 will apply to requests for admissions and requests for additional SNF days.

We're also offering training opportunities for skilled nursing facilities who need to learn how to use our e-referral system. Visit the **training tools** page of our **ereferrals.bcbsm.com** website to learn about the e-referral system before attending a webinar. Register for one of the webinars by clicking on the appropriate link.

Title	Date and Time	WebEx Link
e-referral Overview for Skilled Nursing Facilities	Tuesday, November 10 10 to 11:30 a.m.	**Click here** to register
e-referral Overview for Skilled Nursing Facilities	Wednesday, November 11 2 to 3:30 p.m.	**Click here** to register
e-referral Overview for Skilled Nursing Facilities	Thursday, November 12 10 to 11:30 a.m.	**Click here** to register
e-referral Overview for Skilled Nursing Facilities	Tuesday, November 17 2 to 3:30 p.m.	**Click here** to register
e-referral Overview for Skilled Nursing Facilities	Wednesday, November 18 10 to 11:30 a.m.	**Click here** to register
e-referral Overview for Skilled Nursing Facilities	Thursday, November 19 2 to 3:30 p.m.	**Click here** to register
e-referral Overview for Skilled Nursing Facilities	Tuesday, December 1 10 to 11:30 a.m.	**Click here** to register
e-referral Overview for Skilled Nursing Facilities	Wednesday, December 2 2 to 3:30 p.m.	**Click here** to register

Benefit period extended for authorized PT, OT and ST for BCN HMO (commercial) members during COVID-19 emergency

Effective Aug. 28, 2020, the benefit period for completing authorized physical, occupational and speech therapy (and physical medicine services by chiropractors) has been extended to 270 days for BCN HMO℠ members whose plans normally have a 60-consecutive-day benefit. The benefit period starts on the date of the first treatment. The extended therapy benefit period will continue until further notice.

What this means

- For any members with therapy authorizations that began on or after March 26 but before Aug. 28 who need an extension beyond 180 days, providers can contact eviCore healthcare® for an extension to 270 days. Providers can request an extension through the eviCore provider portal or by calling 1-855-774-1317.
- If the treatment extends beyond the member's benefit year, the provider must contact eviCore through their provider portal or by calling 1-855-774-1317, to request authorization of services for the new benefit year. The benefit will reset to 270 consecutive days in the new benefit year as long as the extension is still in effect and the member continues to have BCN coverage with the 60-consecutive-day therapy benefit.

Background

We first announced the extension of the benefit period in a web-DENIS message published April 17. At that time, we communicated that members whose plans stipulate a benefit period have 180, not 60, consecutive days within which they must complete therapies that have already been authorized.

We did this to make it easier for members to start or resume their therapies once COVID-19 shelter-in-place restrictions were lifted.

This change is different from — and is in addition to — the extension of the length of time authorizations are valid. That extension is scheduled to conclude Dec. 31. The duration of authorization approvals for elective and non-urgent services was announced in a web-DENIS message on May 29, 2020.

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