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JANUARY – FEBRUARY 2020

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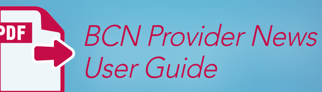

BCN Provider News User Guide

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Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

No referral required for approved BCN providers offering medication-assisted treatment for opioid use disorders

Blue Care Network no longer requires a referral for approved specialists or primary care physicians providing medication-assisted treatment, or MAT, for opioid use disorders involving these medications:

- Buprenorphine (for opioid use disorders)
- Naltrexone for extended-release injectable suspension (Vivitrol®)

We're making this change as part of our efforts to address the opioid use epidemic. In the past, we've required a referral for MAT services when provided by someone other than the member's primary care physician. We hope this change will make it easier for our members to access the treatment they need.

MAT services don't currently require authorization for in-network providers and that will continue to be the case.

Here are some important things you should know:

- This change applies to MAT services for BCN HMO℠ (commercial) members.

  Note: As a reminder, we do not accept referrals of BCN Advantage℠ members to in-network providers. See the article, **BCN no longer accepts referrals for BCN Advantage members staying in-network**, on page 7 of the March-April 2019 *BCN Provider News*.

See Blue Cross, BCN to support providers who offer comprehensive opioid treatment, Page 24

Please see Opioid Use, continued on Page 21

Inside this issue…

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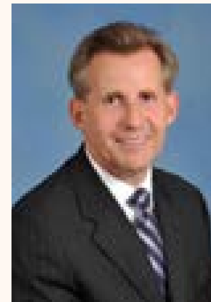
Provider Outreach is now Provider Engagement and Transformation

Provider Outreach has been renamed Provider Engagement and Transformation. The department of provider consultants will continue to provide education on Blue Cross Blue Shield of Michigan and Blue Care Network processes and programs.

"Our team's primary focus is on building and maintaining a strong provider network," said Donna LaGosh, director, Provider Engagement and Transformation for the East, Mid and Southeast Regions. David Brown, director, Provider Engagement and Transformation for the West Region agrees. "Consultants help introduce providers to new programs and help providers have a successful relationship with Blue Cross and BCN," said Brown.

Donna LaGosh



David Brown

Over the next few months, we'll be changing the language to Provider Engagement and Transformation in our provider manuals and on our websites. But don't worry, provider consultants are still available to help with your education needs.

If you need a reminder on where to find information, see our article, *How to find help*, on **Page 3**.

BCN Health e-Blue guide available for providers

We've put together a guide to help providers use the BCN Health e-Blue℠ system. This step-by-step guide shows providers how to find patient detail including eligibility, treatment opportunities by condition and measure, diagnosis gaps and more.

Providers can find this guide on BCN Health e-Blue:

- Visit **bcbsm.com/providers**.
- Click *Login*.
- Log in to Provider Secured Services using your user ID and password.
- Click *BCN Health e-Blue*.
- Click *BCN Health e-Blue User Guide* under *Help Documents* in *Resources*.

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Some reminders about Healthy *Blue* Living physical exams and qualification forms

Each Healthy *Blue* Living℠ HMO member is required to visit his or her primary care physician for an exam within 90 days of enrollment or renewal. Providers can schedule a physical exam for Healthy *Blue* Living HMO members any time throughout the year. If last year's physical was in March, for example, the member can get a physical in January.

There are no limits on how many times a member can schedule a physical exam. BCN encourages each member to see his or her PCP well before the deadline and will accept a qualification form from an office visit occurring up to 180 days prior to the member's renewal date.

Billing for the exam

Providers should use the appropriate ICD diagnosis as the primary diagnosis when billing for the initial or subsequent examination and for the initial assessment for members participating in the Wellness Rewards Tracking program.

Use ICD-10 code Z00.00 or Z00.01. Additional diagnoses may be reported for specific conditions (for example, high blood pressure). There is no member cost-sharing for the completion of the qualification form when the primary diagnosis reported is Z00.00 or Z00.01. There is no member cost-sharing for the office visit when the primary diagnosis is Z00.00 or if a preventive medical examination is reported.

Billing for the qualification form

Providers must file a claim to be paid for completing the Blue Care Network qualification form for a member covered by Healthy *Blue* Living or Healthy *Blue* Living HMO Basic℠ for members participating in BCN's Wellness Rewards Tracking program. Claims for completing the form should be billed in the amount of $40 using the CPT code *99080. Payment will be reflected on the remittance advice.

For detailed billing information for Healthy *Blue* Living:

- Log into Provider Secured Services at **bcbsm.com/providers**.
- Click *BCN Provider Publications and Resources*.
- Click on *Billing/Claims* in the left navigation.
- Click *Healthy* Blue *Living visits and forms* under the "Professional Claims – Billing Instructions" heading

Reminder
How to find help

You're trying to get your work done and you run into a Blue Cross or BCN question or problem that you need to solve. Where do you turn?

Check for help online

You can often save time by looking up information online. Log in to **bcbsm.com** and look in one of our provider manuals or view documents within *BCBSM Provider Publications and Resources* or *BCN Provider Publications and Resources*. If your question is about authorizations or referrals, you may be able to find your answer at **ereferrals.bcbsm.com**.

Call Provider Inquiry

If you can't find your answer online, your first call should be to Provider Inquiry if the question is general in nature or related to claims, benefits or eligibility. Automated information is available 24 hours a day, seven days a week. Plus, you can speak to a Provider Inquiry representative during regular business hours. If your issue isn't satisfactorily resolved, ask the representative to escalate your inquiry to a senior representative.

- 1-800-344-8525 for professional medical providers
- 1-800-482-4047 for vision and hearing providers
- 1-800-249-5103 for facility providers

Consult our provider resource guide

If your question is specific to behavioral health, web technical assistance, pharmacy or several other topics, you can consult our **provider resource guide**. (Blue Cross phone numbers are on the first page and BCN phone numbers are on the second page.)

Please see Finding Help, continued on Page 4

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Updated *Finding your plans and network* guide is now available

The updated *Finding your plans and networks* guide is available and includes a newly revised Blue Cross Blue Shield of Michigan and Blue Care Network list of health plans and provider networks.

This guide helps providers navigate the **Find a Doctor** site on **bcbsm.com** and identifies the plans they accept and the provider networks to which they belong.

When you look yourself up using the Find a Doctor search, you'll find a list of health plans that you can accept. You can use the "Finding your plans and networks" list to help determine the provider networks to which you belong.

The *Finding your plans and networks* guide can be found on web-DENIS. When logged in, follow these steps:

1. Click on *BCBSM Provider Publications and Resources.*
2. Click on *Newsletters and Resources.*
3. Under *Products*, click *Products and Networks.*
4. Click on *Finding your plans and networks.*

You can also find the guide within BCN Provider Publications and Resources.

1. Click on *BCN Provider Publications and Resources.*
2. Under *Products*, click *BCN Products.*
3. Click *Finding your plans and networks.*

Consider keeping a list at your front desk of the health plans accepted by each provider in your office and the provider networks to which they belong. This can help staff answer patient questions.

If you have questions about your network status, call Provider Enrollment and Data Management at 1-800-822-2761. You'll need the following three items when contacting us:

- National Provider Identifier
- The last four digits of the provider's Social Security number (for an individual provider) or tax ID (for a group)
- Primary address and phone number

Finding Help, *continued from Page 3*

Contact a provider consultant

Requests for educational assistance for professional providers should come through a physician organization or medical care group administrator, if you have one. Here's how to find your provider consultant:

- Primary care physicians and medical care groups can look on the **physician organization consultant list**.
- Specialists and other professional providers — To find your list:
  - Go to **bcbsm.com/providers**.
  - Click on *Contact Us* in the upper right corner.
  - Under *Physicians and professionals*, click on either *Blue Cross Blue Shield of Michigan provider contacts* or *Blue Care Network provider contacts.*
  - Click on *Provider consultants* and select your geographic region. (View our **map** to confirm your region.)
- Hospitals and other facility providers – To find your list:
  - Go to **bcbsm.com/providers**.
  - Click on *Contact Us* in the upper right corner.
  - Under Hospitals and facilities, click on either *Blue Cross Blue Shield of Michigan provider contacts* or *Blue Care Network provider contacts.*
  - Click on *Provider consultants* and select your geographic region. (View our **map** for facility providers to confirm your region.)

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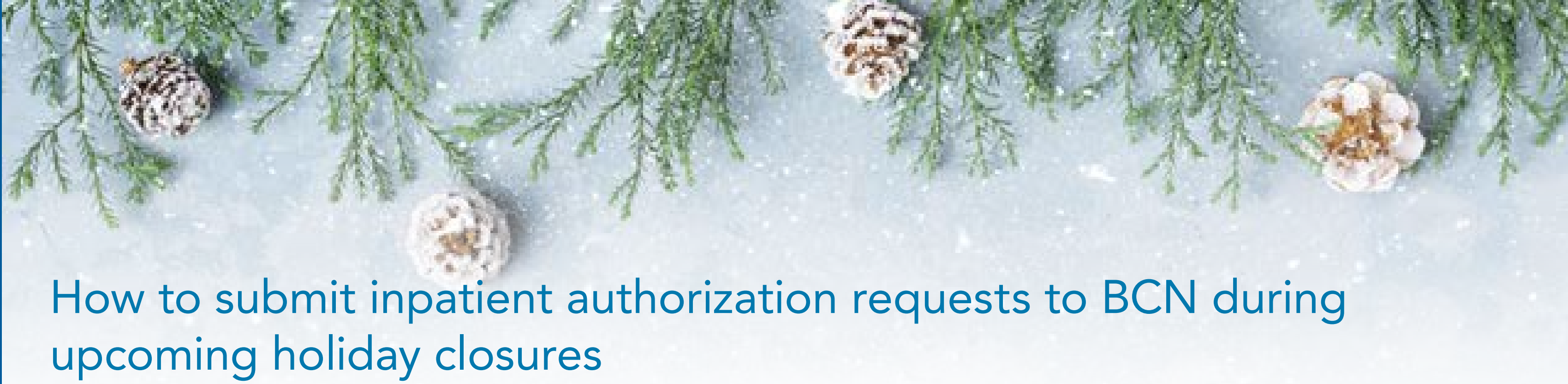

How to submit inpatient authorization requests to BCN during upcoming holiday closures

Blue Cross Blue Shield of Michigan and Blue Care Network corporate offices will be closed on the following dates:

- Dec. 24 and 25 — Christmas
- Dec. 31 and Jan. 1 — New Year's Eve, New Year's Day

During office closures, follow these guidelines when submitting inpatient authorization requests for BCN HMO℠ (commercial) and BCN Advantage℠ members.

Acute initial inpatient admissions

Submit these authorization requests as well as concurrent reviews and discharge dates through the e-referral system, which is available 24 hours a day, seven days a week. If the e-referral system isn't available, fax requests for inpatient admissions and continued stays to BCN HMO (commercial) at 1-866-313-8433 and to BCN Advantage at 1-866-526-1326.

Note: These requests may also be submitted through the X12N 278 *Health Care Services Review — Request for Review and Response* electronic standard transaction.

Refer to the document **Submitting acute inpatient admission requests to BCN** for additional information.

Post-acute initial and concurrent admission reviews

- For BCN HMO (commercial) members, submit these requests by fax at 1-866-534-9994. Refer to the document **Post-acute care admissions: Submitting authorization requests to BCN**
- For BCN Advantage members, naviHealth manages these authorizations. Refer to the document **Post-acute care services: Frequently asked questions for providers**.

Other authorization requests

The types of requests listed below must be submitted by fax. Fax BCN HMO (commercial) requests to 1-866-313-8433. Fax BCN Advantage requests to 1-866-526-1326.

- Authorization requests for sick or ill newborns
- Requests for total parenteral nutrition

Additional information

You can also call BCN's After-Hours Care Manager hotline at 1-800-851-3904 and listen to the prompts for help with the following:

- Determining alternatives to inpatient admissions and triage to alternative care settings
- Arranging for emergency home health care, home infusion services and in-home pain control
- Arranging for durable medical equipment
- Handling emergency discharge planning coordination and authorization
- Handing expedited appeals of utilization management decisions
- Handling of urgent requests that need to be processed within 24 hours

Note: Do not use the after-hours care manager phone number to request authorization for routine inpatient admissions.

As a reminder, when an admission occurs through the emergency room, contact the primary care physician to discuss the member's medical condition and coordinate care before admitting the member.

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Online Training

Sign up for additional training webinars

Provider Experience is continuing its series of training webinars for health care providers and staff. 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 for the upcoming training webinars:

Webinar name	Date and time	Registration
AIM Specialty Health® — Medicare Advantage Medical Oncology	Thursday, January 9, 9 to 10 a.m.	Click here to join session
AIM Specialty Health® — Medicare Advantage Medical Oncology	Wednesday, January 22, 12 to 1 p.m.	Click here to join session
Hyaluronic Acid Knee Injections — Preferred vs. Non-preferred	Thursday, January 30, 1 to 1:30 p.m.	Click here to register
Hyaluronic Acid Knee Injections — Preferred vs. Non-preferred	Tuesday, February 11, 1 to 1:30 p.m.	Click here to register
Hyaluronic Acid Knee Injections — Preferred vs. Non-preferred	Tuesday, February 18, 10 to 10:30 a.m.	Click here to register

We've also posted recordings of previous webinars. You can find them on the *Learning opportunities* and *Provider Training* pages. Here's how to find the links:

For BCN

- Log in to Provider Secured Services.
- Go to *BCN Provider Publications and Resources.*
- Click on *Learning opportunities* under Other Resources.

For Blue Cross

- Log in to Provider Secured Services.
- Go to *BCBSM Newsletters and Resources.*
- Click on *Provider Training* under Popular links.

As additional training webinars become available, we'll communicate about them through web-DENIS, *BCN Provider News*, or *The Record.*

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Improve patient connections with webinar, toolkit and tips

Blue Care Network recognizes the positive impact that online patient portals and member health plan accounts have on improving patient connections, leading to better experiences for patients and providers.

We've put together the following resources to help you engage members with your practice's patient portal, as well as Blue Cross' online member account tools:

Webinar: *Let Us Help You Help Them: Your Patients' Experience*

Watch a recorded presentation to learn about the value of patient portals, how to foster and improve patient engagement with portals and how our member account streamlines accessibility for your patients and makes more efficient use of your time.

Find it on the Provider Secured Services' *BCN Provider Publications and Resources Learning opportunities* page and on the *BCBSM Newsletters and Resources Provider Training* page.

bcbsm.com/ordertoolkit is the easy-to-remember address of the online *Patient Digital Engagement Toolkit* order form. Use it to order our member account registration and mobile app materials. More members with registered Blue Cross accounts add up to fewer inquiries about billing and other coverage-related questions. Active users understand their health plan better, which makes them more prepared and satisfied with the services your practice provides.

Six tips for improving patient engagement with your practice's portal

Physicians and staff should have a basic knowledge of the features of your own patient portal and should be able to offer suggestions about its benefits, how to use it and provide handouts when appropriate.

1. Mention the portal in on-hold messaging and voicemail recordings. Include features patients will enjoy and how to sign up. Emphasize conveniences, such as ability to schedule appointments or to request medications 24/7.
2. Put flyers and posters where patients are waiting for appointments and have time to read.
3. Add a tagline on appointment cards, statements and newsletters, such as: "Tired of playing phone tag? Sign up for our patient portal."
4. Include portal registration details in checkout materials.
5. Put a login link at the top of your website's homepage.

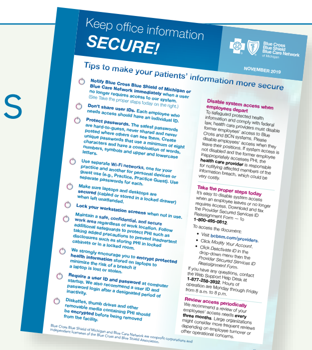
Why improve patient usage of portals?

Online portals offer a convenient and timely method of communication between your practice and patients. Additionally, portals streamline administrative tasks, such as new patient registrations, check-ins and appointment scheduling. Increasing awareness of available self-service tools can deliver better workflows and satisfaction for practices and patients.

Keep information secure flyer available for provider offices

The *Keep office information secure* **flyer** has been redesigned and updated (dated September 2019) and is now available for providers. This flyer offers tips on how providers can make their patients' information more secure including reminders to create strong, unique passwords, using separate Wi-Fi networks and protecting PHI.

Find this flyer on **ereferrals.bcbsm.com** under *Quick Guides*.



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Prior authorization list for Medicare Part B medical specialty drugs is changing in February

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

The following medications will require authorization for dates of service on or after Feb. 3, 2020:

- J3490/C9399 Beovu®
- J3590 Zolgensma®
- J3590 Skyrizi™
- J3490 Spravato™
- J7170 Hemlibra®
- J1555 Cuvitru™
- J1599 Panzyga®
- Q4074 Ventavis®

How to bill

For Medicare Plus Blue and BCN Advantage, we require authorization for these medications for the following sites of care when you bill the medications as a professional service or an outpatient facility service and you bill electronically through an 837P transaction or on a professional CMS 1500 claim form:

- Physician office (place of service code 11)
- Outpatient facility (place of service code 19, 22 or 24)
- Home (place of service code 12)

We also require authorization when you bill electronically through an 837I transaction or using a UB04 claim form for a hospital outpatient type of bill 013x.

Important reminder

You must obtain authorization before administering these medications. Use the NovoLogix® online tool to submit your authorization requests. It offers real-time status checks and immediate approvals for certain medications. Also note:

- For Medicare Plus Blue, if you have a Type 1 (individual) NPI and you checked the "Medical Drug PA" box when you completed the Provider Secured Access Application form, you already have access to NovoLogix. If you didn't check that box, you can complete an **Addendum P form** to request access to NovoLogix and fax it to the number on the form.
- For BCN Advantage, if you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix.

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

List of requirements

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

The authorization requirements for these drugs will be reflected on the drug list on Jan. 1, 2020.

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Get ready for annual visits for your Medicare Advantage patients

In the new year, you'll start seeing new and existing BCN Advantage[SM] patients for their Welcome to Medicare visits, annual wellness visits or routine physical exams. Here's some important information about these different visits to help you prepare:

- New BCN Advantage members should be scheduling their Welcome to Medicare preventive visit, also known as the initial preventive examination, and their routine physical exams.
- Existing BCN Advantage members should begin scheduling their annual wellness visit and their routine physical exams.

Welcome to Medicare visit

This preventive visit is sometimes referred to as the initial preventive examination. This is a one-time appointment for new Medicare patients to be scheduled within their first 12 months of enrollment. Medicare pays for one Welcome to Medicare visit per member, per lifetime.

This visit is a great way to get up-to-date information on health screenings, shot records, family medical history and other preventive care services. These visits can be scheduled at the same time or coordinated with the patient's routine physical exam to get the best picture of your patient's health.

The Welcome to Medicare visit will include a health risk assessment and self-reported information from your patient to be completed before or during the visit. For more information about health risk assessments, visit **Framework for Patient-Centered Health Risk Assessments** on the Centers for Disease Control and Prevention website.

During this visit, you should:

- Perform a health risk assessment.
- Record your patient's medical and social history (like alcohol or tobacco use, diet and activity level).
- Check height, weight and blood pressure.
- Calculate body mass index.
- Perform a simple vision test.
- Review potential risk for depression and patient level of safety.
- Offer to talk about creating advance directives.
- Educate the patient on preventive services and prescribe appropriate services.
- Create a screening schedule (checklist) for appropriate preventive services.
- Give flu and pneumococcal shots, and referrals for other care, if needed.

Billing code for Welcome to Medicare visit, also called initial preventive physical examination
G0402

Annual wellness visit

The annual wellness visit is a chance for you to develop or update your patient's personalized prevention plan based on his or her current health situation and risk factors.
A health risk assessment is also part of the annual wellness visit. It includes self-reported information from your patient to be completed before or during the visit.

Medicare will cover an annual wellness visit every 12 months for patients who've been enrolled in Medicare for longer than 12 months. Patients can schedule their annual wellness visit on the same day or coordinate it with their routine physical exam (see below) to help give you a complete view of their health.

Services at the annual wellness visit include:

- Health risk assessment
- Review of medical and family history
- Develop or update a list of current providers and prescriptions
- Height, weight, blood pressure and other routine measurements
- Detection of any cognitive impairment
- Personalized health advice
- A list of risk factors and treatment options

Please see Annual Visits, continued on Page 10

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Annual Visits, *continued from Page 9*

- Educate on preventive services and prescribe appropriate services
- A review and update of the screening schedule (checklist) for appropriate preventive services
- Advance care planning

Billing codes for annual wellness visits, which include a personalized prevention plan of service
G0438 — First visit AWV, can only be billed one time, 12 months after a G0402 (IPPE)
G0439 — Annual wellness visit (subsequent)

Note: G0438 or G0439 must not be billed within 12 months or previous billing of a G0402 (IPPE)

Routine physical exam

This exam is typically covered annually by the patient's Medicare Advantage health care plan. These exams are part of preventive services that aren't part of the Welcome to Medicare or annual wellness visit.

Routine physical exams are used to get information about the patient's medical history, family history and perform a head-to-toe assessment with a hands-on examination to assess your patient's health, address any abnormalities or signs of disease. Routine physical exams should include the following:

- A visual inspection
- Palpitation
- Auscultation
- Manual examination

Billing codes for annual exams or physicals	
New patient	**Established patient**
*99386 (40-64 years old) *99387 (65 years and older)	*99396 (40-64 years old) *99397 (65 years and older)

Care plans

These preventive visits are an excellent opportunity for you and your patients to plan their care for the year. Care plans should include a schedule for preventive services and health screenings, many of which are required annual services to meet Healthcare Effectiveness Data and Information Set, commonly known as HEDIS® specifications.

You'll need to recommend and prescribe — or refer your patient —preventive services that apply to his or her care plan. Some examples of preventive services include:

- Colon cancer screening
  - FOBT yearly
  - Sigmoidoscopy every five years
  - Colonoscopy every 10 years
  - Cologuard every three years
- Breast cancer screening
  - Mammography every two years
- Osteoporosis testing in older women
  - Bone mineral density testing in women ages 65 to 85 every two years
- Comprehensive diabetes care
  - A1c blood sugar screening — two to four times per year
  - Urine microalbumin screening — yearly
  - Retinal eye exam — every other year if negative or every year if positive

These visits also provide an opportunity to review or create a risk assessment for your patients, including a full list of their long-term chronic conditions. This will help your patients take advantage of disease and care management programs, as well as prevention initiatives.

These visits benefit both you and your patient by:

- Uncovering care management opportunities
- Identifying practice patterns
- Managing patient medications better
- Reducing avoidable hospital admissions

For more information on risk adjustment and HEDIS best practices, refer to our online provider manuals.

Note: BCN Advantage only reimburses one evaluation and management code on a date of service.

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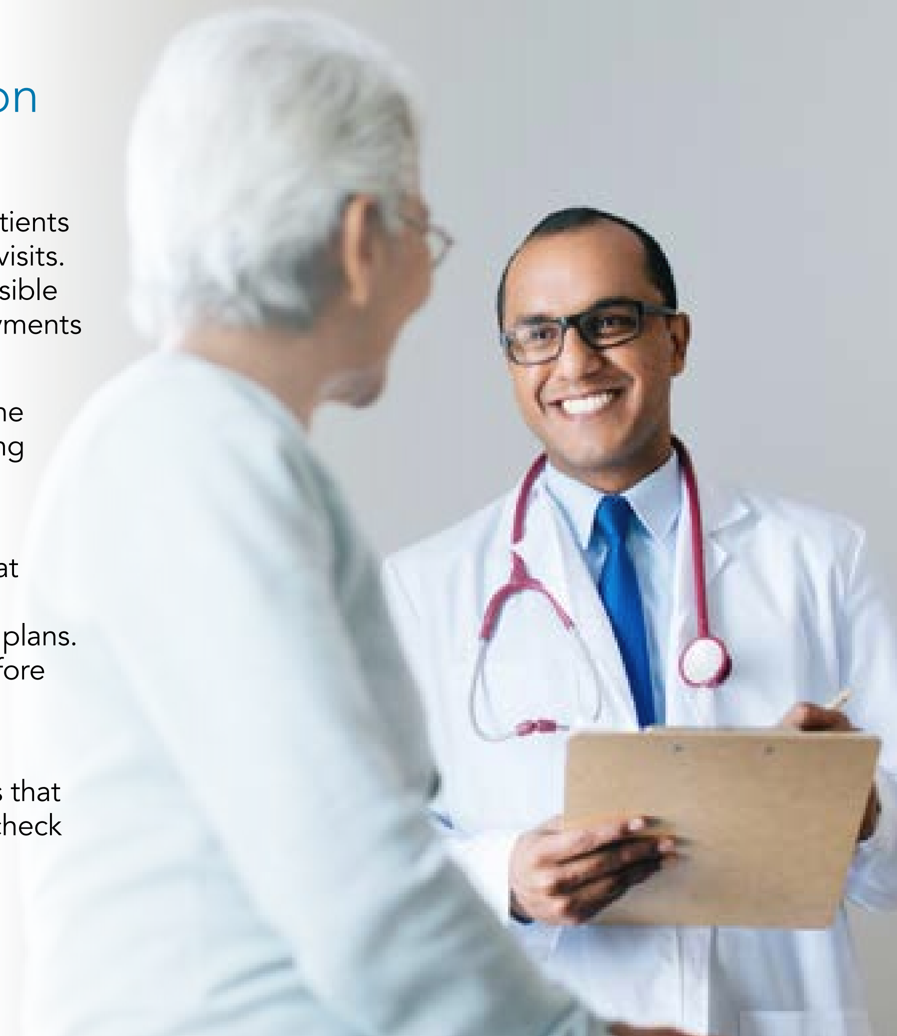
Providers need to get authorization for out-of-network visits



We require providers who refer their BCN Advantage℠ patients to out-of-network providers to get authorization for those visits. If the services are not authorized, the member isn't responsible for any costs apart from their applicable deductible, copayments or coinsurance.

Likewise, if a member thinks a service is covered because he or she was referred by an in-network provider, the rendering physician can't bill the patient for that service other than applicable deductible, copayments or coinsurance.

The Centers for Medicare & Medicaid Services requires that we educate our contracted physicians about specific items and services that are covered by our Medicare Advantage plans. If you're unclear, contact us to request an authorization before providing the service or referring a member to an out-of-network provider.

Make sure you seek authorization for services for providers that are considered out-of-network. And remember to always check web-DENIS for plan eligibility and benefits.

Reminder
BCN Advantage product changes for 2020 include premium decreases

We announced BCN Advantage℠ product changes for 2020 in the previous issue. Premiums decreased significantly for some plans.

We also introduced an over-the-counter benefit and a new Snowbird Travel Care program for seniors who spend time outside of Michigan.

See the **November-December 2019** issue for details. Articles appear on pages 1, 7 and 8 of the issue.

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Reminder

AIM oncology webinars available in January for BCN Advantage

Non-clinical provider staff can learn about the new medical oncology program and how to use the AIM *ProviderPortal*[SM] by attending a webinar. Dates are available in January.

As a reminder, providers will need to obtain authorizations from AIM Specialty Health® for some medical oncology and supportive care medications, beginning in January. See the article on Page 9 of the November-December 2019 ***BCN Provider News*** for details.

To attend a webinar, click on your preferred date and time below and then click Add to my calendar. (The times below are all Eastern time. If the link opens for you in Pacific time, just save it to your calendar. It should automatically change to Eastern time.)

Thursday, Jan. 9, 2020, 9 to 10 a.m.,

Wednesday, Jan. 22, 2020, 12 to 1 p.m.

Providers need to use the AIM *ProviderPortal* to obtain authorizations for some medical oncology medications starting in January. For information about registering for and accessing AIM *ProviderPortal*, see the **Frequently Asked Questions** page of the AIM website.

Document and use the body mass index assessment in the primary care setting

When collecting documentation on height and weight in the medical record, don't forget to calculate the patient's body mass index. BMI is considered the most efficient and effective method for assessing excess body fat.

Careful monitoring of BMI will help health care providers identify adults who are at risk and provide focused advice and services to help them reach and maintain a healthier weight.

There is a HEDIS® star measure that assesses adults ages 18 to 74 who had an outpatient visit with BMI documentation in the past two years. Documented calculation of BMI is commonly overlooked. We can't meet the criteria for this measure without it.

View the star measure tip sheet on the right for ICD-10 codes to include on claims and tips for talking with patients who are at increased risk of developing diseases associated with obesity.

Star measure tip sheet

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Options for treatment-resistant depression

By Dr. Kristyn Gregory

For many patients experiencing major depressive disorder, antidepressants and therapy can bring relief and allow them to regain function. However, a subset of the population with the disorder, classified as treatment-resistant depression, doesn't respond to standard treatments.

Treatment-resistant depression, also called TRD, is characterized as a major depressive disorder that persists even after adequate antidepressant therapy. While there is a lack of consensus on a definition of TRD, a patient is generally considered therapy-resistant when consecutive treatments with two different antidepressant products — used for a sufficient length of time and at an adequate dose with affirmation of treatment adherence — fail to induce a clinically meaningful improvement.

TRD is by no means a rare disorder. Current estimates show prevalence ranging from 10% to 29% of adults with major depressive disorder having symptoms that don't respond significantly to treatment, according to a peer-reviewed article in **PLOS Journal**.

Strategies for treatment-resistant depression can be classified into optimization (increasing the dose), augmentation (with an additional agent or therapy), combination (two or more anti-depressants), switching (to an agent in another class) and somatic **therapies** (electroconvulsive therapy and transcranial magnetic stimulation).

In addition to the above strategies, Blue Care Network provides coverage for these treatment options with prior authorization.

ECT

Electroconvulsive therapy, or ECT, is considered a somatic therapy and is one of the oldest treatments available for both depression and treatment-resistant depression. ECT, used in large-scale clinical studies of depression, has been found to be more effective than antidepressant drugs. **ECT** is a valid therapy for the treatment of depression, including severe and resistant forms. In addition to being effective, ECT acts quicker than traditional antidepressants that can take six to eight weeks to have the desired effect. The need for anesthesia, as well as memory and cognitive concerns, can limit the use of ECT in some patients.

Please see From the medical director, continued on Page 14

Dr. Kristyn Gregory is a medical director at Blue Care Network.

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From the medical director, *continued from Page 13*

TMS

Transcranial magnetic stimulation, or TMS, sends bursts of energy from electromagnets to specific areas of the brain to affect nerve cell communication. The procedure can be done in a physician's office and is noninvasive. Sessions last about 30 minutes and treatment is generally delivered five days a week for four to six weeks. Accrued **evidence** from meta-analyses suggests that TMS has moderate effect in both major depressive disorder and treatment-resistant depression, comparable, though less robust, to those seen in patients treated with ECT, and similar to those seen with antidepressant treatment in TRD. Predictors of response include lower age, lower degrees of treatment resistance and the absence of comorbid anxiety or psychotic symptoms.

Esketamine (Spravato nasal spray)

Spravato™ is a non-competitive N-methyl D-aspartate receptor antagonist indicated, in conjunction with an oral antidepressant, for the treatment of treatment-resistant-depression in adults. Spravato gained approval from the U.S. Food and Drug Administration for TRD in adults on March 5, 2019. It is intended for patient administration under the direct observation of a health care provider and requires that patients are monitored by a health care provider for at least two hours after administration.

In addition to the above requirements, it also has REMS (Risk Evaluation and Mitigation Strategy) requirements: (REMS is a drug safety program that the FDA can require for certain medications with safety concerns to make sure the medication benefits outweigh the risks.)

- Spravato is available only through a limited distribution program that is part of the SPRAVATO™ REMS program.
- All health care settings and pharmacies must be certified in the Spravato REMS program before they can purchase, dispense or supervise administration of Spravato.
- All patients must be enrolled in the Spravato REMS program before they can receive the drug.

The process is described more in depth at the **Spravato website**.

Get information about BCN prior authorization for Spravato in the document, **Blue Cross and BCN utilization management medical drug list**.

You can find instructions on how to access the Novologix application on the **ereferrals.bcbsm.com** website.

Help patients get annual health screenings

Blue Care Network is preparing for annual HEDIS medical record reviews. BCN team members will be contacting provider offices from January to May to request medical records. As always, we appreciate your cooperation and collaboration in making HEDIS 2020 a success.

As part of our joint effort in making this happen, we've created this checklist for you to help patients take care of their heath.

- ✓ Get an early start with patients in 2020. Take a BMI on every patient. Note that all patients under 20 years old need a BMI percentage, height and weight measure.
- ✓ For children ages 3 to 17, complete counseling for nutrition. Complete checklist verifying nutrition discussion and counseling for physical activity. Recommend patients exercise one hour per day; complete checklist verifying discussion of physical activity.
- ✓ For diabetics complete the following: HbA1c, nephropathy monitoring (urine for protein or on ACE/ARB medications, or renal diagnosis), controlled blood pressure (≤139/89), diabetic eye exam. Schedule follow-up visits as results indicate.
- ✓ For patients with hypertension, follow-up on medication regimen; document lifestyle changes and blood pressure to ensure appropriate management. A controlled blood pressure is 139/89 or lower.
- ✓ For members discharged from an inpatient setting, complete a medication reconciliation within 30 days of discharge.
- ✓ Review history and order colon cancer screening, if needed (age 50 to 75, colonoscopy every 10 years). For patients that refuse a colonoscopy, suggest they complete a FOBT or FIT-DNA test.
- ✓ Order a mammogram for women ages 50 to 74 (if they haven't completed one in the last 24 months) and a cervical cancer screening for women ages 21 to 64 (if they haven't had one in three years or five years). Patients must be 30 years old on the date of service of the PAP/HPV to meet the five-year interval requirement.
- ✓ Talk to every patient about the need for physical exercise — 30 minutes a day.
- ✓ For seniors assess the following: fall risk, safe environment, incontinence management, immunizations.
- ✓ Schedule a depression assessment.
- ✓ Childhood and adolescent immunizations: Check immunization record on MCIR and schedule visits to have complete and timely immunizations.

Blue Care Network appreciates your efforts to keep our members healthy.

For information on preventive services, call the Quality and Population Health's HEDIS® message line at 1-855-228-8543.

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Criteria corner

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

Question:

For Adult/Geriatric Psychiatry – Inpatient – Episode Day 2-13 – Symptoms Improving or Expected to Improve and Not Clinically Stable for Discharge – Finding Present within Last 24 Hours – Positive Acute Psychotic Symptoms Uncontrolled, would this also include an exacerbation of chronic symptoms?

For instance: If a patient was chronically psychotic at baseline (responding to internal stimuli, paranoid ideation without risk of harm to self or others, delusional but without risk of harm to self or others), but was experiencing an increase in the severity of these symptoms (auditory hallucinations telling them to harm themselves, paranoid to the point of refusing medications), would we be able to select this criteria point?

Answer:

Yes, acute exacerbation of a chronic issue may be used to apply criteria, as long as "Finding present within last 24 hours" is true.

Question:

The Intervention criteria point found across several levels of care, Modification of the treatment plan based upon patient response to the plan (as in Adult/Geriatric Psychiatry or Child/Adolescent Psychiatry – Inpatient – Episode Day 2-13 and 14-X), doesn't have a footnote with additional information.

Are there scenarios or examples that would demonstrate to new staff what these sorts of modifications would include? Things like adjustments to medications and changes in one-to-one staffing status are addressed elsewhere in the criteria.

Answer:

A modification to the treatment plan can include increasing contacts with therapists, adding an additional family meeting, ordering consultants or psychological testing. The goal is to ensure that active treatment is being provided.

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February focus is on heart health

In support of American Heart Month in February, Blue Care Network is reminding providers to screen patients for conditions that can affect heart health. BCN supports Michigan Quality Improvement Consortium guidelines, including those for screening and management of high cholesterol, high blood pressure, overweight and obesity and tobacco control.

High blood pressure is a serious condition that can lead to coronary heart disease, kidney disease and possibly stroke. About one in three adults in the United States has hypertension that usually starts from the ages of 35 to 50, according to the Centers for Disease Control and Prevention. There are no symptoms or warning signs and it can affect anyone regardless of race, age or gender.

Risk factors that can't be controlled

- Age (45 and older in men, 55 and older for women)
- Family history of early heart disease
- Race and ethnicity

Risk factors that can be controlled by the member with guidance from the provider

- High cholesterol (high LDL or "bad" cholesterol)
- Low HDL ("good" cholesterol)
- Smoking
- High blood pressure
- Diabetes
- Obesity, overweight
- Physical inactivity
- Diet

Factors that determine LDL ("bad") cholesterol level

- Heredity
- Diet
- Weight
- Physical activity and exercise
- Age and gender
- Alcohol
- Stress

Refer to the MQIC guidelines for **lipid screening and management** and **Management of overweight and obesity in adults** for more information.

Providers can also refer members to the **National Heart Lung and Blood Institute** website for information about heart disease.

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Tools to help educate your pregnant patients

Everyone expects pregnancy to bring an expanding waistline. But some women are surprised when other body changes occur, such as:

- Body aches
- Fatigue
- Heartburn
- Morning sickness

All these changes make it important for women to see their doctor for prenatal care not only for the baby, but for themselves.

The U.S. Department of Health and Human Services' **website on women's health** offers information on body changes and pregnancy-related discomfort to help educate women on what to expect and how to manage symptoms. The site addresses such symptoms as body aches, breast changes, dizziness, hemorrhoids and nasal problems.

The number of prenatal tests that women are expected to get can also be confusing and overwhelming. Expectant mothers may wonder what kind of prenatal tests need to be done and why. Share the *Common prenatal tests* flyer below that lists common prenatal tests, with your patients. For more information about pregnancy care and tests, go to **womenshealth.gov**.

Resources

Blue Cross offers the Pregnancy Assistant program through Blue Cross Health & Well-Being, powered by WebMD®. It provides information and activities for women who are pregnant, planning to become pregnant or those supporting someone who's pregnant.

PreNatal Tests Flyer

WebMD Health Services is an independent company supporting Blue Care Network by providing health and well-being services.

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

- Cryoablation of peripheral nerves (IOVERA® System)
- In-office needle arthroscopy

Covered services

- Transcatheter aortic valve implantation for aortic stenosis
- Intravitreal corticosteroid implants
- Light and laser therapy for vitiligo and atopic dermatitis
- Refractive keratoplasties, phototherapeutic keratectomy and implantation of intrastromal corneal ring segments
- Stereotactic radiosurgery and stereotactic body radiotherapy
- Amniotic membrane and amniotic fluid
- Sleep disorders, diagnosis and medical management
- Urinary biomarkers for cancer screening, diagnosis and surveillance
- Heart-kidney transplant combined
- Lung/double lung and liver transplant combined
- Moderate penetrance variants associated with breast cancer in individuals at high breast cancer risk
- Genetic testing — molecular markers in fine needle aspirates (FNA) of the thyroid
- KRAS, NRAS and BRAF variant analysis in metastatic colorectal cancer
- Fecal calprotectin

Medical Policy Updates

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Blue Cross co-sponsors medication-assisted waiver training courses

The Michigan Center for Clinical Systems Improvement and Michigan Opioid Collaborative are hosting the American Society of Addiction Medicine: Treatment of Opioid Use Disorder course, which will provide the required eight educational hours to obtain the medication-assisted treatment waiver to prescribe buprenorphine in office-based treatment of opioid use disorders.

In partnership with MOC, Mi-CCSI (through a secured grant with the state of Michigan) is providing these scholarships to attend and complete the in-person training:

- $500.00 for providers, MD and DO
- $250 for NP/PAs

  Payment goes to the first 15 registrants. If you have questions, email Amy Wales at amy.wales@miccsi.org or call 1-616-551-0795, ext. 11

Use the links below to register.

January 20, 2020 | 8 am - 5 pm
Lyon Meadows Conference Center
53200 Grand River Ave.
New Hudson, MI 48165

April 27, 2020 | 8 a.m. – 5 p.m.
Hagerty Center, Rm A+B
715 E. Front St.
Traverse City, MI 49686

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We've discontinued our fax line for the Behavioral Health Incentive Program

We suspended the Behavioral Health Incentive Program self-reported Therapeutic Alliance and Primary Care Physician Contact measures on July 2018. Since these submissions are no longer accepted, we've discontinued the BHIP fax line.

Coordination between primary care physician and behavioral health professional is essential to diagnose and treat ADHD

Research shows that many children with attention deficit hyperactivity disorder aren't treated consistently, if they get treatment at all.

The American Academy of Pediatrics recommends a multidisciplinary approach to diagnose and treat ADHD. This includes coordination between the patient's pediatrician and a behavioral health professional.

ADHD is one of the most common mental disorders affecting children. The average age of diagnosis is 7 years old, and symptoms usually first appear between 3 and 6 years old.

Eleven percent of American children have been diagnosed with ADHD and 6.1% are treated with medications, according to the healthline.com, a health information website.

The National Institute of Mental Health Multimodal Treatment Study on ADHD demonstrated that significant improvement in behavior can be achieved in children who receive carefully monitored medication in combination with behavioral treatment.

Follow-up Care for Children Prescribed ADHD Medication is one of the HEDIS® measures. It evaluates the effectiveness of care by measuring the percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one within 30 days of initiating the ADHD medication. For more information on the measure, refer to the HEDIS tip sheet below.

ADHD HEDIS Tip Sheet

Providers can also reference clinical practice guidelines on our secure provider portal and Michigan Quality Improvement Consortium **guidelines** for ADHD. An MQIC app for Android and iOS devices is available at Google Play and the App store.

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References:

Retrieved from ncqa.org/hedis/measures***

1. Visser, S.N., M.L. Danielson, R.H. Bitsko, J.R. Holbrook, M.D. Kogan, R.M. Ghandour, … & S.J. Blumberg. 2014. "Trends in the parent-report of health care provider-diagnosed and medicated attention-deficit/hyperactivity disorder: United States, 2003-2011." Journal of the American Academy of Child & Adolescent Psychiatry, 53(1), 34–46.
2. The American Psychiatric Association. 2012. Children's Mental Health. **psychiatry.org/mental-health/people/children*****
3. Center for disease Control and Prevention. (2017, April 10). *Behavior therapy for young children with ADHD.* Retrieved from Center for disease Control and Prevention: **https://www.cdc.gov/ncbddd/adhd/behavior-therapy.html**
4. Healthline (2019) Retrieved from **https://www.healthline.com/health/adhd/facts-statistics-infographic**

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Opioid Use, *continued from Page 1*

- This applies only to providers identified in the BCN claims system as offering MAT and only to claims with diagnosis codes F10 through F1999, F55 through F558, F01 through F09, F20 through F54, and F59 through F99.
- You must bill using procedure codes *99201 through *99205 (for initial visits) and *99212 through *99215 (for subsequent office visits).
- You must bill modifier 25 with both initial and subsequent visits.
- Behavioral health providers must submit MAT claims using the appropriate procedure codes, with modifier 25 as the primary modifier and their appropriate behavioral health modifier as a secondary modifier on the claim line.

If you're a primary care physician who is paid through capitation, you can also submit claims for reimbursement of MAT services; these services will be paid on a fee-for-service basis outside of your capitation.

How to qualify for approval as a MAT provider

Providers must qualify to be reimbursed for MAT services by us.

First, whether you're a specialist or a primary care physician, you must let us know that you offer MAT services so we can verify your qualifications and update our systems. To notify us, email BCNContracts@bcbsm.com and request a copy of the *MAT Questionnaire*.

Next, you must complete the questionnaire, indicating, among other things, the types and location of the MAT services you provide, and return it to us.

Once we approve you as a MAT provider, your MAT claims will be eligible for reimbursement without a referral on record.

Check our online provider directory

You can check our online provider directory to determine whether you're already approved as a MAT provider.

Providers who are approved for MAT show "Medication Assisted Treatment (MAT) for Opioid Use - Suboxone/ Buprenorphine" or "Medication Assisted Treatment (MAT) for Opioid Use – Vivitrol/Naltrexone" as an area of focus.

To check our online directory:

1. Visit **bcbsm.com**.
2. Click Find-a-Doctor.
3. Click **Search without logging in**.
4. Click *Doctors by name*.
5. Enter your name.
6. Click the search icon.
7. Scroll down and review the "Areas of Focus" designated for you.

Members can also use the online provider directory to locate providers who are approved for MAT.

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

Reminder

Michigan board-certified behavior analysts must be licensed starting Jan. 7 to be reimbursed by BCN and Blue Cross

Starting Jan. 7, 2020, board-certified behavior analysts practicing in Michigan must have a current license from the state to be eligible for reimbursement from Blue Cross and Blue Care Network. BCBAs without licenses aren't eligible for reimbursement for services provided on or after Jan. 7, 2020.

For information on the licensing process, refer to the **Behavior Analysts webpage** of the Michigan Department of Licensing and Regulatory Affairs website.

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We're sending reminders to patients to adhere to ADHD follow-up visits

We're sending letters to encourage members whose children have received a prescription for attention deficit hyperactivity disorder medication to see their physicians for follow-up visits as outlined in the ADHD HEDIS® measure.

Children 6 to 12 years old should see a physician within 30 days of first being prescribed medication to treat ADHD. If they stay on the medical for at least 210 days, they should have two follow-up visits with nine months after the initiation phase.

We're also sending letters to remind physicians to schedule the follow-up visits as noted in the HEDIS measure.

Physicians may need to adjust a medication dose or discuss strategies to alleviate side effects. We also encourage you to coordinate care with other behavioral health physicians or primary care doctors who are seeing your patients.

Telehealth visits are acceptable for the continuation and maintenance phase visits. However, only one of the two visits may be a telephone visit. (See the HEDIS tip sheet and article on **Page 20** for more information.)

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Governor Whitmer signs bill maintaining current practice standards for licensed professional counselors

Governor Gretchen Whitmer has signed a bill into law maintaining that licensed professional counselors can continue their clinical practices without interruption. This move blocks new rules recently drafted by the Michigan Department of Licensing and Regulatory Affairs that would have prohibited licensed professional counselors from clinically diagnosing and providing psychotherapy to their clients. **Public Act 96 of 2019** also makes training requirements for LPCs match up with current practice. The law is effective Jan. 27, 2020.

Blue Cross Blue Shield of Michigan and Blue Care Network will continue working with licensed professional counselors as they're currently contracted with no interruption in providing services to our members.

Encourage follow-up care after emergency room visits

In the United States, 18% of adults and 13% to 20% of children experience mental illness, according to the National Committee for Quality Assurance.

Follow-up care for mental health issues is crucial to:

- Decrease repeat visits to the emergency room
- Improve physical and mental function
- Increase compliance with follow-up instructions

In 2016, NCQA also found that 20.1 million Americans older than age 12 were classified as having a substance use disorder. The study showed timely follow-up care for these individuals helped to reduce:

- Substance use
- Future ER use
- Hospital admissions and length of stay

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Blues Brief debuts Behavioral health edition

We've introduced a special issue of *Blues Brief* that covers topics of interest to behavioral health providers. It'll be published at least annually.

Blues Brief, BCN Provider News and *The Record* are available by email subscription.

To add *Blues Brief* to your subscriptions, click the *Manage Subscriptions* link at the bottom of your *BCN Provider News* or *The Record* newsletter emails. You can also visit the subscription page at **bcbsm.com/providers** to choose your preferred *Blues Brief* versions and manage your other subscriptions.

Blue Cross co-sponsors medication-assisted treatment waiver training

The Michigan Center for Clinical Systems Improvement and Michigan Opioid Collaborative are hosting the American Society of Addiction Medicine: Treatment of Opioid Use Disorder course, which will provide the required eight educational hours to obtain the medication-assisted treatment waiver to prescribe buprenorphine in office-based treatment of opioid use disorders.

See article on **Page 19** for details and registration links.

BCN behavioral health fee schedule for 2020 now available

The BCN behavioral health fee schedule for 2020 is now available on our website.

This fee schedule is effective for services on or after Jan. 1, 2020. It applies to Michigan behavioral health professional providers participating with the BCN HMO℠ and BCN Advantage℠ provider networks.

You can access the 2020 BCN behavioral health fee schedule on BCN's Behavioral Health page within Provider Secured Services. To access this document:

- Visit **bcbsm.com/providers**.
- Click *Login*.
- Log in to Provider Secured Services using your user ID and password.
- Click *BCN Provider Publications and Resources* on the right side of the Provider Secured Services welcome page.
- Click *Behavioral Health*.
- Look under the "General resources" heading.

New MAT incentive part of BHIP program

In 2020, BCN will add a new incentive opportunity for psychiatrists who deliver medication-assisted treatment to patients diagnosed with opioid use disorder. The $500 incentive will pay based on each patient who is treated with naltrexone or buprenorphine. (Methadone is not part of this incentive opportunity.)

The incentive is available to providers who are currently providing MAT or those who choose to begin this as a new service.

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Blue Cross, BCN to support providers who offer comprehensive opioid treatment

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

What this means

Starting Jan. 1, 2020, Blue Cross and BCN will use bundled rates to reimburse providers who offer certified opioid treatment programs, or OTPs. The bundled payment includes both drug and non-drug components and may allow for intensity add-on codes to be used when needed.

This will apply to services for our Medicare Advantage members (Medicare Plus Blue℠ PPO and BCN Advantage℠) and our commercial members (Blue Cross' PPO and BCN HMO℠).

Once this change goes into effect, certified OTPs may qualify for bundled reimbursement.

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

Blue Cross and BCN will implement this program beginning Jan. 1, 2020, as required by the SUPPORT Act. For Blue Cross and BCN members, applicable member cost-sharing amounts will apply. See sidebar about the SUPPORT program.

Here's some additional information you need to know.

What is an OTP?

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

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

What's next?

Remember to watch for our upcoming communications on OTPs.

About the CMS SUPPORT program

Section 2005 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act established a new Medicare Part B benefit for opioid use disorder treatment services, including medications for medication-assisted treatment, furnished by opioid treatment programs.

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

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

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HEDIS 2019 results

The Healthcare Effectiveness Data and Information Set, or HEDIS®, is the most widely used set of performance measures in the managed care industry and is used by the National Committee for Quality Assurance for accreditation.

HEDIS is part of an integrated system to establish accountability in managed care organizations. It was originally designed to address private employers' needs as purchasers of health care and has been adopted for use by public purchasers, regulators and consumers. It's now used by Centers for Medicare & Medicaid Services for their star ratings.

Blue Care Network noted the following areas of improvement in 2019:

Commercial

- Adult BMI assessment
- Antidepressant medication management — effective acute and continuation phase treatment
- Appropriate testing for children with pharyngitis
- Appropriate treatment for children with upper respiratory infection (inverted rate)
- Asthma medication ratio
- Avoidance of antibiotic treatment in adults with acute bronchitis (inverted rate)
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening in women
- Childhood immunizations — combo 10
- Colorectal cancer screening
- Comprehensive diabetic care — HbA1c testing, poorly controlled >9.0% (inverted rate), control <8%, eye exam, blood pressure control
- Controlling high blood pressure
- Emergency department utilization
- Follow-up care after hospitalization for mental illness — seven days and 30 days
- Follow-up care for children prescribed ADHD medication — initiation, continuation and maintenance phase
- Immunization for adolescents — Combo 2
- Initiation and engagement of alcohol and other drug dependence treatment — engagement phase
- Medication management for people with asthma
- Pharmacotherapy management of COPD exacerbation — bronchodilators and systemic corticosteroid
- Plan all-cause readmissions
- Prenatal and postpartum care — timeliness of prenatal care and postpartum care
- Statin therapy for patients with cardiovascular disease — adherence
- Statin therapy for patients with diabetes — adherence
- Weight assessment and counseling for children and adolescents — nutrition counseling and physical activity counseling
- Well-child visits in the first 15 months of life — six or more visits
- Well-child visits in the third, fourth, fifth and sixth years of life

Marketplace or Qualified Health Plan

- Adult BMI assessment
- Annual monitoring for patients on persistent medications
- Antidepressant medication management — effective acute and continuation phase treatment
- Appropriate testing of children with pharyngitis
- Appropriate treatment for children with upper respiratory infection (inverted rate)
- Cervical cancer screening
- Childhood immunizations — combo 3
- Colorectal cancer screening
- Comprehensive diabetes care — HbA1c control < 8.0%, eye exam, medical attention for nephropathy

Please see HEDIS results, continued on Page 26

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- Controlling high blood pressure
- Immunization for adolescents — combo 2
- Medication management for people with asthma
- Plan all-cause readmissions
- Prenatal and postpartum care — timeliness of prenatal care
- Use of imaging studies for low back pain (inverted rate)
- Weight assessment and counseling for children and adolescents — BMI %, nutrition counseling and physical activity counseling
- Well-child visits in the third, fourth, fifth, and sixth years of life

Medicare

- Adult BMI assessment
- Antidepressant medication management — effective acute and continuation phase
- Breast cancer screening
- Colorectal cancer screening
- Comprehensive diabetic care — HbA1c testing, poorly controlled >9.0% (inverted rate), control <8%, eye exam, blood pressure control, medical attention for nephropathy
- Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis
- Initiation and engagement of alcohol and other drug dependence treatment — initiation phase
- Hospitalizations for potentially preventable complications
- Medication reconciliation post-discharge
- Non-recommended PSA-based screening in older men
- Osteoporosis management in women who had a fracture
- Persistence of beta-blocker treatment after heart attack
- Pharmacotherapy management of COPD — systemic corticosteroid and bronchodilators
- Plan all-cause readmissions
- Statin therapy for patients with cardiovascular disease — therapy and adherence
- Statin therapy for patients with diabetes — therapy and adherence

Thank you to all our affiliated practitioners for providing quality care to our members and allowing us to conduct medical record reviews for HEDIS and various audits.

Primary care practitioners can still find opportunities to provide aggressive intervention in the management and care of our members with diabetes and high blood pressure, and in ordering procedures for breast, cervical and colorectal cancer screening.

We're involved in activities throughout the year that positively impact our HEDIS rates, including:

- Physician Quality Rewards Program which is tied to some of the HEDIS measures
- Health e-Blue℠ website
- Member gaps in care letters
- Member outreach reminder telephone calls
- Member and physician education through publications
- Member health fairs
- Care management calls and letters
- Member incentive programs
- HEDIS interventions
- HEDIS/CAHPS summits

We look forward to working with you to promote continued improvement in all areas of patient care.

If you'd like more information about HEDIS, call the Quality Management & Population Health Department at 1-855-228-8543.

HEDIS 2019 Commercial results

HEDIS 2019 Marketplace/ QHP results

HEDIS 2019 Medicare results

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Tips to manage acute low back pain in adults

According to the Michigan Quality Improvement Consortium, 90% of low back pain episodes resolve within six weeks, regardless of treatment. Typically, imaging isn't required within the first six weeks, unless red flags are present. Red flags include:

- Cauda Equina Syndrome
- Cancer
- Infection
- Spinal fracture
- Loss of bladder control or bowel control

Without red flags, a conservative approach is preferred. You might recommend that the patient:

- Stay active as tolerated by pain.
- Avoid bed rest.
- Do back exercises and stretches.
- Be careful of injuries.
- Use over-the-counter pain relievers.

MQIC published **Management of Acute Low Back Pain in Adults** as a guideline for providers. It recommends focusing on patient reassurance, detailed history and physical exam, therapy, referrals and medication strategies.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure changes for 2020

The HEDIS® 2020 measure, Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis, has changed for 2020 to include members 3 months and older. It previously included members 18 to 64.

This measure assesses whether a member received an antibiotic on or three days after the diagnosis of acute bronchitis or bronchiolitis. Members who didn't receive an antibiotic medication indicates appropriate treatment for this condition.

The measure is now episode-based (previously a member-based measure), meaning the member is eligible for the measure for every diagnosis of acute bronchitis or bronchiolitis.

Certain comorbid conditions or competing diagnoses can exclude the member from the measure. These conditions or diagnoses include COPD, HIV, malignant neoplasms and pharyngitis.

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Quality improvement program information available upon request

We provide you with ongoing information about our quality improvement programs and clinical practice guidelines through this newsletter. Approved clinical practice guidelines are available to all Blue Care Network primary care physicians, primary care groups and specialists. Copies of the complete guidelines are available on our secure provider portal. To access the guidelines:

- Log 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 that focus on improving health outcomes for BCN members. Examples include member and provider incentives, reminder mailings, phone calls, newsletter articles and educational materials. We use medical record reviews and quality studies to monitor compliance with the guidelines.

Document and use the body mass index assessment in the primary care setting

When collecting documentation on height and weight in the medical record, don't forget to calculate the patient's body mass index. BMI is considered the most efficient and effective method for assessing excess body fat.

See details in the article on **Page 12**.

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Ketoprofen 25 mg will require authorization and have new quantity limits for BCN HMO and Blue Cross PPO commercial members

The following changes are coming for Blue Cross' PPO (commercial) and BCN HMO℠ (commercial) members:

- For new courses of treatment involving ketoprofen 25 mg that begin on or after Dec. 1, 2019, you'll have to obtain authorization. If you don't obtain authorization, the member may be responsible for the full cost of the drug.
- Effective March 1, 2020, ketoprofen 25 mg will be limited to four capsules per day or 120 capsules per 30 days. Requests for Blue Cross Blue Shield of Michigan and Blue Care Network to cover greater quantities will need to include documentation showing that the greater quantity is medically necessary.

Members who start taking ketoprofen before Dec. 1, 2019, can continue their treatment courses. However, as of March 1, 2020, you'll need to obtain authorization for these members to continue therapy.

For treatment courses starting on or after Dec. 1, 2019, you'll need to obtain authorization before members begin taking ketoprofen.

We'll notify affected members of these changes, and we'll encourage them to talk to you if they have concerns.

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

These requirements don't apply to Medicare Plus Blue℠ PPO or BCN Advantage℠ members.

We're adding some medications to the Part B specialty prior authorization drug list

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

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

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

We'll change how we cover some brand name and generic drugs, starting Jan. 1, 2020. We'll also set new quantity limits on certain drugs.

We continuously review prescription drugs to provide the best value for our members, control costs and make sure our members are using the right medication for the right situation.

Note: Changes vary by drug list as specified below. For a complete list of covered drugs go to **bcbsm.com/pharmacy** and click *Drug lists*.

These changes apply to members with commercial pharmacy benefits (not Medicare D). They don't apply to the Federal Employee Program®.

Preferred Drug List changes

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

The brand-name drugs that will have a higher copayment are listed with the covered preferred alternatives that have similar effectiveness, quality and safety. The example brand names of covered 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	Covered preferred alternatives
Absorica®	Acne	Amnesteem®, Claravis®, Myorisan®, Zenatane®
Amitiza®	Constipation	lactulose, Linzess®, Trulance®
Arcapta Neohaler®	Respiratory conditions	Serevent Diskus®
Atrovent HFA®	Respiratory conditions	Atrovent solution®, Incruse Ellipta®
Byvalson®	Heart conditions	Bystolic® plus Diovan®, Tenormin® plus Diovan®, Toprol XL® plus Diovan®
Fulphila®	Hematopoietic agent	Neulasta®, Udenyca®
Gralise®	Neuropathic pain	Cymbalta®, Elavil®, Neurontin®, Tofranil®, Ultram®
Hexalen®	Chemotherapy	Go to **bcbsm.com** for a complete list of covered alternatives. Members should discuss treatment options with their doctors.
Moxeza®	Antibiotic	Ciloxan® drops, Garamycin®, Tobrex® drops, Vigamox®
Relenza®	Influenza	Tamiflu®
Sancuso®	Nausea and vomiting	Emend® capsules, Kytril®, Zofran®
Tabloid®	Chemotherapy	Go to **bcbsm.com** for a complete list of covered alternatives. Members should discuss treatment options with their doctors.
Xofluza®	Influenza	Tamiflu®
Zontivity®	Heart conditions	Aspirin plus Plavix®, Effient®

Please see Drug coverage, continued on Page 31

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Drug coverage, *continued from Page 30*

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

The brand-name and generic drugs that won't be covered are listed with the covered 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 covered alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs to be excluded	Common use	Covered preferred alternatives
Akynzeo®	Nausea and vomiting	Emend® capsules, Kytril®, Varubi® tablets, Zofran®
Altabax®	Skin conditions	Bactroban® ointment, gentamicin cream, ointment
Amrix®	Muscle relaxants	Flexeril®, Norflex®, Parafon Forte DSC® 500 mg, Robaxin®, Zanaflex®
Aubagio®	Multiple sclerosis	Gilenya®, Mayzent®, Tecfidera®
Bactroban® cream	Skin conditions	Bactroban® ointment, gentamicin cream, ointment
Conzip®, tramadol extended-release biphasic capsules	Pain (opioid)	Ryzolt®, Ultram®
Denavir®	Skin conditions	Generic oral antivirals (Famvir®, Valtrex®, Zovirax®); Zovirax® ointment
Diabetes meters and test strips: All **except** Freestyle and OneTouch	Diabetes	Freestyle and OneTouch meters and test strips
Doral®	Insomnia	Ambien®, Ambien® CR, Lunesta®, Restoril®, Sonata®
Emend® powder packets for suspension	Nausea and vomiting	Emend® capsules, Kytril®, Varubi® tablets, Zofran®
Epaned®	Heart conditions	Vasotec®
Fibricor®	High cholesterol	Lofibra®, Tricor®, Trilipix®
Firdapse®	Lambert-Eaton myasthenic syndrome	Ruzurgi®
Generic Kristalose®	Constipation	lactulose
Granix®	Hematopoietic agent	Nivestym®, Zarxio®
Indocin® suspension	Pain (non-steroidal anti-inflammatory (NSAID))	Generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®)
Jadenu®, Sprinkle	Chelating agent	Desferal®
Lorzone®	Muscle relaxants	Flexeril®, Norflex®, Parafon Forte DSC® 500 mg, Robaxin®, Zanaflex®
Mulpleta®	Thrombocytopenia	Doptelet®
Onzetra Xsail®	Migraines	Amerge®, Frova®, Imitrex®, Imitrex® nasal spray, Maxalt®
Orfadin®	Hereditary tyrosinemia Type 1	Nityr®
Pandel®	Skin conditions	Diprosone® lotion; Elocon® cream, lotion, solution; Kenalog® ointment, spray; Synalar® ointment; Westcort® ointment

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Drugs to be excluded	Common use	Covered preferred alternatives
Pennsaid® 2%	Pain (non-steroidal anti-inflammatory (NSAID))	Flector® patches, Pennsaid® 1.5%
Qbrelis®	Heart conditions	Prinivil®
Sitavig®	Antiviral	Famvir®, Valtrex®, Zovirax®
Striverdi Respimat®	Respiratory conditions	Serevent Diskus®
Subsys®	Pain (opioid)	Actiq®, Dilaudid®, morphine sulfate IR, oxycodone IR
Tivorbex®	Pain (non-steroidal anti-inflammatory (NSAID))	generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®)
Tudorza®	Respiratory conditions	Incruse Ellipta®
Vivlodex®	Pain (non-steroidal anti-inflammatory (NSAID))	generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®)
Xatmep®	Immunosuppressant	methotrexate tablet
Xerese®	Skin conditions	generic oral antivirals (Famvir®, Valtrex®, Zovirax®); Zovirax® ointment
Zipsor®	Pain (non-steroidal anti-inflammatory)	generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®)
Zovirax® cream	Skin conditions	generic oral antivirals (Famvir®, Valtrex®, Zovirax®); Zovirax® ointment

Clinical Drug List and Custom Drug List changes

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

The brand-name drugs that will have a higher copayment are listed with the covered preferred alternatives that have similar effectiveness, quality and safety. The example brand names of covered 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	Covered preferred alternatives
Alocril®	Allergies	Alrex®, Bepreve®, Elestat®, Opticrom®, Optivar®, Pataday®, Patanol®, Pazeo®
Alomide®	Allergies	Alrex®, Bepreve®, Elestat®, Opticrom®, Optivar®, Pataday®, Patanol®, Pazeo®
Granix®	Hematopoietic agent	Nivestym®, Zarxio®
Neupogen®	Hematopoietic agent	Nivestym®, Zarxio®

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

The brand-name and generic drugs that won't be covered are listed with the covered 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 covered alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs to be excluded	Common use	Covered preferred alternatives
Aerospan®	Respiratory conditions	Arnuity Ellipta®; Asmanex®, HFA; Flovent® HFA, Diskus; Pulmicort Flexhaler®; Pulmicort solution®; Qvar RediHaler®
Altabax®	Skin conditions	Bactroban® ointment; gentamicin cream, ointment
Amrix®	Muscle relaxants	Flexeril®, Norflex®, Parafon Forte DSC® 500 mg, Robaxin®, Zanaflex®
Aplenzin®	Mood disorders	Wellbutrin®, Wellbutrin® SR, Wellbutrin® XL
Bactroban cream®	Skin conditions	Bactroban® ointment; gentamicin cream, ointment
Conzip®, tramadol extended-release biphasic capsules	Pain (opioid)	Ryzolt®, Ultram®
Denavir®	Skin conditions	Zovirax® ointment
Doral®	Insomnia	Ambien®, Ambien® CR, Lunesta®, Restoril®, Sonata®
Fibricor®	High cholesterol	Lofibra®, Tricor®, Trilipix®
Forfivo® and bupropion XL 450mg tablet	Mood disorders	Wellbutrin®, Wellbutrin® SR, Wellbutrin® XL
Indocin® suspension	Pain (non-steroidal anti-inflammatory (NSAID)	generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®)
Kristalose®	Constipation	lactulose
Lazanda®	Pain (opioid)	Actiq®, Dilaudid®, morphine sulfate IR, oxycodone IR
Lorzone®	Muscle relaxants	Flexeril®, Norflex®, Parafon Forte DSC® 500 mg, Robaxin®, Zanaflex®
Nascobal®	Vitamins	cyanocobalamin injection (vitamin B-12)
Pandel®	Skin conditions	Diprosone® lotion; Elocon® cream, lotion, solution; Kenalog® ointment, spray; Synalar® ointment; Westcort® ointment
Xerese®	Skin conditions	generic oral antivirals (Famvir®, Valtrex®, Zovirax®); Zovirax® ointment
Zovirax® cream	Skin conditions	generic oral antivirals (Famvir®, Valtrex®, Zovirax®); Zovirax® ointment

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Custom Select Drug List changes

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

The brand-name drugs that will have a higher copayment are listed with the covered preferred alternatives that have similar effectiveness, quality and safety. The example brand names of covered 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	Covered preferred alternatives
Alocril®	Allergies	Alrex®, Bepreve®, Elestat®, Opticrom®, Optivar®, Pataday®, Patanol®, Pazeo®
Alomide®	Allergies	Alrex®, Bepreve®, Elestat®, Opticrom®, Optivar®, Pataday®, Patanol®, Pazeo®

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

The brand-name and generic drugs that won't be covered are listed with the covered 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 covered alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs to be excluded	Common use	Covered preferred alternatives
Aerospan®	Respiratory conditions	Arnuity Ellipta®; Asmanex®, HFA; Flovent® HFA, Diskus; Pulmicort Flexhaler®; Pulmicort solution®; Qvar RediHaler®
Brand Harvoni®	Hepatitis	Epclusa®, Zepatier®
Chorionic gonadotropin®	Infertility	Pregnyl®
Exalgo®	Pain (opioid)	Butrans®, Duragesic®, methadone, MS Contin®, Opana ER®, Ultram ER®
Fibricor®	High cholesterol	Lofibra®, Tricor®, Trilipix®
Granix®	Hematopoietic agent	Nivestym®, Zarxio®
Indocin® suspension	Pain (non-steroidal anti-inflammatory (NSAID))	generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®)
Neupogen®	Hematopoietic agent	Nivestym®, Zarxio®
Novarel®	Infertility	Pregnyl®

Quantity limits

These drugs will have changes to the amount that can be filled. These changes apply to all drug lists.

Drug	Quantity limit effective Jan. 1, 2020
Lyrica® capsules (all strengths)	Three capsules daily
EpiPen®, Epipen® Jr., epinephrine auto- injector, Symjepi®	Four pens per fill, maximum of eight pens per year

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Blue Care Network will no longer cover select drugs under the medical benefit for commercial members starting in February

BCN HMO℠ commercial plans will no longer cover the following medications when administered by a doctor or other health care professional under the medical benefit. This is effective Feb. 1, 2020.

HCPCS billing code	Short description	Brand name
J0135	Adalimumab injection	Humira®
J1438	Etanercept injection	Enbrel®
J1595	Injection glatiramer acetate	Copaxone®
J1826/Q3027/ Q3028	Interferon beta-1a injection	Avonex®, Rebif®
J1830	Interferon beta-1b / .25 mg	Betaseron®, Extavia®
J2941	Somatropin injection	-
J3110	Teriparatide injection	Forteo®
J8515	Cabergoline, oral 0.25 mg	-
S0136	Clozapine, 25 mg	-
S0137	Didanosine, 25 mg	Videx®
J2170	Mecasermin injection	Increlex®
J1324	Enfuvirtide injection	Fuzeon®

These therapies can be safely and conveniently self-administered in the home and don't require administration by a health care professional.

Blue Cross isn't making any other changes to the management of these therapies. All are covered by BCN HMO prescription drug plans and are available through pharmacies that dispense specialty drugs. Your patients can also find them through an AllianceRx Walgreens Prime Specialty Pharmacy.

As with any specialty drug, members should call their retail pharmacy first to see if that particular medicine is available.

We'll send a letter to the affected members to advise them to talk to their doctors about this change and to prescribe this medication for purchase from a pharmacy. Providers who continue to administer these medications to their patients on or after Feb. 1 will be responsible for the cost.

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We'll cover select hyaluronic acid products, starting Jan. 1

Blue Cross Blue Shield of Michigan and Blue Care Network will consider the following hyaluronic acid products to be either covered or preferred under the medical benefit, effective Jan. 1, 2020.

- Durolane®
- Euflexxa®
- Gelsyn-3™
- Supartz FX™

We'll consider the following to be either noncovered or nonpreferred hyaluronic acid products, also effective Jan, 1: Gel-one®, GenVisc 850®, Hyalgan®, Hymovis®, Monovisc®, Orthovisc®, Synvisc®, Synvisc-One®, TriVisc®, Visco-3™, Synojoynt™ and Triluron™.

This change will apply to Blue Cross' PPO (commercial), Medicare Plus Blue℠ PPO, BCN HMO℠ (commercial) and BCN Advantage℠ members. This change won't apply to self-funded General Motors, Fiat Chrysler Automobiles, Ford Motor Company and UAW Retiree Medical Benefit Trust commercial groups.

Blue Cross' PPO and BCN HMO commercial members

- Members who began receiving noncovered hyaluronic acid products before Jan. 1, 2020, can continue their treatment courses to completion. For future treatment courses that begin on or after Jan. 1, 2020, we encourage providers to talk to their patients about using a covered hyaluronic acid product.
- For treatment courses that begin on or after Jan. 1, 2020, we'll require members to use a covered hyaluronic acid product; these products don't require authorization.
- We'll deny claims for noncovered hyaluronic acid drugs.
- We'll notify affected members of these changes and encourage them to discuss treatment options with you.

Medicare Plus Blue and BCN Advantage members

- Members who began receiving nonpreferred hyaluronic acid products before Jan. 1, 2020, can continue their treatment courses to completion. For future treatment courses that begin on or after Jan. 1, 2020, we encourage providers to talk to their patients about using a preferred hyaluronic acid product.
- For treatments on or after Jan. 1, 2020, we'll require members to use preferred hyaluronic acid products; these products won't require authorization. If you select a nonpreferred hyaluronic acid product for a member, you'll have to obtain authorization.

The U.S. Food and Drug Administration has approved 16 hyaluronic acid products. To date, no study has shown that one hyaluronic acid product is superior to others.

Note: See Page 6 for dates and registration information on hyaluronic acid webinars.

Save time and submit prior authorization requests electronically for pharmacy benefit drugs

Providers can now use their electronic health record or CoverMyMeds®* to submit prior authorizations for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members with commercial pharmacy benefits.

For details, read the article on Page 24 of the November-December ***BCN Provider News***.

Documentation and coding for rheumatoid arthritis

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Nearly 1.5 million people in the United States — 70% of whom are women — have rheumatoid arthritis, or RA. Symptoms usually begin between the ages of 30 and 60, but may occur later in life for men. A family history increases the odds of having RA; however, most people with RA have no family history. Although the exact cause of RA is unknown, scientific evidence shows that genes, hormones and environmental factors play a role in the abnormal response of the immune system.

Documentation and coding tips

- Information about coding for RA can be found in Chapter 13 ("Diseases of the Musculoskeletal System and Connective Tissue") of the ICD-10-CM coding book. Look under "Inflammatory polyarthropathies (M05-M14)."
- Involvement of any joints, body systems and organs should be specified in order to code RA to the highest specificity.
- Most codes have site and laterality designations. Site represents the joint or organ involved.
- For categories where no "multiple site" codes are provided, and more than one joint or organ is involved, multiple codes should be used to represent the different sites involved.
- Rheumatoid factor test results and interpretation should be documented to code to the highest specificity.

The chart below gives some examples of rheumatoid arthritis with or without rheumatoid factor, and with or without organ and systems involvement:

Condition	ICD-10 code
Rheumatoid lung disease with rheumatoid arthritis of right shoulder	M05.111
Rheumatoid vasculitis with rheumatoid arthritis of left hip	M05.252
Rheumatoid arthritis of right ankle and foot with involvement of other organ and systems	M05.671
Rheumatoid arthritis with rheumatoid factor of left knee without organ or systems involvement	M05.762
Rheumatoid polyneuropathy with rheumatoid arthritis of right hip	M05.551
Rheumatoid heart disease with rheumatoid arthritis of right elbow	M05.321
Rheumatoid arthritis with rheumatoid factor of left shoulder without organ or systems involvement	M05.712

Sources:

- arthritis.org
- 2019 ICD-10-CM Professional for Physicians

None of the information included in this article is intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with all applicable state and federal laws and regulations.

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How to submit multiple-line surgery claims for a hospital-based facility

When submitting a multiple-line surgery in a hospital-based facility to Blue Care Network, there are guidelines you need to follow for correct reimbursement. One of the frequent errors we receive is submitting each surgery line with charges.

You need to enter the total amount for the surgery charges on the first surgery line and zero on each additional surgery line. All lines submitted are considered in the reimbursement. Claims need to be submitted this way because the processing system rolls the lower RVU lines up to the highest for the correct reimbursement amount. Typically, the procedure with the highest relative value unit should be listed first.

For more information, refer to the Claims chapter in the *BCN Provider Manual* or the document *Multiple-line surgery in a hospital-based facility*.

- Log in to Provider Secured Services.
- Go to *BCN Provider Publications and Resources*.
- Click on *Billing/Claims* in the left-hand navigation.
- Scroll down to Facility Claims/Billing Instructions.
- The document is listed under Outpatient services.

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:

- Applying ICD-10 codes
- Clinical editing appeals reminders
- Procedures with pay percent reductions

Clinical editing billing tips

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We've made changes in authorizing human organ transplants for BCN members

We've changed the authorization process for human organ transplants for BCN HMO℠ and BCN Advantage℠ members, starting Nov. 1, 2019.

Here's what's staying the same:

- Continue to submit transplant authorization requests either through the e-referral system or by calling BCN Utilization Management at **1-800-392-2512**.
- Continue to fax your initial clinical information to BCN Utilization Management at **1-800-675-7278**.

Here's what's changing:

- **Checklist for additional clinical information, if required.** If we need additional clinical information, you'll receive a checklist from the corporate Human Organ Transplant Program unit. It'll include these important numbers:
  - Fax: **1-866-752-5769**
    Use this number to submit additional clinical information.
  - Phone: **1-800-242-3504**
    Human Organ Transplant Program unit.
    Call this number with any questions after you submit your initial request.
- **Two authorization numbers.** You'll receive two authorization numbers for approved requests — one for the transplant procedure and one for the inpatient stay. (Before Nov. 1, you received only one authorization number that covers both the procedure and the stay.)
- **Where to find the authorization numbers.** Once we make a decision, you'll see both authorization numbers in the e-referral system. You'll also receive a letter that will show both numbers. We'll fax the letter to the person who requested the authorization. (Before Nov. 1, you saw one number in the e-referral system and didn't receive any letters.)
- **Attachment A included.** For approved authorizations, the letter you receive will include the *Human Organ Transplant Program Attachment A: Authorization Form*. This will indicate that your claim will be reimbursed with a global rate, which includes payment for both the procedure and the inpatient stay. (Before Nov. 1, you didn't receive this form for BCN authorizations.)
- **You must initiate reauthorization after one year.** If the patient doesn't receive the transplant within one year of the initial authorization date, you must request a new authorization either through the e-referral system or by calling BCN Utilization Management at **1-800-392-2512**. (Prior to Nov. 1, the reauthorization request was handled internally by BCN.)

We're working to minimize any inconvenience in how we handle this authorization process. If you have any questions or need after-hours assistance, call **1-800-242-3504**.

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We're aligning peer-to-peer review request processes for acute non-behavioral health non-elective inpatient admissions

The process for requesting a peer-to-peer review with a Blue Cross Blue Shield of Michigan or Blue Care Network medical director for acute non-behavioral health, non-elective inpatient admissions is now the same for all lines of business.

It applies to inpatient admission authorization requests denied for Blue Cross' PPO, Medicare Plus Blue℠ PPO, BCN HMO℠ and BCN Advantage℠ members.

Here's what you need to know:

- Submit all requests using the **Physician peer-to-peer request form** (for non-behavioral health cases). Complete and fax the form to 1-866-373-9468, from 8 a.m. to 5 p.m. Eastern time (except weekends and holidays).
  - **Note:** We'll reach out to you the next business day. The peer-to-peer review will be held Monday through Friday between 9 a.m. and 4 p.m. Eastern time (except holidays).
- Using the form is optional for now but will be **mandatory** starting Jan. 1, 2020.
  - **Note:** Continue to call 1-866-346-7299 for Blue Cross' PPO and Medicare Plus Blue peer-to-peer review requests through the end of the year. The number will be taken out of service Jan. 1, 2020.
- The request process is not changing for BCN HMO and BCN Advantage. Currently, you submit BCN requests using the form. It's the process for Blue Cross' PPO and Medicare Plus Blue requests that's changing.
- The form is available on our **ereferrals.bcbsm.com** website, on the **Blue Cross Authorization & Requirements & Criteria page** and the **BCN Authorization & Requirements & Criteria page**. We've updated the form for use with all lines of business.

Additional information

For information about requesting peer-to-peer reviews on denied authorization requests for various types of services, read **How to request a peer-to-peer review with a Blue Cross or BCN medical director**. This document is also available on the Blue Cross and BCN Authorization Requirements & Criteria pages on **ereferrals.bcbsm.com**.

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BCN to deny claims for unauthorized outpatient toxicology lab services by non-JVHL labs starting Jan. 1

Blue Care Network will deny claims for outpatient toxicology laboratory services provided by an out-of-network laboratory without authorization from Joint Venture Hospital Laboratories, starting Jan. 1. This applies to BCN HMO℠ (commercial) claims.

BCN contracts with JVHL to provide the statewide provider network for all outpatient laboratory services. This means:

- Claims for outpatient toxicology laboratory services are eligible for payment only if the service provider is affiliated with JVHL or proper authorization is obtained from JVHL for out-of-network services.
- Claims for outpatient laboratory services must be submitted to JVHL.
- Referring providers should use JVHL network laboratories.
- To obtain a service that is not provided by a JVHL laboratory, you must first submit a request for clinical review to JVHL.

What you need to know

- The physician who orders the toxicology laboratory services is responsible for knowing whether the laboratory is in network and whether the procedure is covered by BCN. This information can be verified by JVHL.
- The procedure must be properly authorized before the service is provided and the specimen is directed to an out-of-network laboratory.
- A provider may not balance bill a BCN member whose toxicology laboratory services are denied as out of network.

For help identifying a JVHL network laboratory, call the JVHL administrative offices at 1-800-445-4979. JHVL business hours are 8 a.m. to 4:30 p.m. Eastern time, Monday through Friday; they're closed from noon to 1 p.m. You can leave a message 24/7.

Updated e-referral questionnaires coming for BCN and Medicare Plus Blue PPO

By Jan. 26, 2020, we expect the following updated questionnaires to open in the e referral system for certain procedures. In addition, we'll update preview questionnaires, authorization criteria and medical policies on the **ereferrals.bcbsm.com** website as updated questionnaires are released.

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

Updates to existing questionnaires

Updated questionnaires will open in the e-referral system for BCN HMO, BCN Advantage and Medicare Plus Blue℠ PPO authorization requests (unless otherwise noted) for the following services:

- Deep brain stimulation — Opens only for BCN HMO and BCN Advantage members
- Hip replacement surgery, initial

Please see e-referral questionnaires, continued on Page 42

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e-referral questionnaires, *continued from Page 41*

- Hyperbaric oxygen — Opens only for BCN HMO members
- Hyperbaric oxygen — Opens only for BCN Advantage members
- Knee arthroscopy, chondroplasty — Opens only for BCN HMO and BCN Advantage members
- Knee arthroscopy, diagnostic — Opens only for BCN HMO and BCN Advantage members
- Knee arthroscopy, limited synovectomy — Opens only for BCN HMO and BCN Advantage members
- Knee arthroscopy, major synovectomy — Opens only for BCN HMO and BCN Advantage members
- Knee arthroscopy, removal of loose body or foreign body — Opens only for BCN HMO and BCN Advantage members
- Knee arthroscopy, removal or stabilization of intra-articular osteochondral lesion — Opens only for BCN HMO and BCN Advantage members
- Knee arthroscopy, resection or repair of stable or unstable meniscus tear — Opens only for BCN HMO and BCN Advantage members
- Knee replacement, initial nonunicondylar
- Knee replacement, initial unicondylar
- Other lumbar spine surgery procedures — Opens only for BCN HMO and BCN Advantage members
- Shoulder replacement surgery, initial

In addition, we'll simplify the questionnaires for some authorization requests as follows:

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

Preview questionnaires

For all these services, you can access preview questionnaires at **ereferrals.bcbsm.com**. They show the questions that are in the e-referral system to help you prepare your answers ahead of time.

To find the preview questionnaires:

- For BCN: Click *BCN* and then **Authorization Requirements & Criteria**. Scroll down and look under the Authorization criteria and preview questionnaires heading.
- For Medicare Plus Blue: Click *Blue Cross* and then **Authorization Requirements & Criteria**. In the Medicare Plus Blue PPO members section, look under the "Authorization criteria and preview questionnaires — Medicare Plus Blue PPO" heading.

Authorization criteria and medical policies

We also posted links to the pertinent authorization criteria and medical policies on the Authorization Requirements & Criteria pages.

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Providers will need to submit authorization requests to TurningPoint for musculoskeletal procedures with a date of service on or after June 1

Providers will need to submit authorization requests through TurningPoint Healthcare Solutions for musculoskeletal surgical procedures, with a date of service on or after June 1, 2020. This includes spine and joint replacement surgeries and other related procedures, We're also expanding the number of musculoskeletal services requiring authorization. This change will apply to BCN HMO℠ (commercial), BCN Advantage℠ and Medicare Plus Blue℠ PPO.

In selecting TurningPoint, we're working toward aligning all utilization management for specific musculoskeletal procedures under one umbrella for BCN HMO (commercial), BCN Advantage and Medicare Plus Blue PPO product lines. TurningPoint specializes in musculoskeletal utilization management and offers provider-friendly systems with a specialized focus on improving patient outcomes.

Here are some things you should know:

- For procedures currently authorized by BCN, such as joint replacements and arthroscopies:
  - If the date of service is **before June 1, 2020**, providers should continue to seek authorization through e-referral.
  - If the date of service is **on or after June 1**, providers should seek authorization through TurningPoint.

  TurningPoint will be able to begin receiving authorization requests on May 1, 2020.
- If there are new codes requiring authorization from TurningPoint that don't require prior authorization today, providers will need to seek authorization from TurningPoint, **but not until May 1, 2020**, when their phone and fax lines and provider portal will be active. This applies to procedures for dates of service **on or after June 1, 2020**.

We'll provide more information in the next issue about how to submit authorizations to TurningPoint and which procedure codes are affected. We'll also publish a webinar schedule for you and your office staff.

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e-referral upgrades coming in February

Two new enhancements are coming to the e-referral system mid-February 2020. Individual users will be able to flag referrals and authorizations that they determine need follow up for any reason. Each Details page will include a My List check box. Selecting the box adds it to My List and displays a flag next to the record in Search results and on the Home page; deselecting removes it. You will be able to flag up to 150 cases.

- A new feature in the My List page and the Case Communications panel will let you see at a glance if you have read a specific incoming communication. Unread communications will display a blue dot on the envelope icon. Once read, the icon will change to just the envelope.

To learn more about these changes, please attend one of our upcoming *Learning to use the New Features of e-referral* webinars:

- **Tuesday, January 21, 10 to 10:30 a.m.**
- **Thursday, January 23, 1 to 1:30 p.m.**
- **Tuesday, January 28, 2 to 2:30 p.m.**
- **Wednesday, January 29, 11 to 11:30 a.m.**
- **Tuesday, February 4, 10 to 10:30 a.m.**
- **Thursday, February 6, 1 to 1:30 p.m.**

The **e-referral User Guide** and **e-Learning modules** will be updated on the ***Training Tools* page** of **ereferrals.bcbsm.com** to reflect these changes. Please watch **ereferrals.bcbsm.com** for the latest updates and information.

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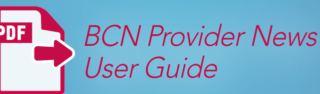

BCN Provider News User Guide

Blue Distinction Specialty Care takes aim at opioid use disorders

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

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

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

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

Please see Blue Distinction, continued on Page 2

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

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

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

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

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Feedback | Subscribe

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Blue Distinction, *continued from Page 1*

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

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

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

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

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

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

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

Take our *Blues Brief* survey

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

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

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

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Provider survey, *continued from Page 1*

Room for improvement

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

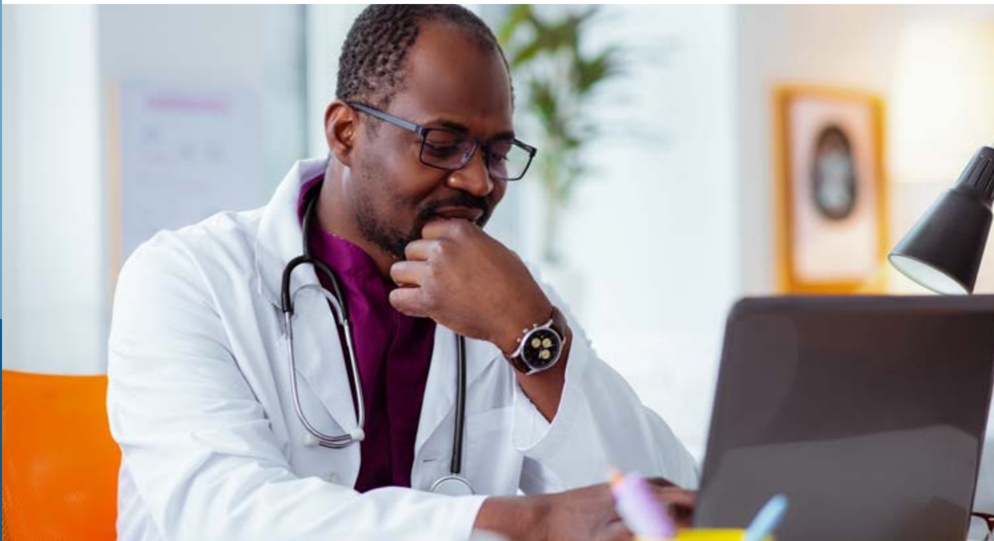
- The ability to check referral and authorization requirements by patient at a CPT code level
- Consistent benefit and eligibility functionality across all product lines
- Access to a graphic of a real patient ID card (both front and back)
- Benefit Explainer to be easier to use
- An accumulator for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

Next steps

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

How we conducted the survey

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



We're expanding CAQH ProView to include delegated credentialing practitioners

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

We're doing this to:

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

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

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

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

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

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

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

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

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

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

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

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

Clinical review decisions are based solely on appropriateness of care

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

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

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

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

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BCN medical directors are a resource for physicians

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

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

Providers may discuss decisions with BCN physician reviewers

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

If you're a practitioner and would like to discuss a denial of an authorization request with one of our plan medical directors, request a phone appointment by following the process outlined in the document titled **How to request a peer-to-peer review with a BCN medical director**. To discuss an urgent case after normal business hours, call 1-800-851-3904. This number is for non-behavioral health cases only.

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

How to obtain a copy of utilization management criteria

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

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

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

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

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How to request a member transfer

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

Submit a Member Transfer Request Form

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

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

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

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

Criteria for requesting a member transfer

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

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

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

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

BCN staff available to our members for utilization management issues

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

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

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

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

See related article, "Behavioral health providers may discuss decisions with BCN physician reviewers," **Page 20**.

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Blue Cross updates its concierge medicine policy

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

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

About concierge medicine

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

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

Policy changes

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

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

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

Providers may charge a concierge fee if:

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

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

Reminder: Direct reimbursement available to clinical nurse specialists

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

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

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

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

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

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

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

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

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

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Online Training

Sign up for additional training webinars

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

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

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

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

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

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

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

Through the NovoLogix® online tool

- J3590 Adakveo®
- J3490 Scenesse®
- J3490 Reblozyl®

Through the AIM Specialty Health® *ProviderPortal*℠

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

How to bill

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

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

Important reminder

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

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

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

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

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

List of requirements

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

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Learn more about health concerns addressed in Medicare Health Outcomes Survey

According to the National Committee for Quality Assurance:

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

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

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

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

HOS tip sheet

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

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

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

Providers should bill 99422 for telemedicine service for BCN Advantage members

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

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

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

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

Definition of fraud

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

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

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

Definition of abuse

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

Differences between fraud and abuse

Fraud is distinguished from abuse in that there is clear evidence that fraudulent acts were committed knowingly and intentionally. Abusive practices, on the other hand, may not be intentional or it may be impossible to show that intent existed. Although these types of practices may initially be classified as abusive, they may develop into fraud if there is evidence that the provider or patient was intentionally conducting an abusive practice.

Definition of waste

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

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

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

Fraud, waste and abuse prevention

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

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

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

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

Online: **Medicare.gov/fraud**.

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

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Correction: Annual visits for Medicare Advantage patients

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

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

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

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

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

We apologize for the error.

Star measure tip sheet

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

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

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

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

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

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

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...from the medical director

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

By Dr. Marc Keshishian

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

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

What's in it for you?

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

What's in it for your patients?

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

Economic impact

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

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

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

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Criteria corner

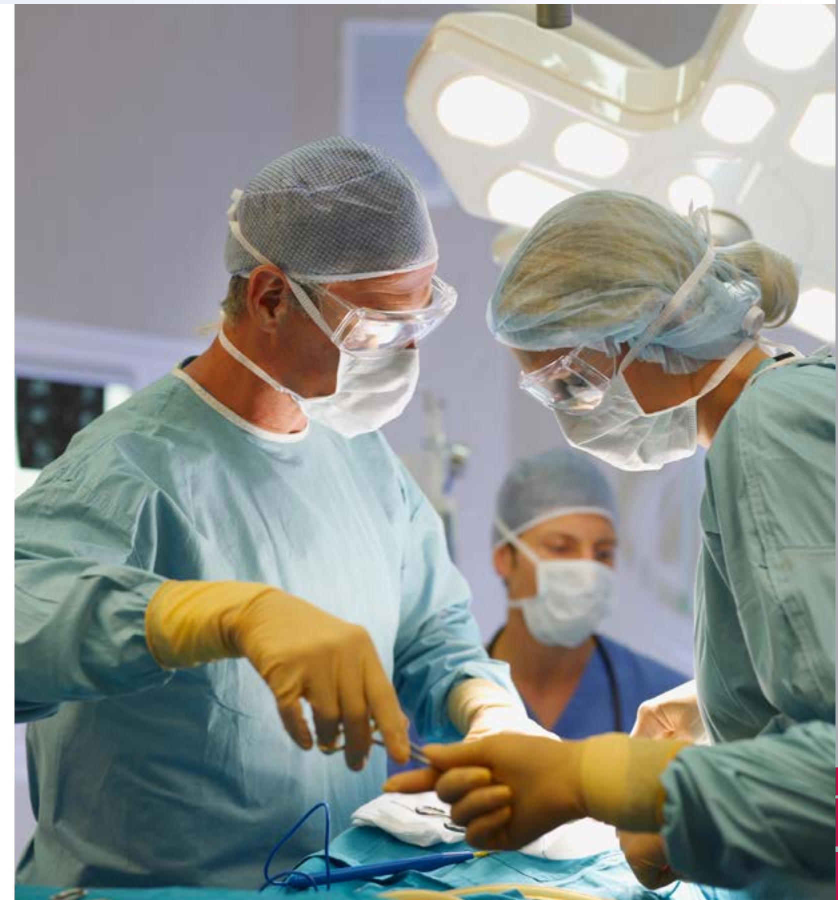
Blue Care Network uses Change Healthcare's InterQual Level of Care when conducting admission and concurrent review activities for acute care hospitals. To ensure that providers and health plans understand the application of the criteria and local rules, BCN provides clarification from Change Healthcare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

Question:

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

Answer:

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



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Know member rights and responsibilities

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

Members have a right to:

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

Members have a responsibility to:

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

A complete list of these rights and responsibilities is available on our **website**.

Medical policy updates

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

Noncovered services

- Surface electromyography
- Surgery for groin pain in athletes

Covered services

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

Medical Policy Updates

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

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

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

What this means

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

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

Additional information you need to know

- This applies to Medicare Plus Blue and BCN Advantage members only — not to our commercial members (BCN HMO℠ and Blue Cross' PPO).
- Member cost-sharing applies for these services.
- The bundled OTP reimbursement is for professional services only:
  - For Medicare Plus Blue, payment is based on the Medicare physician fee schedule.
  - For BCN Advantage, payment is based on the flat rates for non-drug costs released in December 2019 by CMS in **Opioid Treatment Programs (OTPs) Medicare Billing and Payment Fact Sheet** (MLN 8296732).
  - HCPCS codes G2067 through G2080 must be billed with place of service 58.
- The reimbursement does not include drug costs. You'll need to bill these as pharmaceutical services using standard billing practices.

What's an OTP?

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

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

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

About the CMS program

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

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

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

Please see Update, continued on Page 18

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Update, *continued from Page 17*

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

Blue Cross and BCN have implemented this program beginning Jan. 1, 2020, as required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment, or SUPPORT, for Patients and Communities Act. However, for Blue Cross and BCN members, applicable member cost-sharing amounts apply.

What's next?

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

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

Tell your patients about the risks of medication noncompliance

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

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

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

- Patients with hypertension who aren't taking high blood pressure medication correctly are three to seven times more likely to suffer a stroke, according to the American College of Cardiology.
- More than 12% of adults in the U.S. ages 20 and older had total cholesterol higher than 240 mg per dl, the CDC found. But only 55% of adults who could benefit from statin medication are currently taking it.
- Of U.S. adults diagnosed with asthma, 61.9% don't have their asthma controlled and are five times more likely than children to die from asthma, according to the CDC.
- Patients with Type 2 diabetes who are noncompliant with their diabetes medication are more likely to be hospitalized or visit the emergency room than patients who are compliant, according to the National Center for Biotechnology Information.

Suggestions

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

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

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Additional free waiver training opportunities offered

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

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

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

Date and time	Location and registration link
March 2 from 8 a.m. to 5 p.m.**	Muskegon Community College Stevenson Center, Room 2318 221 S. Quarterline Road Muskegon To register, click **here**:
April 27 from 8 a.m. to 5 p.m.	Hagerty Center 715 E. Front St. Room A and B Traverse City To register, click **here**:
May 28 from 8 a.m. to 5 p.m.	Upper Peninsula Health Group Conference Room 853 W. Washington St. Marquette To register, click **here**:
June 5 from 8 a.m. to 5 p.m.	Thunder Bay National Marine Sanctuary 500 W Fletcher St. Alpena To register, click **here**:
Sept. 21 from 8 a.m. to 5 p.m.	Kent County Health Department 700 Fuller Ave. NE. Grand Rapids To register, click **here**:

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

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

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

This incentive is only for the March 2 session.

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Behavioral health providers may discuss decisions with BCN physician reviewers

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

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

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

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

How to obtain a copy of behavioral health criteria

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

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

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

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

We also added this important information:

For BCN HMO℠ (commercial) claims only

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

For BCN Advantage℠ claims only

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

For both BCN HMO and BCN Advantage claims

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

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

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

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

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

Here's additional information you need to know:

- Those codes must be billed on the same day and by the same practitioner as the companion evaluation and management or psychotherapy codes.
- You can bill these codes for BCN HMO℠, BCN Advantage℠ or Medicare Plus Blue℠ PPO members only. You can't bill them for Blue Cross' PPO members currently but watch for future updates.
- For BCN HMO members, standard referral requirements currently apply. In the near future, no referral will be required.
- These services don't require authorization for any member.
- The following licensed providers can bill these codes for services related to behavioral health:
  - Psychiatrists who are board-eligible or board certified
  - Psychologists who have a doctorate or master's degree and a full or limited license
  - Master's-level social workers and professional counselors who have a master's degree and a full license
  - Marriage and family therapists who have a master's degree and a full license
  - Clinical nurse specialists and nurse practitioners who are certified and licensed
  - Physician assistants who have a master's degree and are licensed
- You must comply with the American Medical Association's billing guidelines.
- The medical record must clearly show the medical necessity for using these codes.
- You should document your intervention and revise the member's treatment plan as needed if the member needs these interventions frequently. You may also request consultation if the member isn't making progress.
- We're reviewing our medical policies to include using these codes for a broader range of services than is currently reflected in those policies.

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Fully licensed psychologists can be reimbursed for ABA services

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

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

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

Submit an attestation form

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

Access this form as follows:

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

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

Additional information

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

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

See the following documents for more information:

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

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Quality corner: Primary care physician contact

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

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

Why is it important?

Collaboration is important to improve outcomes, since at least 70% of visits to primary care physicians may be due to psychological issues.[2] Underlying psychological problems can also complicate and contribute to physical problems, such as obesity, hypertension and chronic pain.[3] When regular contact occurs between behavioral health and primary care doctors, providers can ensure the greatest impact and value for patient health.

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

Meaningful contact

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

References

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

Blue Distinction Specialty Care takes aim at opioid use disorders

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

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

See full article on **Page 1**.

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HEDIS medical record reviews begin in February

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

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

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

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

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

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We're announcing HEDIS quality measure changes

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

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

Important changes

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

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

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

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

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

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

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

Controlling high blood pressure

Comprehensive diabetes care

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MQIC continues to review clinical guidelines for opioid prescribing

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

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

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

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

MQIC's evidence-based clinical practice guidelines help ensure that providers in Michigan can conform to one set of guidelines endorsed by participating health plans. To date, 13 health plans participate.

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

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

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

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

Quality improvement program information available upon request

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

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

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

The Michigan Quality Improvement Consortium guidelines are also available on the **MQIC website**. BCN promotes the development, approval, distribution, monitoring and revision of uniform evidence-based clinical practice guidelines and preventive care guidelines for practitioners. We use MQIC guidelines to support these efforts. These guidelines facilitate the delivery of quality care and the reduction in variability in physician practice and medical care delivery.

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

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We've changed requirements for some commercial medical benefit drugs

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

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

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

**Will become a unique code.

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

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

Additional notes

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

To access the list:

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

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

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

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

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

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

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

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

What to do by April 1

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

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

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

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

If the infusion therapy provider can accommodate the member, they'll work with the member and the member's practitioner to make this change easy. The member may also contact the ordering practitioner directly for help with the change.

More about the authorization requirements

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

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

List of requirements

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

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

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

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Xanax will have a quantity limit, effective May 1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How to bill

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

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

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

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

Important reminder

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

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

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

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

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

Clinical editing billing tips

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

This issue's tips include:

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

Clinical editing billing tips

Fully licensed psychologists can be reimbursed for ABA services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Important information about peer-to-peer reviews and appeals

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

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

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

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

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

Requesting a peer-to-peer review

- **Purpose**. A peer-to-peer review is a conversation between the member's health care provider and a Blue Cross or BCN medical director about the clinical nuances of the member's medical condition and the medical necessity of the services.
- **Process**. The process for submitting a request for a peer-to-peer review is outlined in the document titled **How to request a peer-to-peer review with a Blue Cross or BCN medical director.** The process differs by type of service and line of business.

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

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

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

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

Don't submit clinical information after an authorization is denied

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

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

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

Please see important information continued on Page 35

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Important information, *continued from Page 34*

How to file an appeal

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

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

Additional information

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

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

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

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

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

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

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

How to submit authorization requests

Submit authorization requests to eviCore in one of these ways:

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

Additional information

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

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

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

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

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

Here's what's changing.

Home health services

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

- For BCN HMO℠ (commercial) and BCN Advantage℠ members covered through the UAW Retiree Medical Benefits Trust, home health no longer requires authorization. This was effective in December 2019 and applies to both contracted and noncontracted providers.
- For BCN HMO and BCN Advantage members not covered through the UAW Retiree Medical Benefits Trust, home health requires authorization for these providers:
  - *Noncontracted providers.* Call these authorization requests in to BCN Utilization Management at 1-800-392-2512.
  - *Providers who are contracted with BCN but who do not belong to the provider network associated with the member's plan.* Submit these authorization requests through the e-referral system.

TPN and IDPN services

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

Additional information

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

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

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

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

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

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

See full article on **Page 29**.

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

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

Here's some important information you need to know:

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

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

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

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

Webinar training and portal registration

Provider offices can register for the TurningPoint portal as follows:

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

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

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

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

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

Professional providers can register for training **here**.

Facility providers can register for training **here**.

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

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

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

Here's what you need to know.

Submit requests for swallow services to BCN

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

Here are the requirements for these services:

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

Refer to the **e-referral User Guide** for instructions on how to submit plan notifications and authorization requests using the e-referral system.

Submit requests for speech therapy to eviCore

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

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

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

We've updated our documents

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

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

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We've changed requirements for some commercial medical benefit drugs

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

See complete article on **Page 28**.

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

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

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

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

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

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

Here's some additional information you need to know:

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

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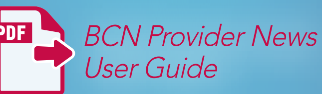

BCN Provider News User Guide

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

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

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

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

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

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

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

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

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

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

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

This is effective until the statewide emergency has been lifted.

Other important information

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

Please follow these guidelines:

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

For out-of-state providers

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

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

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References to "Blue Care Network" and "BCN" in this publication refer to all Blue Care Network of Michigan, Blue Care of Michigan, Inc., BCN Services Company and Blue Cross Complete of Michigan products, except where noted otherwise. Clinical information in this issue is consistent with *BCN Clinical Practice Guidelines* and applies to the care of BCN and BCN subsidiary/affiliate corporation members regardless of product. More information is available in the *BCN Provider Manual* on web-DENIS. Specific benefit information is available on web-DENIS, PARS or by calling Provider Inquiry.

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

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

Expanded use of telehealth

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

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

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

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

There's also eLearning available on our Coronavirus webpage.

Find more information

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

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

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

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

The 90-day extension includes the following:

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

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

A note about Weight Watchers

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

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

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

New hours of operation requirements

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

Benefits of enrolling as an urgent care center

Benefits include:

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

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

J&B needs documentation to replace insulin pumps

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

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

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

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

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

Are you completing your medical residency training this summer?

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

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

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

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

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

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We've renamed two *BCN Provider Manual* chapters

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

"Health, Well-Being and Coordinated Care" chapter

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

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

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

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

"Utilization Management" chapter

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

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

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

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

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

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

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

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

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

Authorization requirements

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

- Q5103 Inflectra®
- Q5104 Renflexis®

Preferred biosimilar drugs

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

- J3590 Avsola™
- Q5103 Inflectra
- Q5104 Renflexis

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

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

List of requirements

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

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

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

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

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

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

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

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

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

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

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

How to bill

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

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

Important reminder

For these drugs, submit authorization requests through the NovoLogix online tool. It offers real-time status checks and immediate approvals for certain medications. Also note:

- For Medicare Plus Blue, if you have a Type 1 (individual) NPI and you checked the "Medical Drug PA" box when you completed the Provider Secured Access Application form, you already have access to NovoLogix. If you didn't check that box, you can complete an **Addendum P** form to request access and fax it to the number on the form.
- For BCN Advantage, if you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix.

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

List of requirements

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

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Advanced illness and frailty exclusions for certain HEDIS star measures

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

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

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

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

Home health care moratorium has been lifted

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

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

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

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Blue Care Network promotes continuity of care in some situations

Continuity of care services are available for the following members:

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

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

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

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

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

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

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

An active course of treatment is defined as:

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

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

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

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

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

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

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Blue Care Network promotes coordination of care between practitioners

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

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

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

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

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

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

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Medical record guidelines policies require providers to maintain member records

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

Content of the medical record should include:

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

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

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

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

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

Medical policy updates

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

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

Noncovered services

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

Covered services

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

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

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

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

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

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

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

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

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

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

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Collaborative care codes now payable with no member cost sharing

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

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

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

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

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

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

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

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

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

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

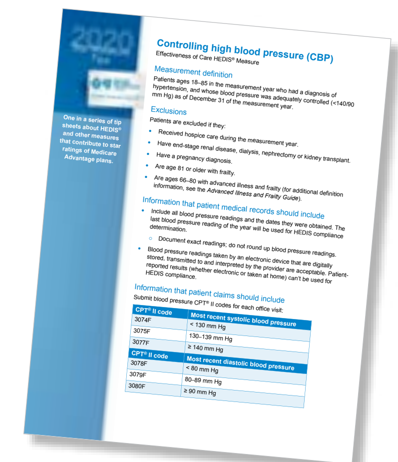
The Controlling High Blood Pressure Healthcare Effectiveness Data and Information Set measure has been updated to assess patients ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the last reading of the year.

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

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

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

CBP tip sheet



One in a series of tip sheets about HEDIS® and other measures that contribute to star ratings of Medicare Advantage plans.

Controlling high blood pressure (CBP)

Effectiveness of Care HEDIS® Measure

Measurement definition

Patients ages 18–85 in the measurement year who had a diagnosis of hypertension, and whose blood pressure was adequately controlled (<140/90 mm Hg) as of December 31 of the measurement year.

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year.
- Have end-stage renal disease, dialysis, nephrectomy or kidney transplant.
- Have a pregnancy diagnosis.
- Are age 81 or older with frailty.
- Are ages 66–80 with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*).

Information that patient medical records should include

- Include all blood pressure readings and the dates they were obtained. The last blood pressure reading of the year will be used for HEDIS compliance determination.
  - Document exact readings; do not round up blood pressure readings.
- Blood pressure readings taken by an electronic device that are digitally stored, transmitted to and interpreted by the provider are acceptable. Patient-reported results (whether electronic or taken at home) can't be used for HEDIS compliance.

Information that patient claims should include

Submit blood pressure CPT® II codes for each office visit:

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

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

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

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

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

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

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- Q5104 Renflexis®

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- J3590 Avsola™
- Q5103 Inflectra
- Q5104 Renflexis

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

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

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

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

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

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

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

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

More about the authorization requirements

The authorization requirements apply only to groups that are currently participating in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit.

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

List of requirements

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

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

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

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

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Quarterly update: Requirements changed for some commercial medical benefit drugs

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

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

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

**Will become a unique code.

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

Additional notes

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

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Quantity limits for some migraine medications will change

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

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

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

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

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

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

CORONAVIRUS
COVID-19

COVID-19 billing guidelines

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

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

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

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

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

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

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

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

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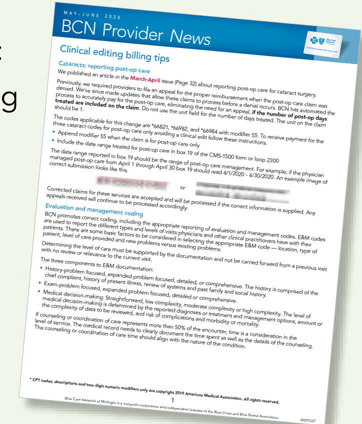
Clinical editing billing tips

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

This issue's tip includes:

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

Clinical editing billing tips



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

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

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

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

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

Please see e-referrals, continued on Page 22

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Submit all required clinical information

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

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

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

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

Decision time frames

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

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

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

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

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

Check the status of your request in e-referral

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

The status of your request will be one of these:

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

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

Additional information

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

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

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

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

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

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

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

Use the links below to register for webinars:

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

Important information for facilities

Facilities should have an authorization before scheduling surgery.

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

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

Include only procedure codes authorized for musculoskeletal procedures on your claims

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

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

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

Where to find more information

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

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

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

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

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

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

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

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

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

How to submit authorization requests

Submit authorization requests to eviCore in one of these ways:

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

Additional information

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

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

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

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

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

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

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

Additional information

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

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

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

Quarterly update: Requirements changed for some commercial medical benefit drugs

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

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

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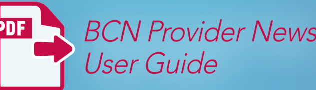

BCN Provider News User Guide

Meeting members' behavioral health needs in a time of crisis

Blue Cross Blue Shield of Michigan and Blue Care Network want to make it easier for you to care for your patients during the COVID-19 pandemic. We also want to encourage our members to continue to seek care with you during this crisis and make them feel safe while doing so.

As a result, we've made the following changes to meet members' behavioral health needs.

Several of these changes involve telemedicine. For additional information about telemedicine services for behavioral health providers, see the **Telehealth for behavioral health providers** document.

Telemedicine incentives

Through the Physician Group Incentive Program, or PGIP, we introduced incentives to assist behavioral health providers with funding the adoption of telemedicine.

Please see Behavioral health, continued on Page 2

At war with a virus: A roundup of recent news about the COVID-19 pandemic

Blue Cross Blue Shield of Michigan and Blue Care Network have made many changes to support providers and protect members during the COVID-19 public health crisis. These changes date back to a few days before the first Michigan cases of COVID-19 were reported. Since then, we've focused our efforts on facilitating testing and treatment, expanding telehealth services, reducing utilization management requirements, ensuring patients have access to the medications they need and extending many deadlines to support you and our members.

View a list of COVID-19 temporary changes

To make it easy for you to find and understand the changes we've made, we created a document, **Temporary changes due to the COVID-19 pandemic**, which lists each temporary change, along with the start and end date of the change. We're updating this document as additional changes are made or if dates are extended.

See *COVID-19 resources and information for providers* (**Page 4**) for instructions on how to find this document and other COVID-19 materials.

Please see COVID-19 news, continued on Page 4

Inside this issue…

10 Temporary sequestration relief and DRG enhancement for Medicare Advantage providers treating COVID-19 patients

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Behavioral health, *continued from Page 1*

Member cost share waived

Through June 30, 2020, we're waiving cost share for the most common behavioral health services when delivered through telehealth for Blue Cross' PPO and BCN HMO℠ members.

Through Dec. 31, 2020, we're waiving cost share for the most common behavioral health services when delivered through telehealth for Medicare Plus Blue℠ PPO and BCN Advantage℠ members. In addition, cost share is waived through Dec. 31 for in-person behavioral health services for Medicare Advantage members. Some groups are still making decisions on this waiver; watch for a web-DENIS message with more information.

Examples of common behavioral health services are counseling and medication reviews. For a list of specific procedure codes for which we are waiving cost share, see the **Telehealth procedure codes for COVID-19** document.

Group therapy sessions via telemedicine

Some of our provider partners are offering group therapy sessions via telemedicine that are focused on addressing stress related to COVID-19. If you're offering COVID-19-related group therapy sessions by telemedicine, let us know by calling our Behavioral Health department at 1-800-482-5982. We'll share your information with members in your area who ask about these services.

Members can call the appropriate phone number to contact Behavioral Health for more information:

- Blue Cross' PPO members: 1-800-762-2382
- Medicare Plus Blue℠ PPO members: 1-888-803-4960
- BCN HMO℠ members: 1-800-482-5982
- BCN Advantage℠ members: 1-800-431-1059

Crisis hotline

We established a 24-hour behavioral health crisis hotline to provide emotional support to members and non-members during this crisis. The hotline is staffed by our behavioral health partner New Directions®.

The phone number for the hotline is 1-833-848-1764.

Autism services by telemedicine

With the release of our updated **Telemedicine Medical Policy**, the following autism services are covered when delivered via telemedicine.

- ***97151:** Assessments. **Temporary change:** During this crisis and until further notice, we're allowing providers to perform assessments via telehealth. This will allow them to collect information through interviews, questionnaires and rating scales.
- ***97155:** Protocol modification. **Temporary change:** During this crisis and until further notice, a parent or caregiver can perform this service in place of a technician 100% of the time. In addition, a licensed behavior analyst, or LBA, may troubleshoot treatment protocols directly with the parent or caregiver.
- ***97156:** Caregiver training, which can be provided using telehealth for up to 100% of the time during which services are provided.
- ***97157:** Multi-family caregiver training, which can be provided using telehealth for up to 100% of the time during which services are provided.

Please see Behavioral health, continued on Page 3

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Behavioral health, *continued from Page 2*

Psychiatric illnesses and substance use disorders

During this crisis and until further notice, we enabled providers to conduct intensive outpatient programs and partial hospital programs using telemedicine. This allows providers to continue to serve the acute needs of members with psychiatric illnesses or substance use disorders that require a higher level of care.

Also, we support using outpatient protocols for detoxification and delivering outpatient services by telemedicine when medically appropriate. The **Outpatient detoxification and follow-up-care protocols for treating substance use disorders** document provides information that will help providers develop detoxification programs and follow-up care for patients being treated for substance use disorders.

Blue Cross® Coordinated Care

Blue Cross Coordinated Care staff are reaching out to members who are high risk, seniors or those affected by the virus to check on their welfare during this time of social isolation.

Also, the Wellframe mobile app now includes COVID-19 modules. (Wellframe is the mobile app through which care teams communicate with members.)

Provider-delivered care management

Through June 30, 2020, we expanded provider-delivered care management options for Blue Cross' PPO members to include the following:

- Helping to connect members to their families to have important discussions about their care and get updates from hospital providers and the care team
- Directing family members to appropriate behavioral health resources

Through June 30, care coordination services that typically must be delivered in a face-to-face setting can be delivered by telemedicine (audiovisual or telephone). PDCM procedure codes *98961, *98962, G9001 and G9002 are affected by this temporary change.

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As a reminder, nurses, social workers and other licensed providers who are working as part of the care team can bill under the physician's provider identification number, as described in the PDCM billing guidelines. Medical assistants and other non-licensed professionals can bill telephone-only codes under the guidance of a care team.

myStrength program

The myStrength program is an online tool offered through Livongo®, a trusted vendor. There is a module specifically for coping with COVID-19; it provides stress management strategies, parenting tips and emotional support tools, and covers the following topics:

- Coping skills during COVID-19
- Mental wellness and resilience in difficult times
- Keeping your relationships strong
- Staying connected while social distancing
- Simple ways to practice mindfulness

Through Dec. 31, 2020, all Blue Cross and BCN members have access to the myStrength program at no cost.

To get started, members can go to **bh.mystrength.com/bcbsmcvd19** and create a free account.

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COVID-19 news, *continued from Page 1*

Gov. Gretchen Whitmer appoints Blue Cross director to Michigan Coronavirus Task Force on Racial Disparities

Bridget Hurd, senior director, Diversity and Inclusion at Blue Cross Blue Shield of Michigan, will serve on a **state task force** investigating racial disparities related to COVID-19 outcomes in Michigan. The task force will make recommendations that address transparent reporting data, reduce medical bias in testing and treatment and reduce barriers to physical and mental health care, among other items.

"It is a great opportunity to focus on the short- and long-term needs of underserved populations and address the health and health care disparities that have been around for a very long time," Hurd said.

Blue Cross Blue Shield of Michigan employees volunteer to join the frontline against COVID-19

More than 30 Blue Cross and Blue Care Network health care specialists, including MDs and nurses, among others, **volunteered** to assist in treating COVID-19 patients. The company received more than 25 applications in the first day after announcing the request. "We're immensely grateful to every health care professional fighting this pandemic, caring for those affected and saving lives throughout Michigan and beyond," said Blue Cross Blue Shield of Michigan President and CEO Daniel J. Loepp.

Blue Cross Blue Shield of Michigan and 26 Michigan hospitals join effort to collect comprehensive COVID-19 data

Blue Cross Blue Shield of Michigan and 26 Michigan hospitals are collecting comprehensive clinical data on COVID-19 patients to be included in an extensive registry that will provide insight into best practices in treating patients with the virus. The data, collected from hospitals throughout the state, will provide a comprehensive clinical picture that's not typically available from smaller registries that contain data from just one hospital or health system. The initiative, called **MI-COVID 19**, hopes to identify factors associated with higher levels of critical COVID-19 illness as well as what patient characteristics and treatments led to improved outcomes.

COVID-19 resources and information for providers

Blue Cross and BCN providers in Michigan, visit **bcbsm.com/coronavirus** and click the *For Providers* tab. Log in to Provider Secured Services for your best Blue Cross resources for the coronavirus. You'll find the most up-to-date information there.

For the latest COVID-19 information from **Michigan State Medical Society**, visit its ***COVID-19 Resource Center for Physicians and Patients*** webpage.

The **Michigan Osteopathic Association** also has a ***COVID-19 Resources*** webpage.

The **Centers for Disease Control and Prevention** provides updated COVID-19 information for health care providers on their ***Coronavirus Disease 2019 (COVID-19)*** page.

The **American Medical Association** provides helpful tools for providers on their ***COVID-19: Frequently asked questions*** page

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Blue Care Network extends *Healthy* Blue *Living* deadlines

Due to the ongoing COVID-19 pandemic, Blue Care Network is providing new extensions for *Healthy* Blue *Living*SM requirements for members in groups that are new or renewing January through July of this year.

We ran a previous article in the May-June issue communicating a 90-day extension. Members will now have the entire plan year to complete the requirements.

The extension includes the following program elements:

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

Providers should continue to communicate to patients and reschedule appointments as appropriate.

Information you should know:

- All members missing one or more HBL requirements will remain in the benefit status level they are currently in. These members will have the entire plan year to complete the requirements.
- Members who start their year in the standard level, will move to the enhanced level with lower costs once they complete all HBL requirements. They will have until the end of their plan year to complete requirements and we'll apply the enhanced level retroactively to the first day of the plan year.
- The new deadlines, based on plan year, are below:
  - For January groups, requirements must be completed by Dec. 31, 2020
  - For February groups, requirements must be completed by Jan 31, 2021
  - For March groups, requirements must be completed by Feb. 28, 2021
  - For April groups, requirements must be completed by Mar. 31, 2021
  - For May groups, requirements must be completed by Apr 30, 2021
  - For June groups, requirements must be completed by May 31, 2021
  - For July groups, requirements must be completed by June 30, 2021

We're mailing letters to both groups and members to let them know of these changes.

Groups that renew in August 2020 or later will follow standard deadlines.

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Provider symposium transitions to virtual format

The 2020 provider symposium, *A Prescription for Success*, is transitioning to a virtual format due to current social distancing recommendations.

We've scheduled virtual sessions throughout July, as follows, for physician office staff and coders. Keep in mind that you can register for more than one session. (June dates have been published in *The Record*.)

Sessions for physician office staff responsible for closing gaps in care related to quality measures and creating a positive patient experience:

Topic	Date and time	Registration link
HEDIS® measures — details and exclusions, Consumer Assessment of Healthcare Providers and Systems Survey and Health Outcomes Survey	July 14 at noon	Click here to register.
	July 16 at noon	Click here to register.
	July 22 at noon	Click here to register.
	July 29 at 8 a.m.	Click here to register.
Patient experience: Expectations for convenience in a dynamic health care environment	July 14 at 8 a.m.	Click here to register.
	July 16 at 8 a.m.	Click here to register.
	July 22 at 8 a.m.	Click here to register.
	July 29 at noon	Click here to register.

Sessions for coders, billers and administrative staff:

Topic	Date and time	Registration link
Updates on telehealth and CPT, ICD-10-CM and evaluation and management codes	July 15 at 8 a.m.	Click here to register.
	July 21 at noon	Click here to register.
	July 30 at 8 a.m.	Click here to register.

New this year: In addition to coders, nurses can receive continuing education credits for attending the sessions.

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

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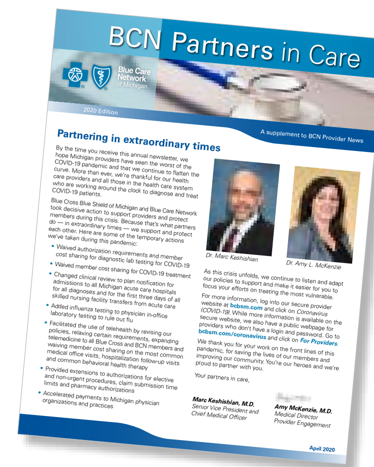
BCN Partners in Care mailed to BCN physicians

The 2020 issue of *BCN Partners in Care* has been mailed to provider offices the week of May 18, 2020. The annual publication tells providers where to find our online tools and publications and features a letter from Dr. Marc Keshishian and Dr. Amy McKenzie highlighting Blue Cross' actions during the COVID-19 pandemic and thanking providers and health care staff for all their hard work on the front lines.

We mailed one copy per address to health care physicians and ancillary providers. Copies were also mailed to contracted hospitals and facilities.

If you don't receive a copy of the newsletter, you can find it posted on our **newsletter archives** page.



BCN Partners in Care

Blue Care Network of Michigan

2020 Edition

A supplement to BCN Provider News

Partnering in extraordinary times

By the time you receive this annual newsletter, we hope Michigan providers have seen the worst of the COVID-19 pandemic and that we continue to flatten the curve. More than ever, we're thankful for our health care providers and all those in the health care system who are working around the clock to diagnose and treat COVID-19 patients.

Blue Cross Blue Shield of Michigan and Blue Care Network took decisive action to support providers and protect members during this crisis. Because that's what partners do — in extraordinary times — we support and protect each other. Here are some of the temporary actions we've taken during this pandemic:

- Waived authorization requirements and member cost sharing for diagnostic lab testing for COVID-19
- Waived member cost sharing for COVID-19 treatment
- Changed clinical review to plan notification for admissions to all Michigan acute care hospitals for all diagnoses and for the first three days of all skilled nursing facility transfers from acute care
- Added influenza testing to physician in-office laboratory testing to rule out flu
- Facilitated the use of telehealth by revising our policies, relaxing certain requirements, expanding telemedicine to all Blue Cross and BCN members and waiving member cost sharing on the most common medical office visits, hospitalization follow-up visits and common behavioral health therapy
- Provided extensions to authorizations for elective and non-urgent procedures, claim submission time limits and pharmacy authorizations
- Accelerated payments to Michigan physician organizations and practices

Dr. Marc Keshishian

Dr. Amy L. McKenzie

As this crisis unfolds, we continue to listen and adapt our policies to support and make it easier for you to focus your efforts on treating the most vulnerable.

For more information, log into our secure provider website at **bcbsm.com** and click on *Coronavirus (COVID-19)*. While more information is available on the secure website, we also have a public webpage for providers who don't have a login and password. Go to **bcbsm.com/coronavirus** and click on ***For Providers***.

We thank you for your work on the front lines of this pandemic, for saving the lives of our members and improving our community. You're our heroes and we're proud to partner with you.

Your partners in care,

Marc Keshishian, M.D.
Senior Vice President and Chief Medical Officer

Amy McKenzie, M.D.
Medical Director Provider Engagement

April 2020

Clarification: New Blue Cross, BCN members to be issued alphanumeric contract numbers in 2021

Blue Cross Blue Shield of Michigan and Blue Care Network will issue alphanumeric contract numbers to new members starting sometime in 2021. This effort was originally planned to start July 1, 2020, as we reported recently in *BCN Provider News*.

The alphanumeric contract numbers will be issued only to new members for Blue Cross' PPO, Medicare Plus Blue℠ PPO, BCN HMO℠ and BCN Advantage℠. Existing members will keep the contract numbers they now have.

The new contract numbers will include the letter M after the standard prefix. For example, an existing enrollee ID looks like this: XYH912345678. The prefix is XYH and the contract number (nine digits) is 912345678.

The new enrollee ID will follow this format: XYHM91234567. The prefix is XYH and the alphanumeric contract number of nine characters is M91234567. When providers check a member's eligibility or benefits in web-DENIS, for example, they should use the nine-character alphanumeric contract number once this change goes into effect.

We'll publish additional information on this topic once the exact implementation date is identified.

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

Are you completing your medical residency training this summer?

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

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

You must complete the CAQH ProView application to begin the credentialing process with Blue Cross Blue Shield and Blue Care Network of Michigan.

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

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

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BCN increases its skilled nursing facility reimbursement rates

Blue Care Network is increasing its fees for skilled nursing facilities reimbursed at BCN SNF fee schedule rates. This applies to:

- BCN HMO℠ (commercial) members
- Dates of service on or after July 1, 2020

To obtain the new rates, contact your provider consultant.

You can find the contact information for each consultant by visiting **bcbsm.com/providers**.

- Click *Contact Us*, at the top of the page.
- Click *Blue Care Network provider contacts*, under the "Hospitals and facilities" heading.
- Click *Provider consultants.*
- Click the appropriate region or click *View our map* to determine the appropriate region.

Webinar recordings available for 2020 webinars

Provider Experience is continuing to offer training resources to help your clinical and administrative staff work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

You can now access recordings of the provider training webinars we've delivered so far in 2020. Find them on the *Learning opportunities* and *Provider Training* pages of Provider Secured Services. Here's how to find the links:

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

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

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Temporary sequestration relief and DRG enhancement for Medicare Advantage providers treating COVID-19 patients

In accordance with our provider agreements and changes to Original Medicare payments under the federal CARES Act, Blue Cross Blue Shield of Michigan and Blue Care Network are implementing temporary sequestration relief and DRG enhancement for Medicare Advantage providers, including network and non-network providers. These changes will be implemented by Blue Cross and BCN as noted below.

The changes will offer financial relief to health care providers during the COVID-19 pandemic and apply to services provided to members with Medicare Plus Blue℠ PPO and BCN Advantage℠ coverage. We initially announced this through a provider alert in web-DENIS on April 20, 2020. Here's what you need to know.

Temporary sequestration relief: Background

In accordance with the terms of Blue Cross and BCN Medicare Advantage provider agreements that pay according to Original Medicare methodologies, 2% sequestration reimbursement reductions have been in place for Blue Cross and BCN Medicare Advantage professional and facility providers since 2013. Consistent with Original Medicare, the 2% reimbursement adjustment is applied after determining any applicable member deductible, copayment or other member liability.

Durable medical equipment, end stage renal disease and lab providers were not included on the original sequestration reimbursement reductions and are, therefore, unaffected by the current temporary suspension.

Temporary relief

Consistent with Original Medicare, Blue Cross and BCN will temporarily suspend the 2% sequestration reduction. This means reimbursement to applicable provider types will increase by 2%, effective for dates of service beginning May 1, 2020, through Dec. 31, 2020.

Reimbursement to providers who have not been affected by sequestration previously, such as DME, ESRD and lab providers, won't be affected by this change.

We expect to reinstate the 2% sequestration reimbursement reduction on Jan. 1, 2021.

DRG enhancements for inpatient treatment for COVID-19 patients

The CARES Act includes a temporary 20% increase in the weighting factor for inpatient diagnosis-related group payments for Medicare patients diagnosed with COVID-19 during the COVID-19 emergency period. Blue Cross and BCN are working toward implementing the increased payments. Once implemented, the increased payments will affect discharges retroactively, dating back to discharges occurring on or after the emergency declaration on Jan. 27, 2020. Any affected claims will be reprocessed; facilities won't need to take any additional action.

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Blue Cross and BCN waiving cost share for Medicare Advantage members

As announced on May 7, Blue Cross Blue Shield of Michigan and Blue Care Network are waiving cost share for their Medicare Advantage individual and fully insured group members for certain in-person and virtual services. Members will not be liable for any copays, coinsurance or deductibles for the following in-network services from May 1 through Dec. 31, 2020:

- In-person primary care services, including laboratory testing processed in the office and radiology services performed in the office
- Behavioral health office visits
- Telehealth services for both medical and behavioral health

Some Medicare Advantage groups are still making decisions on this waiver, and we'll give further guidance as soon as possible for those groups.

During the State of Emergency, cost share for these services will also be waived for out-of-network services as Medicare Advantage organizations are required to provide the same cost-sharing for the enrollee at a non-contracted facility as if the service or benefit had been furnished at a plan-contracted facility.

The waiving of member cost share will be accurate on the remittance advice but may not be reflected when checking benefits in our systems.

In-person medical services

BCN Advantage℠ members: Cost share is waived for any in-person medical services provided by the member's primary care provider.

Medicare Plus Blue℠ PPO members: Cost share is waived for all in-person medical services billed with a rendering provider based on the designations below with the following place of service codes: 03, 11, 12, 13, 14, 15, 19, 22, 34, 49, 50, 71 and 72.

- Certified nurse specialist
- General practice
- Geriatric medicine
- Family nurse practitioner
- Family practice
- Internal medicine
- Obstetrics/gynecology
- Nurse practitioner
- Pediatric medicine
- Pediatric nurse practitioner
- Physician assistant

Member cost share is not waived for:

- Services provided by medical specialists other than the provider types listed above
- Services provided in urgent care centers
- Laboratory services ordered by a physician and sent to an outside laboratory provider (other than COVID-19 testing)
- Medicare Part B medications administered in the office
- Supplies received from the physician in the office

Please see MA cost share, continued on Page 12

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MA cost share, *continued from Page 11*

In-person behavioral health services

Member cost sharing is waived for Medicare Advantage members seeking behavioral health services in a physician's office including individual therapy, psychiatric medication consultation and group therapy.

BCN Advantage members: Evaluation and management services are covered at no cost share for the following diagnoses:

- F10-F1999
- F55-F558
- F01-F09
- F20-F54
- F59-F99

Medicare Plus Blue PPO members: Evaluation and management services are covered at no cost share when used with the following specialties:

- Psychiatry
- Clinical psychologist (billing independently)
- Addiction medicine
- Licensed clinical social worker
- Neuropsychiatry
- Adult psychiatric mental health nursing

CPT codes for behavioral health in-person visits covered with no cost share for both Medicare Plus Blue PPO and BCN Advantage members follow:

Evaluation and management services: *99201-*99205, *99211-*99215

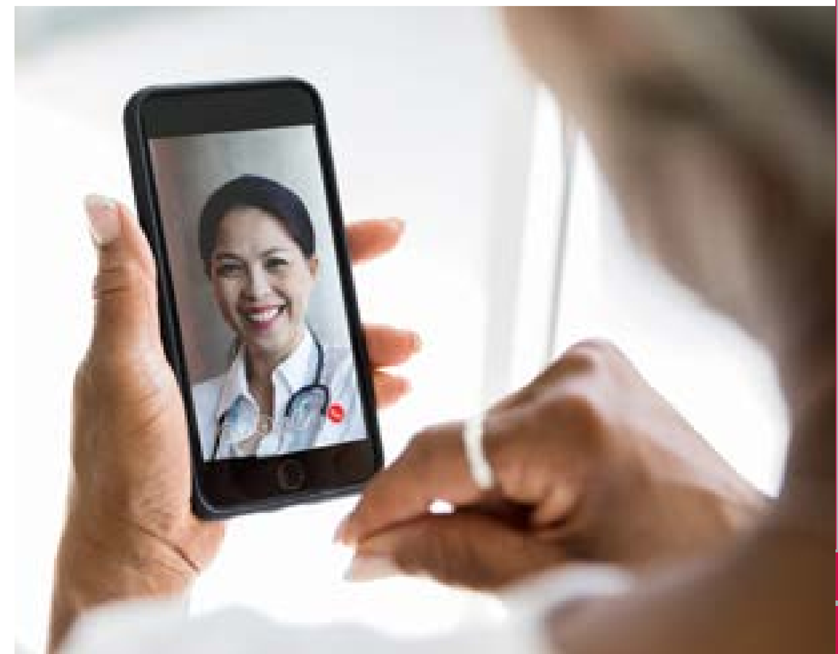
Other: *90791, *90792, *90832, *90833, *90834, *90836, *90837, *90838, *90846, *90847, *90853, *96101, *96102, *96111, *90839, *90840, *90849

Telehealth services

On April 30, the Centers for Medicare & Medicaid Services further expanded the list of services covered through telehealth to allow providers to care for patients and mitigate the risk of spreading the coronavirus. Clinicians can provide these services to new or established patients.

Blue Cross and BCN are waiving cost share for telehealth services for both medical and behavioral health for their Medicare Advantage members effective March 16 through December 31. Medicare Plus Blue℠ PPO and BCN Advantage℠ members can receive telehealth and other communications technology-based services wherever they are located. As mentioned earlier in this article, some self-funded Medicare Advantage groups are still making decisions on this waiver, but have waived cost share through at least June 30 for these telehealth services. We'll give further guidance as soon as possible for those groups.

Refer to our ***Telehealth procedure codes for COVID-19*** document for the list of covered telehealth services for our Medicare Advantage members as well as Blue Cross (commercial) PPO and BCN HMO (commercial) members.



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

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Two star measures support importance of statin therapy for patients with cardiovascular disease and diabetes

The Centers for Disease Control and Prevention estimates that adults with diabetes are 1.7 times more likely to die from cardiovascular disease than adults without diabetes. Additionally, almost two out of five people with diabetes who could benefit from statin therapy to lower their risk of future heart attack, stroke and related deaths were not prescribed one, according to the *Journal of the American College of Cardiology*.

To support its importance, the Centers for Medicare & Medicaid Services includes two star measures aimed at the use of statin therapy. Consider prescribing statins for your patients diagnosed with atherosclerotic cardiovascular disease and diabetes.

See the Medical director column on **Page 14** for more information about statins.

To learn more about the use of statin therapy, view these tip sheets.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Statin Use in Persons with Diabetes (SUPD)

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

We're adding authorization requirements for four specialty drugs covered under the medical benefit for Medicare Plus Blue℠ PPO, BCN HMO℠ and BCN Advantage℠ members.

For dates of service on or after July 24, 2020, the following drugs will require authorization through AIM Specialty Health®:

- Trodelvy™ (sacituzumab govitecan-hziy, J3490, J3590, J9999)
- Jelmyto™ (mitomycin, J3490, J3590, J9999)
- Darzalex Faspro™ (daratumumab and hyaluronidase-fihj, J3490, J3590, J9999)

For dates of service on or after Aug. 24, 2020, the following drug will require authorization through AIM:

- Imlygic® (talimogene laherparepvec, J9325)

See the article on **Page 28** for more information and how to submit authorization requests.

Bill facility claims with taxonomy code

Providers should bill facility claims for BCN Advantage℠ members with their taxonomy code to expedite claims payment. This has always been a billing requirement.

Without a taxonomy code, your claims will be returned, and you'll have to resubmit them.

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Physicians should address patient concerns about statins

By Dr. William H. Herman

Nearly two decades ago, the Heart Protection Study demonstrated that people ages 40 to 80 with coronary artery disease, cerebrovascular disease, intermittent claudication and histories of vascular procedures could reduce their incidence of major adverse cardiovascular events by a quarter with statin therapy (simvastatin 40 mg daily) compare to placebo.[1] Similarly, participants with diabetes with and without cardiovascular disease could reduce their risk for a first major vascular event by about a quarter and substantially reduce their risk of subsequent major vascular events with statin therapy.[2] In both instances, the benefits of statin therapy were observed *irrespective of the participants' initial cholesterol levels* and the benefits were additive to those of other cardioprotective treatments such as aspirin, ß-blockers and ACE-Is. These findings supported the recommendations that patients with cardiovascular disease, and those with diabetes with or without cardiovascular disease all be treated with statins.

Despite this evidence, only about 80% of BCN and BCN Advantage℠ members with cardiovascular disease are treated with statins and only about three-quarters of them exhibit at least 80% adherence. Similarly, only two-thirds to three-quarters of diabetic members are prescribed statins and only two-thirds to three-quarters of them are adherent. According to the National Committee for Quality Assurance, these performance levels are in the 25th to 50th percentile for BCN and in the 50th to 75th percentile for BCN Advantage. Five-star performance levels for prescribing are ≥87% and ≥83%, respectively, for patients with cardiovascular disease and diabetes.

A number of studies have explored barriers to uptake and adherence to statin therapy[3]. As for any prescription medication, non-adherence may be related to a lack of knowledge as to why the medication is prescribed (10% of participants) and logistical barriers to adherence, such as trouble remembering to take the medication (9%). By far, however, the major reasons for non-adherence to statins relate to patients' preferences to lower cholesterol with lifestyle changes alone (66%) and concerns about the risks or side effects of statin therapy (50%)[3]. In addition, those with lower perceived risk of heart attack are significantly less likely to be adherent.[3]

Dr. Herman is an associate medical director, Blue Care Network. He also holds these titles: Stefan S. Fajans/GlaxoSmithKline Professor of Diabetes; Professor of Internal Medicine and Epidemiology; Director, Michigan Center for Diabetes Translational Research

Please see From the medical director, continued on Page 15

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From the medical director, *continued from Page 14*

Physicians should be prepared to address these concerns and especially patients' interests in adopting unproven alternative cholesterol-lowering therapies such as dietary supplements and fad diets. In addition, physicians should recognize and address the fact that despite their proven effectiveness, statins have developed a bad reputation driven by a proliferation of unscientific criticisms found across the internet. Statins appear to have become a prime example of the "nocebo effect". The opposite of the placebo effect (which occurs when a patient's positive expectations of a treatment improve his or her clinical outcome), the "nocebo effect" occurs when a patient's negative expectations cause the treatment to have more negative side effects than it otherwise would.

Physicians should acknowledge the adverse effects associated with statin therapy. Several meta-analyses have demonstrated that statin therapy is associated with a modest increase in the risk for new onset Type 2 diabetes. In high-risk populations with cardiovascular disease, this risk is more than offset by the benefits of statin treatment on cardiovascular outcomes, and among people with diabetes, it's not a clinical concern. Severe liver injury has also been reported in approximately 1 in 100,000 statin users with most patients experiencing liver injury within three to four months after starting therapy. Despite this, the U.S. Food and Drug Administration doesn't recommend routine monitoring of liver enzymes in statin-treated patients because monitoring hasn't been shown to be effective in predicting or preventing rare occurrences of statin-associated serious liver injury. Finally, although statins are often described on the internet as contributing to mild cognitive impairment and dementia, there is no clinical trial evidence that statin therapy is associated with cognitive impairment and, indeed, the scientific evidence suggests just the opposite.[4]

Rhabdomyolysis may also occur with statin therapy, but this side effect is rare, affecting only about 1 in 5,000 treated patients. Myalgias are a more common side effect. Rates of statin-related muscle problems in clinical practice are higher than rates observed in randomized controlled clinical trials. In observational studies, as many as 10% of patients report muscular symptoms within a month of starting high dose statin therapy. For patients experiencing muscle complaints, attention should be paid to potential statin-drug interactions especially the concomitant use of CYP3A4 inhibitors including erythromycin, clarithromycin, cyclosporine, diltiazem and verapamil in conjunction with atorvastatin, simvastatin and lovastatin. Vitamin D deficiency, hypothyroidism and vigorous exercise training have also been associated with statin intolerance.[4]

For patients experiencing non-specific muscle aches without muscle weakness or CK elevation, the next step is to either reduce the statin dose or discontinue the statin altogether, reassess symptoms, and rechallenge the patient with any statin they have not tried. Several studies have demonstrated that the majority of statin-intolerant patients can tolerate a statin upon blinded rechallenge. Consideration may also be given to the use of statin alternative dosing strategies including the use of a potent statin (rosuvastatin or atorvastatin) at a low dose once or twice weekly or a low potency statin (pravastatin, fluvastatin) nightly or every other night. Several alternative therapies may also be considered for those who are unable to tolerate statins. These include ezetimibe, bile acid sequestrants and PCSK-9 inhibitors.

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Criteria corner

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

Question:

For post ambulatory procedure and patient stayed longer than the "allowed 23 hour observation" or beyond Post-op Day 1 due to complications such as uncontrolled pain, would it be appropriate to use criteria under Post-op Day 2 Observation, Acute, Intermediate, Critical or for Day 3 use Post-op Day 3-21 under Acute, Intermediate or Critical?

Answer:

An outpatient procedure typically includes a recovery period of up to 23 hours for post-operative care or monitoring. If a patient experiences a complication for an ambulatory procedure usually done on an outpatient basis and requires care or monitoring beyond 23 hours, the user may apply criteria for Post-operative Day 1.

The review process offers more information on page 4: *Criteria for patients who have an ambulatory procedure complication requiring Observation can be found on Operative Day or Post-op Day 1, under the Observation level of care within the General Surgical subset. For complications requiring treatment at a higher level of care, apply criteria using the Intermediate or Critical level of care. For complications not included in the General Surgical subset, see the most appropriate condition-specific or general subset based on the patient's symptoms or findings. For example, criteria for deep vein thrombosis can be found in the Deep Vein Thrombosis (DVT) subset.*

It is **not** appropriate to apply Post-op Day 1 criteria at the Acute level of care unless the patient met criteria on the Operative Day. (To meet Operative Day criteria, the procedure must be considered to be appropriate for the inpatient setting.) However, as stated above, the criteria for Intermediate or Critical may be applied if warranted.

If, on Post-op Day 1, the patient met the Intermediate or Critical criteria, continue to attempt to apply on Post Op Day 2.

If on Post-op Day 1 the patient met Observation criteria, follow in Observation to Post Op Day 2. When attempting to apply Observation criteria, there is only Responder and Non-responder criteria available.

Reviewer is recommended to follow accordingly — either meeting Day 1 in a new condition based on clinical findings or the case should be submitted for secondary review.

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COPD diagnosis should include spirometry

Caring for patients with chronic obstructive pulmonary disease begins with diagnosing the condition through spirometry. It's necessary to periodically assess the disease, manage exacerbations and provide smoking cessation support. Pharmacologic therapy is pivotal as it provides important options for improvement of symptoms and treatment of exacerbations.

COPD remains underdiagnosed. Consider testing for COPD in smokers with symptoms or with a history of exposure to other COPD risk factors. This includes smokers older than 60 presenting with a chronic cough, or smokers with diagnosis and treatment for respiratory tract infections or asthma.

A written management plan can facilitate COPD care in your office and helps patients manage their symptoms. Blue Care Network asks physicians to complete the management plan during office visits and provide a copy to the member.

To obtain a copy of BCN's COPD management plan:

- Log in to *Provider Secured Services.*
- Go to *BCN Provider Publications and Resources.*
- Click on *Forms* under Other Resources.
- Click on *COPD Action Plan* in the Chronic Condition Management section.

Spirometry

Spirometry is necessary to establish a diagnosis of COPD, according to BCN's clinical practice guidelines for the diagnosis and management of COPD. Spirometry also provides a useful diagnostic tool for those patients with symptoms suggestive of COPD. (See table below.) A post bronchodilator FEV1/FVC less than 70% confirms the presence of airflow limitation.

BCN's *Guidelines for the Diagnosis and Management of Chronic Obstructive Pulmonary Disease* recommend that you consider COPD in any patient 18 years of age or older with respiratory symptoms and those with a history of exposure (for example, occupational exposure) to risk factors for the disease, especially smoking. Characteristic symptoms include cough, sputum production that can be variable from day to day and chronic or progressive dyspnea.

I: Mild COPD	II: Moderate COPD	III: Severe COPD	IV: Very Severe COPD
FEV1/FVC <0.70	FEV1/FVC <0.70	FEV1/FVC <0.70	FEV1/FVC <0.70
FEV1 ≥ 80% predicted	FEV1 50% ≤ and < 80% predicted	FEV1 30% ≤ and < 50% predicted	FEV1 < 30% predicted or FEV1< 50% with deoxygenating

The 2020 Healthcare Effectiveness Data and Information Set measures the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis. Spirometry testing must be completed during the two years prior to the diagnosis or six months after the diagnosis. CPT codes used to identify spirometry testing for this measure include *94010, *94014-94016, *94060, *94070, *94375 and *94620.

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Medical policy updates

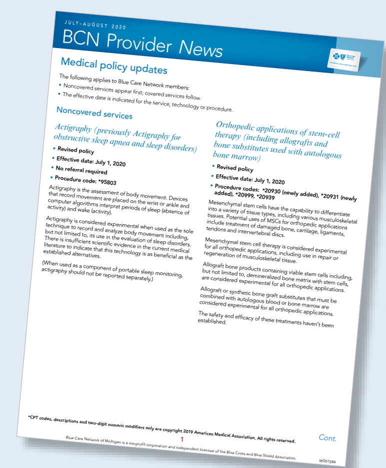
Blue Care Network's medical policy updates are posted on Provider Secured Services. Go to *BCN Provider Publications and Resources* and click on *Medical Policy Manual*. Recent updates to the medical policies include:

Noncovered services

- Actigraphy (previously Actigraphy for obstructive sleep apnea and sleep disorders)
- Orthopedic applications of stem-cell therapy (including allografts and bone substitutes used with autologous bone marrow)

Covered services

- Genetic testing for Lynch syndrome and other inherited colon cancer syndromes
- Cataract removal surgery
- Tumor treating fields therapy
- Endovenous ablation for the treatment of varicose veins (Clarivein®, Venaseal™ closure system)
- Genetic testing — assays of genetic expression in tumor tissue as a technique to determine prognosis in patients with breast cancer
- Positron emission tomography, or PET, for oncologic conditions
- Applied behavior analysis for autism spectrum disorder
- Allergy testing and immunotherapy
- Genetic testing — NGS testing of multiple genes (panel) to identify targeted cancer therapy



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Medical policy updates

The following applies to Blue Care Network members:

- Noncovered services appear first; covered services follow.
- The effective date is indicated for the service, technology or procedure.

Noncovered services

Actigraphy (previously Actigraphy for obstructive sleep apnea and sleep disorders)

- **Revised policy**
- **Effective date: July 1, 2020**
- **No referral required**
- **Procedure code: *95803**

Actigraphy is the assessment of body movement. Devices that record movement are placed on the wrist or ankle and computer algorithms interpret periods of sleep (absence of activity) and wake (activity).

Actigraphy is considered experimental when used as the sole technique to record and analyze body movement including, but not limited to, its use in the evaluation of sleep disorders. There is insufficient scientific evidence in the current medical literature to indicate that this technology is as beneficial as the established alternatives.

(When used as a component of portable sleep monitoring, actigraphy should not be reported separately.)

Orthopedic applications of stem-cell therapy (including allografts and bone substitutes used with autologous bone marrow)

- **Revised policy**
- **Effective date: July 1, 2020**
- **Procedure codes: *20930 (newly added), *20931 (newly added), *20999, *20939**

Mesenchymal stem cells have the capability to differentiate into a variety of tissue types, including various musculoskeletal tissues. Potential uses of MSCs for orthopedic applications include treatment of damaged bone, cartilage, ligaments, tendons and intervertebral discs.

Mesenchymal stem cell therapy is considered experimental for all orthopedic applications, including use in repair or regeneration of musculoskeletal tissue.

Allograft bone products containing viable stem cells including, but not limited to, demineralized bone matrix with stem cells, are considered experimental for all orthopedic applications.

Allograft or synthetic bone graft substitutes that must be combined with autologous blood or bone marrow are considered experimental for all orthopedic applications.

The safety and efficacy of these treatments haven't been established.

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Quality corner: Follow up after hospitalization for mental illness

The Healthcare Effectiveness Data and Information Set® guidelines measure the follow-up after hospitalization for mental illness as the percentage of discharges for members 6 years of age or older hospitalized in an acute inpatient setting for treatment of mental illness or intentional self-harm and had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within seven and 30 days after discharge. Follow-up visits can also include a community mental health center visit, telehealth visit, observation visit, transitional care management services or electroconvulsive therapy.

Why is this measure important?

Getting follow up in a timely manner may:

- Lower the chance of re-hospitalization
- Detect adverse responses to medications early on
- Ensure progress made during hospitalization is retained
- Provide continued support

How can I ensure my patients are getting follow-up visits?

If you are the discharging hospital or the mental health practitioner accepting the patient for outpatient follow up:

- Make sure the patient has a follow-up visit scheduled within seven days before leaving your facility and that the outpatient provider has the capacity to see the patient within seven days. Include this visit information in the discharge information that you send or share with BCN utilization management.
- Educate the member about the importance of attending the appointment so he or she can continue to make progress and avoid readmission.
- Remember that patients are vulnerable after discharge from a psychiatric hospitalization. Continued care after stabilization in the hospital setting is important for them to maintain stability as they transition back into their environment.
- Cooperate with efforts by Blue Care Network and New Directions Behavioral Health (for PPO members) to validate follow-up appointments – their case managers often provide additional reminders to ensure member appointment attendance.

Blue Care Network offers an incentive for this measure as part of its Behavioral Health Incentive Program.

Each time an office completes the measure following HEDIS guidelines, the behavioral health provider qualifies to receive $200 in addition to the billed professional fees. The provider earns the incentive for eligible members who've had a qualifying visit with a behavioral health specialist one to seven days after the acute care discharge.

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Blue Cross and BCN networks add new provider that addresses OCD, phobias and anxiety disorders by telehealth

Blue Cross Blue Shield of Michigan and Blue Care Network recently added a new provider group, called NOCD, that uses telehealth to address obsessive-compulsive disorders, phobias and anxiety disorders. This addition to our network allows our members greater access to the evidence-based treatment called exposure response prevention, or ERP, therapy, which is a sophisticated version of cognitive behavioral therapy. CBT has been the first line treatment for these disorders for many years. While CBT provides relief for many people, exposure response prevention therapy can be helpful when CBT isn't optimally effective.

Until now, we've had a small number of specialized providers that address OCD and phobias, but they've been largely focused around the larger urban areas of Ann Arbor and Grand Rapids.

NOCD's integrated treatment model pairs a network of master's level licensed professionals with online adherence tools and a peer community. Professional staff includes licensed psychologists, counselors and social workers who are specialty-trained in using exposure response prevention therapy for OCD treatment.

NOCD provides:

- OCD-specific clinical diagnostic assessments in a video-based session
- Scheduled video-based teletherapy in all geographic locations
- Electronic messaging between the member and his or her NOCD professional

Other therapeutic tools include:

- Structured electronic-based exercises and tools to assist in the therapy process
- Support during any OCD episode
- The ability to view treatment data in a secure, centralized area
- An online, monitored peer support community to provide non-professional support and find resources to manage OCD

NOCD will also facilitate psychiatric consultation with a member's provider for treatment intervention and coordination of care.

During the COVID-19 crisis, Blue Cross and BCN have allowed the use of telehealth services for all our providers. Overall, we've seen a 70% increase in the utilization in this type of care. NOCD uses telepsychotherapy and telemedicine visits exclusively, so this does not limit their services geographically.

NOCD maintains an ongoing team of subject matter experts and OCD leading advisors, including individuals from the University of California, Los Angeles OCD treatment program; Yale Medical School; University of Southern California Medical School; University of Pennsylvania; Harvard Medical School and the University of Illinois, Chicago.

The addition of this provider adds to our network capacity and provides more evidence-based interventions for our membership. To make an appointment or refer a member, contact NOCD at 312-766-6780, or online at **nocd.com**.

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We're using updated utilization management criteria for behavioral health, starting Aug. 1

Medicare Plus Blue℠ PPO, Blue Cross Blue Shield of Michigan's Medicare Advantage plan, and Blue Care Network's commercial and Medicare Advantage plans (BCN HMO℠ and BCN Advantage℠) will begin using the 2020 InterQual® criteria for behavioral health utilization management determinations on Aug. 1.

In addition, certain types of determinations will be based on modifications to InterQual criteria or on local rules or medical policies, as shown in the table below:

Line of Business	Modified 2020 InterQual Criteria for:	Local Rules or Medical Policies for:
BCN HMO (Commercial) and BCN Advantage	• Substance use disorders: Partial hospital program and intensive outpatient program. • Mental health disorders: Partial hospital program and intensive outpatient program. • Residential mental health treatment (adult/geriatric and child/adolescent)	• Autism spectrum disorder/applied behavior analysis (for BCN HMO only). • Neurofeedback for attention deficit disorder/attention deficit hyperactivity disorder • Transcranial magnetic stimulation • Telemedicine (telepsychiatry/teletherapy)
Medicare Plus Blue PPO	• Substance use disorders: Partial hospital program and intensive outpatient program. • Mental health disorders: Partial hospital program and intensive outpatient program.	None

Note: Determinations on Blue Cross PPO (commercial) behavioral health services are handled by New Directions, an independent company that provides behavioral health services for some Blue Cross members.

Links to the updated versions of the modified criteria, local rules and medical policies are available on the **Blue Cross Behavioral Health page** and the **BCN Behavioral Health page** at **ereferrals.bcbsm.com**.

Also, see the article titled "We'll implement 2020 InterQual criteria Aug. 1 for non-behavioral health determinations," on **Page 23** for information on the updated non-behavioral health criteria we'll use starting Aug. 1, 2020.

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Criteria corner

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

Question:

With the recent closure of schools and many businesses due to coronavirus restrictions, how should we interpret the Partial Hospital Program and Intensive Outpatient Program criteria point "Functioning — Absent from work or school? "Depending on the level of care and Episode Day, this absence may be between one and three days. Is it reasonable to interpret this point as being met if we have reason to believe a member would have met this criterion *without the impact of coronavirus on their work or school?*

For example, if we have an adolescent member attending a partial hospitalization program five days per week, from 8 a.m. to 3 p.m., which would normally be during school hours, would it be reasonable to infer that they'd meet this criterion point? Likewise, if a member would otherwise be employed but is attending a substance abuse partial hospitalization program during what would normally be working hours, would this apply?

Answer:

Yes, it's reasonable to consider the functioning criteria as met if the reviewer has reason to believe the member would have met criteria without the impact of the coronavirus on their work or school obligations. However, if the member has homeschooling or work-from-home as an option, then it's recommended the reviewer apply the criteria based on functionality under current conditions.

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We'll implement 2020 InterQual criteria Aug. 1 for non-behavioral health determinations

Blue Cross Blue Shield of Michigan and Blue Care Network will implement the 2020 InterQual criteria starting Aug. 1, 2020, for all levels of care. We'll use these criteria to make utilization management determinations for requests to authorize non-behavioral health services subject to review for the following members:

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

When BCN requests clinical information for a medical or surgical admission or other service, we require submission of the specific components of the medical record that validate that the request meets the criteria.

Blue Cross and BCN also use local rules — modifications of InterQual criteria — in making utilization management determinations. The 2020 local rules will also be implemented starting Aug. 1, 2020.

By the end of July, you'll be able to access the updated versions of the modifications (local rules), as applicable, for:

- BCN — on the **Authorization Requirements & Criteria** page in the BCN section of our **ereferrals.bcbsm.com** website. Look under the "Referral and authorization information" heading.
- Blue Cross — on the **Authorization Requirements & Criteria** page in the Blue Cross section of our **ereferrals.bcbsm.com** website. You'll see links to the criteria in both the Blue Cross PPO and the Medicare Plus Blue PPO sections of that page.

Refer to the table on **Page 24** for specific information on which criteria are used in making determinations for various types of non-behavioral health authorization requests.

Please see InterQual criteria, continued on Page 24

CDC campaign seeks to improve antibiotic prescribing and use

More than 2.8 million antibiotic-resistant infections occur in the United States each year, with 35,000 people dying as a result, according to the Centers for Disease Control and Prevention. This has made improving antibiotic prescribing and use a national priority.

"Be Antibiotics Aware" is the CDC's national campaign to help fight antibiotic resistance and improve antibiotic prescribing and use.

By raising awareness, the CDC aims to:

- Improve the way health care professionals prescribe antibiotics
- Educate patients on when and how to take antibiotics
- Fight antibiotic resistance and ensure these life-saving drugs will be available in the future

When antibiotics are carefully used and prescribed, we can combat antibiotic resistance.

To learn more about antibiotic use, patient education and more, visit the ***Antibiotic Prescribing and Use*** page on the CDC website.

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InterQual criteria, *continued from Page 23*

Criteria/Version	Application
InterQual Acute — Adult and Pediatrics	• Inpatient admissions • Continued stay discharge readiness
InterQual Level of Care — Subacute and Skilled Nursing Facility	• Subacute and skilled nursing facility admissions • Continued stay discharge readiness
InterQual Rehabilitation — Adult and Pediatrics	• Inpatient admissions • Continued stay and discharge readiness
InterQual Level of Care — Long-Term Acute Care	• Long-term acute care facility admissions • Continued stay discharge readiness
InterQual Level of Care — Home Care	• Home care requests
InterQual Imaging	• Imaging studies and X-rays
InterQual Procedures — Adult and Pediatrics	• Surgery and invasive procedures
Medicare Coverage Guidelines (as applicable)	• Services that require clinical review for medical necessity and benefit determinations
Blue Cross/BCN medical policies	• Services that require clinical review for medical necessity
BCN-developed Local Rules (applies to BCN HMO and BCN Advantage)	• Exceptions to the application of InterQual criteria that reflect BCN's accepted practice standards

Note: The information in the table applies to lines of business and members whose authorizations are managed by Blue Cross or BCN directly and not by a vendor.

See the article titled, "We're using updated utilization management criteria for behavioral health, starting Aug. 1," **Page 21** in this newsletter for information on the updated behavioral health criteria we'll use starting Aug. 1, 2020.

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Educate members about cancer statistics; remind them about preventive screenings

In 2020, the American Cancer Society estimates there will be 1,806,950 new cancer cases and 606,520 cancer deaths in the U.S.

Here are statistics from the ACS for three common cancer types in 2020 and previous years:

Cancer type	Estimated new cases, 2020	Estimated deaths, 2020
Breast	279,100	42,690
Cervix	13,800	4,290
Colorectal	147,950	53,200

Incidence and death rates for previous years:

Cancer type	Incidence rates 2012-2016 (per 100,000)	Death rates 2013-2017 (per 100,000)
Breast	125.3	20.3
Cervix	7.6	2.3
Colorectal	38.7	13.9

Regular screening for breast, cervical and colorectal cancer and increased knowledge of symptoms among patients have led to earlier detection and fewer deaths.

Consider these statistics from the National Cancer Institute:

- Between 1989 and 2017, the death rate for breast cancer declined 40%.
- Since the mid-1970s, the death rate for cervical cancer dropped more than half.
- From 1970 to 2017, the death rate for colorectal cancer dropped 54%.

By screening for cancer and modifying risk factors, thousands of additional cancer cases and deaths can be prevented. Approximately 42% of cancer cases and 45% of deaths are attributed to modifiable risk factors.

Visit the **National Cancer Institute** website for more information on modifiable risk factors to share with your patients.

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Blue Cross and BCN will cover Truvada for HIV PrEP, starting July

Effective July 1, 2020, Blue Cross Blue Shield of Michigan and Blue Care Network will cover human immunodeficiency virus, or HIV, medication Truvada® for pre-exposure prophylaxis with no cost sharing for most commercial members at high risk for HIV.

A generic version of Truvada is expected to be released in September 2020. At that time, only the generic version will be covered with no cost shaing. The cost for the brand-name product will depend on the member's benefit.

Truvada and Descovy® are the only two drugs indicated for HIV PrEP. If a member is newly prescribed Descovy for PrEP on or after May 1, 2020, we **won't** cover the prescription unless prior authorization criteria are met. In such situations, prescribers should submit a prior authorization request. Otherwise, the prescription claim won't be covered at the pharmacy.

We'll only approve a prior authorization for Descovy for PrEP if there is documentation of:

- A creatinine clearance (CrCl) <60 mL/min
- Osteoporosis

Truvada and Descovy are very similar and both contain tenofovir and emtricitabine. Each tenofovir component is formulated as a pro-drug.

Differences in pro-drug formulation and subsequent half-life **do not affect efficacy** but can influence side effect profiles. Descovy demonstrated non-inferiority to Truvada in the DISCOVER trial, which means both drugs are equally effective in preventing the transmission of HIV-1.

Both drugs are contraindicated as PrEP in patients with unknown or positive HIV status. Using Descovy or Truvada for PrEP without confirmation of negative HIV status may increase the risk of developing HIV-1 resistance substitutions.

For members using Descovy to treat HIV, their normal cost share will apply.

Which members can receive this at $0 cost share?

This medication will be covered at $0 cost share for Blue Cross and BCN commercial members who are at high risk of contracting HIV. We'll cover generic Truvada for PrEP at $0 cost share when it is available.

This change doesn't apply to grandfathered employees, retirees or groups with religious accommodation exceptions.

Why are we doing this?

The U.S. Preventive Services Task Force has recommended providers offer PrEP with effective antiretroviral therapy to patients at high risk for HIV and that it must be offered with no cost share.

The Centers for Disease Control and Prevention reports that when taken daily, PrEP is highly effective for preventing HIV. Studies have shown that PrEP reduces the risk of contracting HIV through sexual transmission by about 99% when taken daily. Among people who inject drugs, PrEP reduces the risk of getting HIV by at least 74% when taken daily. PrEP is much less effective if it isn't taken consistently.

What is the USPSTF recommendation?

The following is the draft recommendation summary:

Population	Recommendation	Grade
Persons at high risk of HIV acquisition	The USPSTF recommends that clinicians offer PrEP with effective antiretroviral therapy to persons who at high risk of HIV acquisition.	A

A grade of A or B means it must be offered as preventive at $0 cost share.

Who can prescribe PrEP?

Any licensed prescriber can prescribe PrEP. Specialization in infectious diseases or HIV medicine is not required. In fact, primary care providers who routinely see people at risk for HIV acquisition should consider offering PrEP to all eligible members.

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Recommendations for submitting authorization requests for medical oncology drugs to AIM

Follow these recommendations when submitting authorization requests for medical oncology drugs to AIM Specialty Health®:

- Wait to submit the request until you have **all** the pertinent information, including tumor testing results and information on tumor staging and prior therapy regimens.
- Provide **all** the clinical information needed for clinical review, including the rationale for the requested regimen.
- Make sure the phone number you provide is accurate, so AIM can call you to schedule a peer-to-peer consultation if they need more information to establish medical necessity.

When you follow these guidelines, the process of reviewing authorization requests takes less time.

This information applies to all members whose plans require authorization of medical oncology drugs by AIM:

- Medicare Advantage plans: Medicare Plus Blue℠ PPO and BCN Advantage℠
- Commercial plans: BCN HMO℠ and select Blue Cross' PPO groups

How to submit authorization requests

For medical oncology drugs, submit authorization requests to AIM using one of the following methods:

- Through the **AIM *ProviderPortal***
- 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 Specialty Health website.

Lists of requirements

To see the requirements related to drugs covered under the medical benefit, including medical oncology drugs, refer to the following:

- For Medicare Advantage members: **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**
- For commercial members:
  - **Medical oncology prior authorization list for Blue Cross' PPO UAW Retiree Medical Benefits Trust members**
  - **Medical oncology prior authorization list for BCN HMO (commercial) members**

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

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

We're adding authorization requirements for five specialty drugs covered under the medical benefit for Medicare Plus Blue℠ PPO, BCN HMO℠ and BCN Advantage℠ members.

For dates of service on or after May 15, 2020, Sarclisa® (isatuximab-irfc, HCPCS codes J3490, J3590 and J9999) requires authorization through AIM Specialty Health®.

For dates of service on or after July 24, 2020, the following drugs will require authorization through AIM Specialty Health:

- Trodelvy™ (sacituzumab govitecan-hziy, J3490, J3590, J9999)
- Jelmyto™ (mitomycin, J3490, J3590, J9999)
- Darzalex Faspro™ (daratumumab and hyaluronidase-fihj, J3490, J3590, J9999)

For dates of service on or after Aug. 24, 2020, the following drug will require authorization through AIM:

- Imlygic® (talimogene laherparepvec, J9325)

How to submit authorization requests

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

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

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

More about the authorization requirements

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

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

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

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

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We've added a document online with program information for site-of-care requirements for Lemtrada and Tysabri

We published an article in the May-June issue of *BCN Provider News*, titled "**We're adding site of-care requirements for Lemtrada and Tysabri for commercial members, starting May 1**." (Page 17)

We've since added a link to a document on the **ereferrals.bcbsm.com** website. The document, ***Lemtrada and Tysabri site-of-care program: Frequently asked questions by providers***, contains additional program information and details related to safety protocols and authorized administration sites in Michigan and elsewhere in the United States.

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

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

Refer to the article in the previous issue for details.

We're postponing changes we announced for Xanax, Soma products and some migraine medications

We published three articles in the March-April issue of *BCN Provider News* about pharmacy changes we had planned to make. Those changes have been posted. Links to the original articles are included below for your reference.

- We announced the postponement of **quantity limits for Xanax** (Page 30) and its generic equivalent alprazolam.
- We announced that we'll **stop covering certain Soma products** (Page 30).
- We announced quantity limits for certain **migraine medications** (Page 19).

We'll communicate planned changes in future newsletters or web-DENIS messages.

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Vaccine Affiliation Agreement amended

We're amending our Vaccine Affiliation Program to permit pharmacies participating in the program to submit medical claims to Blue Care Network for services listed on the Medical Immunization Pharmacy Providers Payable Vaccines Fee Schedule, which is updated occasionally.

Our Vaccine Affiliation Agreement remains unchanged for Blue Cross Blue Shield of Michigan members.

A previous amendment to the agreement expanded the program to pharmacies participating with BCN with certain exceptions. One of the exceptions was that covered services for BCN members were limited to **adult immunizations only**.

The Second Amendment to the Vaccine Affiliation Agreement removes this limitation and now provides that covered services for BCN members include **adult immunizations and certain other testing** as described in the fee schedule, subject to the other terms and conditions of the agreement.

Correction to pharmacy article: HCPCS code for Palforzia is J3590

An article ran in the May-June issue of *BCN Provider News*, titled, "Quarterly update: Requirements changed for some commercial medical benefit drugs" that contained the wrong HCPCS code for Palforzia™. The correct code is J3590.

The article appeared in Page 18 of the **May-June** issue.

CORONAVIRUS
COVID-19

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Billing tips for COVID-19

There have been many changes announced during the COVID-19 pandemic. To make billing easier for you, we've created two documents for you to reference.

- ***Billing tips for COVID-19*** brings all of the changes together into one reference document.
- ***Billing tips for COVID-19 at a glance*** is a one-page reference of highlights.

Two diagnosis codes for confirmed COVID-19 for dates of service prior to April 1, 2020, were missing from our May-June issue and J20.9 was listed incorrectly instead of J20.8. Please refer to the *Billing tips for COVID-19* for a complete list of diagnosis codes for COVID-19.

The billing tips documents can be found on our *Coronavirus (COVID-19) information updates for providers* page. Log in as a provider at **bcbsm.com** and click on Coronavirus (COVID-19). You can also find information at **bcbsm.com/coronavirus** by clicking on ***For Providers***.

April ICD-10-CM code update now available

The Centers for Medicare & Medicaid Services has added an April ICD-10-CM code update that was effective with dates of service on or after April 1, 2020. This update contains diagnosis code U07.0, which is for a vaping-related disorder.

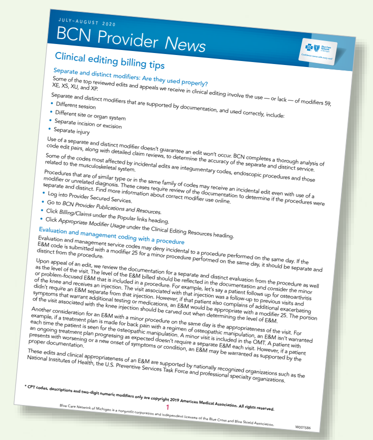
For more information about ICD-10 code updates, visit the **CMS website**.

Clinical editing billing tips

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

This issue's tip includes:

- Separate and distinct modifiers
- Evaluation and management coding with a procedure


JULY–AUGUST 2020
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Separate and distinct modifiers: Are they used properly?

Clinical editing billing tips

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How to coordinate benefits under Michigan's new auto no-fault law

Changes to Michigan's automobile no-fault insurance law may lead to more instances in which providers need to coordinate benefits.

Beginning July 1, 2020, individuals will no longer be required to purchase unlimited personal injury protection, or PIP, with their auto insurance. Under certain circumstances, drivers can select different levels — or opt out — of PIP coverage through their auto insurer. In situations where a member's auto insurance is considered primary to their Blue Care Network coverage, and they select a low level of PIP coverage, their auto insurance benefits may run out. In most cases, BCN is the primary payer and providers will continue to bill BCN first.

What you need to know

- Continue to bill auto accidents as you do today.
- Enter the appropriate value indicating an auto-accident claim.
- Continue to follow existing Medicare guidelines pertaining to billing and secondary payer rules.
- PIP is a 'lifetime per accident per patient" benefit, not an "annual, per family, or per individual" maximum.
- PIP coverage pays for some items that health insurance doesn't, such as attendant care, lost wages and vehicle or housing modifications (PIP also pays for services that Medicare coverage may not.)
- If the auto insurer is considered the primary payer, BCN will reject the claim if we're billed as primary payer.
- When you bill BCN as a secondary payer, you'll need to include on the 837 either the auto insurer's payment decision, or the denial
- When the member's auto PIP benefits are exhausted, you'll receive a rejection from the insurer (PR*119 or PR*149 may be indicated on the denial).

Please see no-fault law, continued on Page 33

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Use our online resources to understand billing guidelines

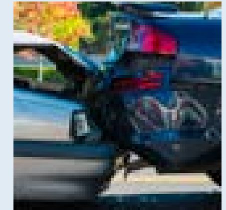
Blue Care Network provides an array of clinical editing and billing resources to help providers bill to avoid clinical edits or denials. Online resources can help you understand how a claim may process.

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

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

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

no-fault law,
continued from Page 32



Determining which insurance is primary

Currently, BCN pays primary on most auto accident-related medical claims.

Provider should ask members:

- Whether they have coverage from more than one insurance carrier
- Whether their injury is the result of an accident

Notify BCN's COB department of any vehicle-related injury so we can initiate an investigation and determine primacy. Call the BCN COB department at 1-800-808-6321 and follow the prompts for: Option 1: Other party liability (OPL), that is, auto and workers' compensation.

If you need more details about coordination of benefits, refer to the manual by logging in to Provider Secured Services. Refer to the COB section located in the "Claims" chapter.

If you have questions about coordinating benefits with a member's existing auto insurer, call Provider Inquiry at 1-800-344-8525.

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Update on temporary changes due to the COVID-19 pandemic

Blue Cross Blue Shield of Michigan and Blue Care Network have made many temporary changes to support providers and protect members during the COVID-19 pandemic. Some of those changes have ended and one has been extended.

These updates apply to Blue Cross' PPO, BCN HMO℠, Medicare Plus Blue℠ PPO and BCN Advantage℠ members, unless otherwise noted.

Temporary changes that have ended	
For dates of service on or after **June 13, 2020**	**Clinical review is again required by Blue Cross / BCN Utilization Management for acute care admissions with non-COVID-19-related diagnoses.** You'll need to submit clinical documentation along with your authorization requests.
For dates of service on or after **July 1, 2020**	**Member cost share once again applies for Blue Cross' PPO and BCN HMO members for common medical and behavioral health visits that are performed using telemedicine.** Notes • As noted below, we'll continue to waive cost share for COVID-19-related treatment through Dec. 31, 2020. This includes COVID-19-related treatment delivered through telemedicine. • For Medicare Plus Blue and BCN Advantage members, cost share will be waived for common medical and behavioral health services through Dec. 31, 2020, for both in-office and telehealth visits. See Blue Cross and BCN waiving cost share for Medicare Advantage members, Page 11 for more information.
	For acute care admissions with COVID-19-related diagnoses, clinical review is once again required.
	For CT scans of the chest to rule out pneumonia diagnosis associated with COVID-19, AIM Specialty Health® again requires clinical review for procedure codes *71250, *71260 and *71270.
	For the first three days of admission to a skilled nursing facility for members transferred from acute care, Blue Cross / BCN Utilization Management and naviHealth once again require clinical review.

Temporary change that has been extended	
End date extended from June 30, 2020 to Dec. 31, 2020	**For Blue Cross' PPO and BCN HMO members, we'll waive member cost share for COVID-19 treatment through Dec. 31, 2020.** Previously, this was scheduled to end on June 30, 2020. Note: As previously communicated, we'll continue to waive cost share for COVID-19 treatment through Dec. 31, 2020, for Medicare Plus Blue and BCN Advantage members. See Blue Cross and BCN waiving cost share for Medicare Advantage members, Page 11.

To determine end dates for other temporary actions Blue Cross and BCN have taken, see the ***Temporary changes due to the COVID-19 pandemic*** document.

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

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We're making some changes to the e-referral system

Blue Care Network is making improvements to the e-referral system to make it easier for you to submit authorization requests. The changes will be effective by late July.

We're hosting four webinars to review the changes.

Here's a preview:

- We're blocking duplicate referrals to prevent unnecessary pends in the system.
- We'll only allow the member's assigned primary care physician to submit certain requests.
- Specialists will be able to submit authorization requests for services only if there's a global referral on file for the member.

Sign up for webinars

We're offering webinars to share helpful tips that can improve your experience with the e-referral system and decrease the need to call BCN.

Webinars will focus on reviewing e-referral best practices and the importance and ease of using e-referral in lieu of contacting the call center.

Register using the links below.

Title	Date and time	Registration links
BCN provider-facing changes to e-referral	Tuesday, July 14, 10 to 11 a.m.	Click here to register
BCN provider-facing changes to e-referral	Thursday, July 16, 2 to 3 p.m.	Click here to register
BCN provider-facing changes to e-referral	Wednesday, July 22, 11 a.m. to 12 p.m.	Click here to register
BCN provider-facing changes to e-referral	Thursday, July 23, 1 to 2 p.m.	Click here to register

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Some Blue Care Network transitional care fax numbers have been discontinued

The following BCN transitional care fax numbers were **discontinued on June 1**.

- 1-866-652-8985
- 1-866-578-5482

If you had been faxing transitional care authorization requests or clinical documentation — or any other documentation — to those numbers, you must submit those materials using a different method.

The only working fax number for BCN transitional care services is 1-866-526-1326. Use that fax number to submit authorization requests for home health care and home enteral feedings **only** when the e-referral system is unavailable.

Here's what you need to know.

Home health care services

For home health care services such as nursing visits and physical, occupational and speech therapy provided by a home health care facility in a member's home:

- For BCN HMO℠ and BCN Advantage℠ members covered through the UAW Retiree Medical Benefits Trust (group number 00278806), don't submit anything to us. Neither referral nor authorization is required for traditional home health care services. This applies to both contracted and noncontracted providers.
- For BCN HMO and BCN Advantage members not covered through the UAW Retiree Medical Benefits Trust, submit home health authorization requests only for these providers:
  - Noncontracted providers: Call these requests in to BCN's Utilization Management department at 1-800-392-2512.
  - Contracted providers who don't belong to the provider network associated with the member's plan: Submit these authorization requests through the e-referral system.

Note: For other contracted providers, don't submit referrals or authorization requests. Neither is required.

Home enteral feedings

For all BCN members, authorization is required for enteral feeding services. Submit authorization requests through the e-referral system and complete the questionnaire that opens.

Note: Authorization is not required for either total parenteral nutrition or intradialytic parenteral nutrition services. This applies to both contracted and noncontracted providers and to all BCN HMO and BCN Advantage members.

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TurningPoint to manage authorization requests for all surgical procedures related to musculoskeletal conditions for dates of service on or after July 1

As we reported in the last issue, you'll need to submit authorization requests for all surgical procedures related to musculoskeletal conditions to TurningPoint, starting June 1, for dates of service on or after July 1. (This date was moved to July 1 due to the COVID-19 pandemic.)

Some important reminders:

- This is effective for BCN HMO℠ (commercial), BCN Advantage℠ and Medicare Plus Blue℠ PPO members.
- Facilities should have an authorization number before scheduling surgery. The ordering physician or provider office must secure the authorization and provide the authorization number to the facility.
- For inpatient professional claims, make sure to include only the procedure codes authorized for musculoskeletal procedures on your claim.
- You can start submitting authorization requests on June 1.

For more details, see the **article** in the May-June issue.

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

Use the links below to register for webinars:

- **Training for professional providers**
- **Training for facility providers**
- **Portal training** (professional providers only)

Where to find more information

For more information about TurningPoint, see the webpages for **BCN** and **Blue Cross** on our **ereferrals.bcbsm.com** website.

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

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

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

Recommendations for submitting authorization requests for medical oncology drugs to AIM

Here are some recommendations to follow when submitting authorization requests for medical oncology drugs to AIM Specialty Health®:

- Wait to submit the request until you have **all** the pertinent information including, but not limited to, tumor testing results and information on tumor staging and prior therapy regimens.
- Provide **all** the clinical information needed for clinical review, including the rationale for the requested regimen.
- Make sure the phone number you provide is accurate, so AIM can contact you to schedule a peer-to-peer consultation if they need more information to establish medical necessity.

See the article on **Page 27** for more details.

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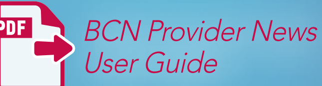

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New secure provider website coming in 2021

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

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

New site will be operated by Availity

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

Watch for more information in future issues of this newsletter.

We've changed preventive screenings to a calendar year schedule

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

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

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

Please see Preventive screenings, continued on Page 2

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13 From the medical director: Isolation and economic uncertainty puts children and adults at increased risk for domestic violence

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

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Preventive screenings, *continued from Page 1*

Annual physical reminder

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

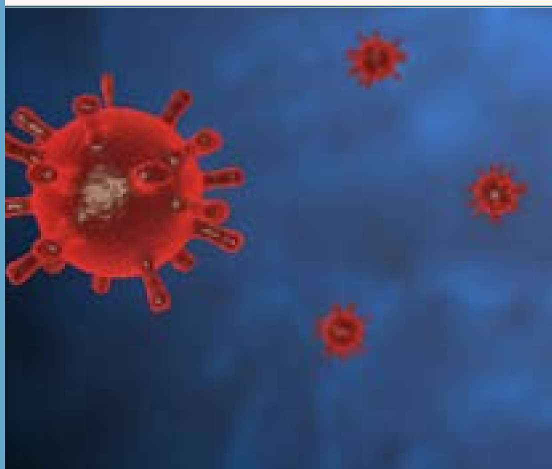
Healthy *Blue* Living℠ HMO members are required to visit their primary care physician for an exam within 90 days of enrollment or renewal. Providers can schedule this physical exam any time. If last year's physical was in March, for example, the member can get a physical in January.

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

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

Preventive screenings for BCN Advantage follow Medicare guidelines

BCN Advantage℠ and Medicare Plus Blue℠ PPO follow guidelines set by the Centers for Medicare & Medicaid Services. Those rules have not changed. More information on the frequency of Medicare screenings is available at **cms.gov**.



Checking the status of temporary measures for COVID-19

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

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

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

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

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

What's changing

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

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

These services are:

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

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

Some groups extend COVID-19 cost share waivers

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

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

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

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

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

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

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

This new policy applies to Blue Cross' PPO, Medicare Plus Blue[SM] PPO, BCN HMO[SM] and BCN Advantage[SM]. It doesn't apply to Blue Cross' PPO self-funded groups.

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

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

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

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

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

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

How to submit authorization requests

Submit authorization requests to eviCore in one of these ways:

- Preferred: Use evicore's provider portal at **www.evicore.com**
- Alternative: Call eviCore
  - BCN/BCN Advantage: 1-855-774-1317
  - Blue Cross PPO/ Medicare Plus Blue: 1-877-917-2583
- Alternative: Fax to eviCore at 1-800-540-2406

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

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

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

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

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

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

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

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

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

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

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

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Blue Care Network program helps members understand surgery options

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

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

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

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

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

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Online Training

On-demand training available

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

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

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

For Blue Cross

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

For BCN

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

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

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Providers find *Blues Brief* helpful and easy to read

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

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

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

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

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

- ***BCN Provider News***
- ***The Record***
- ***Blues Brief***

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

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

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

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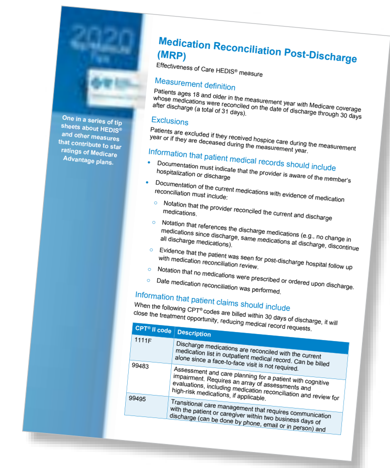
Medication reconciliation post-discharge is critical to patient safety and care coordination efforts

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

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

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



Medication Reconciliation Post-Discharge (MRP)

Effectiveness of Care HEDIS® measure

One in a series of tip sheets about HEDIS® and other measures that contribute to star ratings of Medicare Advantage plans.

Measurement definition

Patients ages 18 and older in the measurement year with Medicare coverage whose medications were reconciled on the date of discharge through 30 days after discharge (a total of 31 days).

Exclusions

Patients are excluded if they received hospice care during the measurement year or if they are deceased during the measurement year.

Information that patient medical records should include

- Documentation must indicate that the provider is aware of the member's hospitalization or discharge
- Documentation of the current medications with evidence of medication reconciliation must include:
  - Notation that the provider reconciled the current and discharge medications.
  - Notation that references the discharge medications (e.g., no change in medications since discharge, same medications at discharge, discontinue all discharge medications).
  - Evidence that the patient was seen for post-discharge hospital follow up with medication reconciliation review.
  - Notation that no medications were prescribed or ordered upon discharge.
  - Date medication reconciliation was performed.

Information that patient claims should include

When the following CPT® codes are billed within 30 days of discharge, it will close the treatment opportunity, reducing medical record requests.

CPT® II code	Description
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and

Medication Reconciliation Post-Discharge tip sheet

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

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

We're adding authorization requirements for three specialty drugs covered under the medical benefit for BCN HMO℠, Medicare Plus Blue℠ and BCN Advantage℠ members.

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

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

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

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Medicare Part B medical specialty drug prior authorization list is changing

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

New authorization requirements

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

- J3590*, abicipar pegol

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

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

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

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

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

Authorization requirement removed

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

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

How to bill

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

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

Important reminder

Submit authorization requests through NovoLogix. It offers real-time status checks and immediate approvals for certain medications. For Medicare Plus Blue and BCN Advantage, if you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix.

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

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

*J3590 is a code is used for unclassified biologics

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

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

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

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

- The member's body mass index is 30 kg/m^2 or greater
- The member's actual body weight is 20% higher than their ideal body weight

This applies to all Medicare Plus Blue and BCN Advantage members who start therapy on or after Dec. 7, 2020, when the therapy is administered by a health care professional in a provider office, at the member's home, in an off-campus outpatient hospital or in an ambulatory surgical center (places of service 11, 12, 19, 22 and 24).

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

Important reminder

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

For Medicare Plus Blue and BCN Advantage, if you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix.

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

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

Pharmacy-benefit drugs: News about electronic prior authorization

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

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

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

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Talk with your patients about osteoporosis

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

Starting the conversation

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

As appropriate, suggest:

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

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

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

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

Checking on osteoporosis care

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

HEDIS measures

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

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

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

The Health Outcomes Survey asks patients:

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

For more information

The U.S. Preventive Services Task Force **webpage on osteoporosis** indicates that doctors should screen all women age 65 and older for osteoporosis.

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

You can also check out the Centers for Disease Control and Prevention's **Older Adult Falls** webpage.

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

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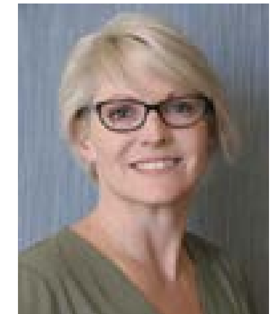
Isolation and economic uncertainly puts children and adults at increased risk for domestic violence

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

William Beecroft, M.D.



Kristyn Gregory, D.O.

Keeping children safe

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

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

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

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

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

Please see From the medical director, continued on Page 14

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From the medical director, *continued from Page 13*

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

Adults at risk

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

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

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

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

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

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

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

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

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

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

See full article on **Page 9**.

Important notice about pediatric feeding programs

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

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

Medical policy updates

Medical Policy Updates

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

Noncovered services

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

Covered services

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

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Blue Cross demonstrates ongoing commitment to members' behavioral health needs

By Dr. Amy McKenzie

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

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

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

We introduced incentives to help providers fund the adoption of telemedicine. Over a four-week period beginning in mid-March, the percentage of primary care physicians and behavioral health providers who are providing telemedicine services grew to more than more than 80% from less than 10%— a truly phenomenal increase.

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

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

Please see Commitment, continued on Page 17

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Commitment, *continued from Page 16*

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

- We're continuing to develop and expand our Psychiatric Consultant Collaborative Care Model. This model incorporates a psychiatric consultant and a behavioral health care manager (who may be a social worker or psychologist) into the patient's care team. It provides care for a patient's mental health concerns within a patient-centered medical home setting. Training on this model will begin in September.
- We launched the myStrength program, an online tool offered through Livongo®, an independent company that works closely with Blue Cross Blue and Blue Care Network. It provides stress management strategies, parenting tips and emotional support tools, including a module for coping with COVID-19. All members have access to the program at no cost through Dec. 31, 2020. You can let your patients who are Blue Cross or BCN members know they can go to **bh.mystrength.com/bcbsmcvd19** and create a free myStrength account.
- We're in the initial stages of developing a pilot program that will help primary care physicians identify patients who have mental health needs and refer them to psychologists in their area.

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

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

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

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

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

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

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

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

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

We updated the following documents to reflect this change:

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

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

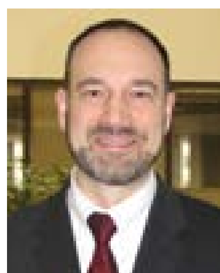
To check whether a member has an autism benefit, follow the instructions on these documents:

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

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

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

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



Duane DiFranco, XXX

William Beecroft, M.D.

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

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

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

The Michigan Psychiatric Society represents the interests and professional needs of psychiatric physicians in Michigan while striving to ensure quality care for people with mental disorders and their families through promotion of education, research and advocacy.

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Quality corner: Initiation and engagement of alcohol and other drug dependence treatment

What does this measure focus on?

Initiation and engagement of alcohol and other drug dependence treatment is a HEDIS® measure. It looks at the percentage of patients ages 13 or older with a new episode of alcohol or other drug abuse or dependence.

Two parts are examined:

- Initiation of AOD treatment — Treatment must be initiated within 14 days of the diagnosis. Treatment can be initiated through:
  - An inpatient alcohol or other drug admission
  - An outpatient visit
  - An intensive outpatient encounter
  - A partial hospitalization
  - Telehealth (including telephone visits, e-visits, virtual check-ins)
  - Medication treatment (also known as medication-assisted treatment, or MAT)
- Engagement of AOD treatment — Considered complete if the first bullet and one of the other two are completed.
  - Member initiated treatment (above)
  - Member whose initiation of AOD treatment was not a medication treatment: Member received two or more AOD engagement visits or one medication treatment event 34 days after the initiation treatment
  - Member whose initiation of AOD treatment was a medication treatment: Two or more AOD engagement events (only one can be a medication treatment event) within 34 days after the initiation event

Why is this important?

Higher morbidity and mortality rates are associated with substance use disorders more than any other preventable health problem. The treatment costs of health conditions caused by a substance use disorder are a strain on the health care system, totaling more than $165 billion each year in health care expenditures alone.

While treating alcohol and other drug dependence leads to improved health and productivity, only 10% of the 23.1 million Americans who need treatment receive it, according to a 2012 estimate from the National Institute on Drug Abuse.

Ensuring patients get care and it counts

Many providers administer the care, but HEDIS looks at specific timeframes and circumstances to ensure the best quality. Providers need to keep timing in mind.

- If you diagnose a patient with AOD dependence, schedule a visit at your own practice or refer the patient to a behavioral health provider as soon as possible so treatment can be started within 14 days of the diagnosis.
- Schedule engagement events within 34 days of the initiation event. HEDIS also specifies certain stipulations when looking at what does and doesn't count. These two important tips can affect whether the service is considered complete by HEDIS standards:
  - The date of an eligible AOD diagnosis and the initiation visit can be on the same day, but must be with two different providers, unless the provider is offering medication treatment
  - The patient can complete more than one engagement visit on the same day, but the visits must be with different providers. Engagement visit and engagement medication treatment can be on the same date with the same provider.

Note: For members in the "other drug abuse or dependence" cohort (for example, members with an AOD diagnosis unrelated to alcohol or opioids), medication treatment does not meet the criteria for either initiation or engagement.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.

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Remind your eligible patients to get mammograms every two years

One in eight women in the United States will be diagnosed with breast cancer in her lifetime, making it the second most common cancer in women. You play an integral role in early detection by recommending regular screenings to your patients. Early detection through regular screening is key to a better outcome.

The Healthcare Effectiveness Data and Information Set breast cancer screening star rating measure is used by the Centers for Medicare & Medicaid Services to drive improvements in patient health. CMS and HEDIS® recommend routine mammogram screenings every 24 months for women ages 50 to 74.

The National Committee for Quality Assurance now allows patients to be excluded from the Breast Cancer Screening HEDIS star quality measure due to advanced illness and frailty. They acknowledge that measured services most likely would not benefit patients who are in declining health.

Please review the Breast Cancer Screening tip sheet to learn more about this HEDIS measure, including information that should be documented in a patient's medical record and included in claims along with tips for talking with patients.

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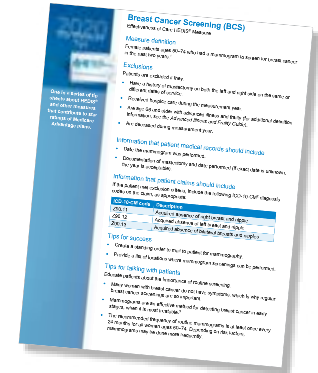

Breast Cancer Screening (BCS)

Breast Cancer Screening tip sheet

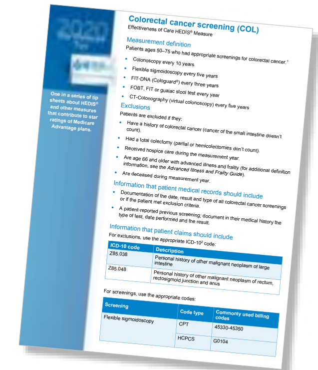
Remind your patients of the importance of colorectal cancer screening

Colorectal cancer is the third most common cancer diagnosed in both men and women in the United States, according to the American Cancer Society. Your patients may assume that a colonoscopy is the only way to test for colorectal cancer, but there are many types of screenings available. Talk to your patients about the importance of early detection and the tests available, including those that are noninvasive.

It's important for providers to document the type of screening performed, or any exclusions, in the patient's medical record. Exclusions for this measure have changed to include advanced illness and frailty of the patient.

Providers should make sure they order the most appropriate colorectal screening, based on the patient's status.

View the Colorectal Cancer Screening tip sheet to learn more about the measure, such as information to include in a patient's record, CPT codes that should be included in claims and tips for talking with patients.


Colorectal cancer screening (COL)

Colorectal Cancer Screening tip sheet

Help improve diabetic patient health while reducing medical record review requests

The Healthcare Effectiveness Data and Information Set Comprehensive Diabetes Care measure provides a comprehensive picture of the clinical management of patients with diabetes. It's a star rating measure used for HEDIS® reporting, which is used by the Centers for Medicare & Medicaid Services to drive improvements in patient health.

Patients who have diabetes require consistent medical care and monitoring to reduce the risk of severe complications and improve outcomes. Interventions to improve diabetes outcomes go beyond glycemic control, as diabetes affects the entire body. That's why the diabetes care measure includes HbA1c control, retinal eye exams, medical attention for nephropathy and blood pressure control.

View the tip sheet to learn more about the measure, new exclusions (including advanced illness and frailty of the patient) and ways you can close gaps in care for patients who have diabetes. The tip sheet also covers required medical record documentation and claim coding, which, if adhered to, can reduce the need for medical record reviews.

2020

One in a series of tip sheets about HEDIS® and other measures that contribute to star ratings of Medicare Advantage plans.

Comprehensive diabetes care (CDC)

Effectiveness of Care HEDIS® Measure

Measurement definition

Patients ages 18–75 with a diagnosis of diabetes (Type 1 or Type 2) in compliance with the following:

- HbA1c control
- Retinal eye exam
- Medical attention for nephropathy
- Blood pressure control

Exclusions

Patients are excluded if they:

- Have gestational or steroid-induced diabetes.
- Received hospice care during the measurement year.
- Are age 66 and older with advanced illness and frailty (for additional definition information, see the *Advanced Illness and Frailty Guide*).
- Are deceased during measurement year.

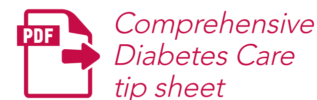
Information that patient medical records should include

HbA1c results: HbA1c should be completed two to four times each year with documented date and distinct numeric result. The last HbA1c result of the year must be less than or equal to nine to show evidence of control.

Retinal eye exam results: A retinal or dilated eye exam must be performed by an eye care professional. When you receive an eye exam report from an eye care provider for your patient with diabetes:

- Review the report and note if there are any abnormalities. If so, add the abnormalities to the patient's active problem list and indicate what follow up is needed and when.
- Place the report in the patient's medical record.
- Make sure the date of service and eye care professional's name and credentials are included for HEDIS compliance.
- If a copy of the report isn't available, document in the patient's medical history the date of the eye exam, the result and the eye care professional who conducted the exam with credentials.
- Patients with positive retinopathy results need an annual exam. Those with negative results may be examined every two years.

Blood pressure readings: The last blood pressure reading of the year must be less than 140/90 to show evidence of control. Don't round up blood pressure readings.



Comprehensive Diabetes Care tip sheet

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Here's new information about electronic prior authorization for drugs covered under pharmacy benefits

Starting Aug. 3, you can use CoverMyMeds® and other free ePA tools such as Surescripts® and ExpressPAth® to submit requests for most pharmacy-benefit drugs for our Medicare Advantage members. These are members who have coverage through Medicare Plus Blue℠ or BCN Advantage℠ plans.

You can continue to submit ePA requests for members who have Blue Cross Blue Shield of Michigan or Blue Care Network commercial coverage.

New feature in CoverMyMeds

For those who use CoverMyMeds to submit ePA requests, there's a new feature that helps ensure you're identifying the correct insurance plan.

In the Plan or PBM Name field, you can now enter the bank identification number, or RxBIN, and the RxGroup found on the member's ID card.

To locate the correct plan for one of our members:

- Enter 610014 as the RxBIN for both Blue Cross Blue Shield of Michigan and BCN.
- Enter one of these RxGroups:
  - Blue Cross' commercial: BCBSMRX1 or BCBSMAN
  - BCN commercial: MiBCNRX
  - Medicare Plus Blue: BCBSMAN
  - BCN Advantage: BCNRXPD

Remember to look for the RxBIN and RxGroup on the member's ID card.

Please see Electroninic prior authorization, continued on Page 23

Benefits of using ePA

Using CoverMyMeds or other ePA tools instead of submitting requests by fax or phone allows you to spend less time on administrative tasks and more time on patient care.

Other benefits of using ePA tools include:

- Automatic approvals for select drugs and improved turnaround time for review and decisions
- Easy use by prescribers, nurses and office staff
- All documentation and requests kept conveniently in one place

Here are some answers to frequently asked questions about ePA.

- **Why should I use ePA?** You'll save time. You can send 11 ePAs in the time it takes to fax just one (based on Comcast and Verizon broadband rates and a fax speed of 33.6 kbps) and patients can receive medications faster.

  The process is intuitive. Providers and their authorized personnel can log in online, submit requests and access determinations.
- **What about ePA tools within the electronic health record?** Using an ePA tool within your electronic health record makes it even easier to submit electronic requests and gives you:
  - Clear direction on clinical requirements
  - The ability to attach required documentation
  - Secure and efficient authorization administration all in one place
  - The capability of renewing existing authorizations proactively, up to 60 days before they expire
  - Streamlined questions that are specific to the prior authorization request you're submitting

Typically, an ePA tool can be integrated into your current EHR workflow. Check with your vendor to ensure you have software that accommodates an ePA tool.

If an ePA tool isn't available within the EHR you use, you can always create a free online account through CoverMyMeds or other ePA tools such as Surescripts® and ExpressPAth® to submit requests. Registration takes only a few minutes.

If you have questions, call the Pharmacy Clinical Help Desk at 1-800-437-3803.

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Electroninic prior authorization, *continued from Page 22*

Submitting ePA requests using CoverMyMeds

To complete an ePA request using your CoverMyMeds online accounts:

1. Go to **covermymeds.com/epa/express-scripts**. (Create a free account if you don't already have one.)
2. Start a prior authorization request:
   - Click *New Request* and select *Michigan* in the *Patient Insurance State* field.
   - **New:** In the *Plan or PBM Name* field, enter the RxBIN and the RxGroup found on the patient's member ID card.
   - Enter the medication, select the appropriate form and click *Start Request*.
3. Complete the request:
   - Complete all information fields marked *Required* and click *Send to Plan*.
   - CoverMyMeds displays a list of patient-specific, clinical questions. Answer all questions that are marked *Required*.
4. Confirm the request:
   - Click *Send to Plan* again to confirm that you've submitted the request.

After Blue Cross or BCN has reviewed your prior authorization request, the determination will appear in your CoverMyMeds account.

CoverMyMeds often returns approval decisions within minutes of submission depending on the complexity of the request or the need for additional review.

IVIG dosing strategy is changing for the Medicare Part B medical specialty drug program, starting Dec. 7

Blue Cross Blue Shield of Michigan and Blue Care Network require authorization for immune globulin products covered under the medical benefit for Medicare Plus Blue℠ PPO and BCN Advantage℠ members.

As part of the authorization process, we're updating our dosing strategy for intravenous and subcutaneous immune globulin therapy to minimize drug waste, reduce unnecessary drug exposure and decrease the risk of adverse events.

Effective Dec. 7, 2020, we'll calculate doses using adjusted body weight for members when:

- The member's body mass index is 30 kg/m^2 or greater
- The member's actual body weight is 20% higher than their ideal body weight

For more information, see the article on **Page 11**.

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Effective Oct. 1, Nivestym and Zarxio are the preferred filgrastim products for all Blue Cross and BCN commercial and Medicare Advantage members

For dates of service on or after Oct. 1, 2020, the preferred filgrastim products for all Blue Cross and Blue Care Network commercial and Medicare Advantage members will be:

- Nivestym® (filgrastim-aafi; HCPCS code Q5110)
- Zarxio® (filgrastim-sndz; HCPCS code Q5101)

For commercial members, these requirements apply only to groups currently participating in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit. They don't apply to non-Medicare members covered through the UAW Retiree Medical Benefits Trust. They also don't apply to members covered by the Federal Employee Program® Service Benefit Plan.

Patients should take the preferred drugs when possible. Here's what to keep in mind about the members who are prescribed these drugs:

- Members starting treatment on or after Oct. 1 should use a preferred filgrastim product.
- Members currently receiving one of the filgrastim products listed below should transition to Nivestym or Zarxio:
  - Neupogen® (filgrastim; HCPCS code J1442)
  - Granix® (tbo-filgrastim; HCPCS code J1447)

We'll notify commercial members currently taking the nonpreferred drugs and encourage them to discuss treatment options with you.

Here are the authorization requirements for members starting or transitioning to the preferred drugs:

- For Blue Cross' PPO members, the preferred drugs don't require authorization.
- For BCN HMO℠, Medicare Plus Blue℠ PPO and BCN Advantage℠ members, the preferred drugs require authorization through AIM Specialty Health®.

Request authorization for patients who must take the nonpreferred drugs

Here are the requirements for members you feel need to take Neupogen or Granix rather than Nivestym and Zarxio:

- For Blue Cross' PPO members, authorization is required. Submit the authorization request through the NovoLogix® online tool.
- For BCN HMO, Medicare Plus Blue and BCN Advantage members, both step therapy and authorization are required. Submit the authorization request through AIM Specialty Health®.

More about the authorization requirements

Authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.

For additional information on requirements related to drugs covered under the medical benefit, see:

- **Blue Cross' PPO and BCN HMO:** **Blue Cross and BCN utilization management medical drug list**
- **Medicare Advantage:** **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**

We'll update the requirements lists with the new information before Oct. 1.

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Medical specialty drug prior authorization lists are changing in September for BCN HMO, Medicare Plus Blue PPO and BCN Advantage members

We're adding authorization requirements for three specialty drugs covered under the medical benefit for BCN HMO℠, Medicare Plus Blue℠ and BCN Advantage℠ members.

For dates of service on or after Sept. 25, 2020, the following drugs will require authorization through AIM Specialty Health®:

- Zepzelca™ (lurbinectedin), HCPCS codes J3490, J3590, J9999
- Phesgo™ (pertuzumab/trastuzumab/hyaluronidase-zzxf), HCPCS codes J3490, J3590, J9999
- Nyvepria™ (pegfilgrastim-apgf), HCPCS codes J3490, J3590, J9999

How to submit authorization requests

Submit authorization requests to AIM using one of the following methods:

- Through the **AIM provider portal**
- By calling the AIM Contact Center at 1-844-377-1278

For information about registering for and accessing the AIM ProviderPortal, see the **Frequently asked questions** page on the AIM website.

More about the authorization requirements

Authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.

For additional information on requirements related to drugs covered under the medical benefit, see:

- **BCN HMO: Blue Cross and BCN utilization management medical drug list and the Medical Oncology Program** list
- **Medicare Advantage: Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**

We'll update these lists with the new information about these drugs before the effective dates.

Praluent and Repatha are no longer designated as specialty drugs

Starting July 1, 2020, the PCSK9 inhibitor drugs Repatha® and Praluent® are no longer designated as specialty drugs.

Specialty drugs require special handling, administration or monitoring. Some can only be filled by a specialty pharmacy.

On or after July 1, 2020, members can fill prescriptions for Repatha and Praluent at any retail pharmacy in our network. Members can fill a 90-day supply of these drugs If their prescription drug benefit allows it.

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Quarterly update: Requirements changed for some medical benefit drugs for BCN HMO members

Blue Cross Blue Shield of Michigan and Blue Care Network encourage proper utilization of high-cost medications that are covered under the medical benefit. As part of this effort, we maintain a comprehensive list of requirements for both Blue Cross' PPO (commercial) and BCN HMO℠ (commercial) members.

During April, May and June 2020, the following medical drugs had authorization requirement updates, site-of-care updates or both for BCN HMO members. We updated the list of requirements to reflect these changes.

HCPCS code	Brand name	Generic name
C9053**	Adakveo®	crizanlizumab-tmca
Q5121**	Avsola™	infliximab-axxq
C9056**	Givlaari®	givosiran
J7170	Hemlibra®	emicizumab-kxwh
J0202	Lemtrada®	alemtuzumab
J0222	Onpattro®	patisiran
J3590*	Palforzia™	Peanut (Arachis hypogaea) allergen powder-dnfp
J0896**	Reblozyl®	luspatercept-aamt
C9061**	Tepezza™	teprotumumab-trbw
J2323	Tysabri®	natalizumab
C9063**	Vyepti™	eptinezumab-jjmr

*Will become a unique code

**Received a unique code on July 1, 2020. Prior to July 1, 2020, this drug was assigned to a not-otherwise-classified (NOC) code.

For a detailed list of requirements, see the **BCN Drugs Covered Under the Medical Benefit** page of the **ereferrals.bcbsm.com** website.

Additional notes

Authorization requirements apply only to groups that currently participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit.

An authorization approval isn't a guarantee of payment. Health care providers need to verify eligibility and benefits for members.

Blue Cross and BCN will have preferred hereditary angioedema medications for our commercial members, effective Nov. 1

Currently, all hereditary angioedema medications require prior authorization for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members. Effective Nov. 1, 2020, Blue Cross and BCN will have preferred medications for HAE therapy for those members.

- We'll require our commercial members to use preferred HAE drugs for acute treatment and for preventive therapy that begins on or after Nov. 1, 2020.
- For commercial members currently receiving a nonpreferred HAE drug:
  - These members are authorized to continue their current therapy until through Oct. 31, 2020.
  - We've proactively authorized therapy with the preferred medications from Nov. 1, 2020, through Oct. 31, 2021, to avoid any interruptions in care.
  - We encourage you to discuss any concerns members may have as they transition to the preferred medications.

We'll be mailing letters to affected members to notify them of these changes.

These changes apply to all Blue Cross' PPO and BCN HMO℠ members.

For HAE therapy covered under the medical benefit, the requirements outlined in this article apply only to groups that are currently participating in the standard commercial Medical Drug Prior Authorization Program. Proactive authorizations for preferred therapy on the pharmacy benefit apply to members who have their pharmacy benefit with Blue Cross Blue Shield of Michigan or Blue Care Network.

Which medications are preferred?

For acute HAE treatment

- Preferred medication: Icatibant (HCPCS code J1744)
- Nonpreferred medications:
  - Firazyr® (brand icatibant, HCPCS code J1744)
  - Berinert® (c1 esterase inhibitor, human, HCPCS code J0597)
  - Kalbitor® (ecallantide, HCPCS code J1290)
  - Ruconest® (c1 esterase inhibitor, recombinant, HCPCS code J0596)

For HAE prevention

- Preferred medications:
  - Haegarda® (c1 esterase inhibitor, human)
  - Takhzyro® (lanadelumab-flyo)
- Nonpreferred medication: Cinryze® (c1 esterase inhibitor, human, HCPCS code J0598)

For additional information on requirements related to drugs for our commercial members, see:

- **Requirements for drugs covered under the medical benefit**
- **Requirements for drugs covered under the pharmacy benefit**

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Use our online resources to understand billing guidelines

Blue Care Network provides an array of clinical editing and billing resources to help providers bill to avoid clinical edits or denials. Online resources can help you understand how a claim may process.

Our clinical editing involves moving a claim through multiple rules and logic as well as application of payment rules. Claims have different rules applied based on multiple criteria, including provider specialty, location, frequency of the service, medical policies and benefits.

Log in to Provider Secured Services. Then go to *BCN Provider Publications and Resources* to find the following:

- The link to the Billing/Claims page is listed under the Popular links heading. On that page, you'll find clinical editing resources.
- A link to the Claims chapter of the *BCN Provider Manual* is on the Billing/Claims page.
- You can also click to open the *Medical Policy Manual*, *Clinical Practice Guidelines* and *Clinical Quality Corner* pages. Those links are found under the Other resources heading in the left navigation.

BCN extends rate increases for in-person home health care and home infusion nursing visits in response to COVID-19

In response to the continuing COVID-19 pandemic, Blue Care Network is extending changes to reimbursement for certain services through Dec. 31, 2020. We're extending these increases to support providers caring for our BCN HMO℠ and BCN Advantage℠ members during this crisis.

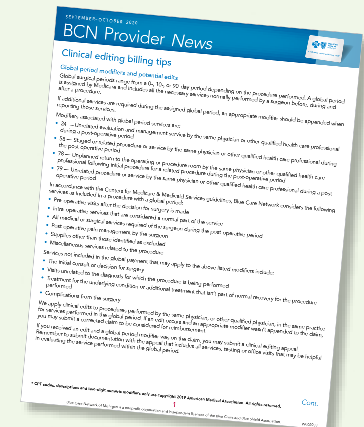
See the article on **Page 3** for details.

Clinical editing billing tips

In most issues, we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and that the performed procedure is correctly reported to us.

This issue's tips include:

- Global period modifiers and potential edits
- Using modifier 50, LT and RT
- Tips for submitting clinical editing appeals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We're extending global referrals through at least Dec. 31 for BCN HMO members

Blue Care Network is implementing another utilization management change aimed at supporting our providers during the COVID-19 emergency.

Change in the duration of global referrals for elective and non-urgent services

Here's what's changing for global referrals submitted for BCN HMO℠ (commercial) members on or after March 13, 2020:

- For referrals with end dates in 2020, the end date will automatically be extended to Dec. 31, 2020.
- For referrals with end dates after Dec. 31, 2020, the end date specified in the e-referral system will apply.

This applies to global referrals submitted by both in-state and out-of-state providers.

This doesn't apply to BCN Advantage℠, Medicare Plus Blue℠ PPO or Blue Cross' PPO members, because global referrals are not required for those members.

We've added this information to the **COVID-19 utilization management changes** document on our **ereferrals.bcbsm.com** website, on the **Blue Cross Authorization Requirements & Criteria** page and the **BCN Authorization Requirements & Criteria** page.

You can also find this document on our public website at **bcbsm.com/coronavirus** and through Provider Secured Services.

Checking the status of temporary measures for COVID-19

In June, some of the temporary measures we put in place for the COVID-19 crisis have concluded.

We'll continue to waive member cost share for COVID 19 treatment through Dec. 31, 2020.

For the latest status of all temporary measures — including those related to utilization management, telehealth, billing and more — see the *Temporary changes due to the COVID-19 pandemic document*, which shows the start and end dates for each measure.

You can find this and related documents on our coronavirus webpage, which is available through Provider Secured Services and on our public website at **bcbsm.com/coronavirus**.

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eviCore has updated corePath for physical and occupational therapy authorizations

Effective immediately, eviCore healthcare® has made changes to the corePath℠ therapy authorization model for first authorization requests for new episodes of treatment. This change applies to:

- Physical therapy providers in categories B and C
- Occupational therapists in category B

Here's what changed

For providers in categories B and C: When initial authorization requests meet certain conditions, eviCore is approving a greater number of visits over a longer authorization duration period. The logic in eviCore's corePath model determines the number of visits and authorization duration based on the patient's condition and complexity.

For more information about how this affects occupational therapy providers, see eviCore's **Physical Therapy Practitioner Performance Summary and Provider Category FAQs** document. See the question titled "How does my category impact my authorization requirements for occupational therapy?"

Note: There haven't been any changes to the number of visits granted or the authorization duration period for providers in category A.

Additional information

To learn more about category assignments, see eviCore's Physical Therapy Practitioner Performance Summary and Provider Category FAQs document referenced above.

You can find additional information on the **ereferrals.bcbsm.com** website:

- On BCN's **Outpatient PT, OT, ST page**
- On the **Blue Cross eviCore-Managed Procedures page**. Look in the "Medicare Plus Blue PPO members" section.

As a reminder, eviCore manages physical and occupational therapy services for non-autism diagnoses for Medicare Plus Blue℠ PPO, BCN HMO℠ (commercial) and BCN Advantage℠ members. eviCore also manages physical and occupational therapy services for adult BCN HMO members ages 19 and older with autism diagnoses.

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eviCore simplifies authorization process for radiation oncology

eviCore healthcare® has simplified the authorization process for radiation oncology by asking Clinical Decision Support questions, rather than its traditional clinical questions. This applies to authorizations for breast, prostate and non-small-cell lung cancer. It was effective July 1.

As a result, you'll need to answer far fewer clinical questions when submitting these authorization requests.

What you need to do

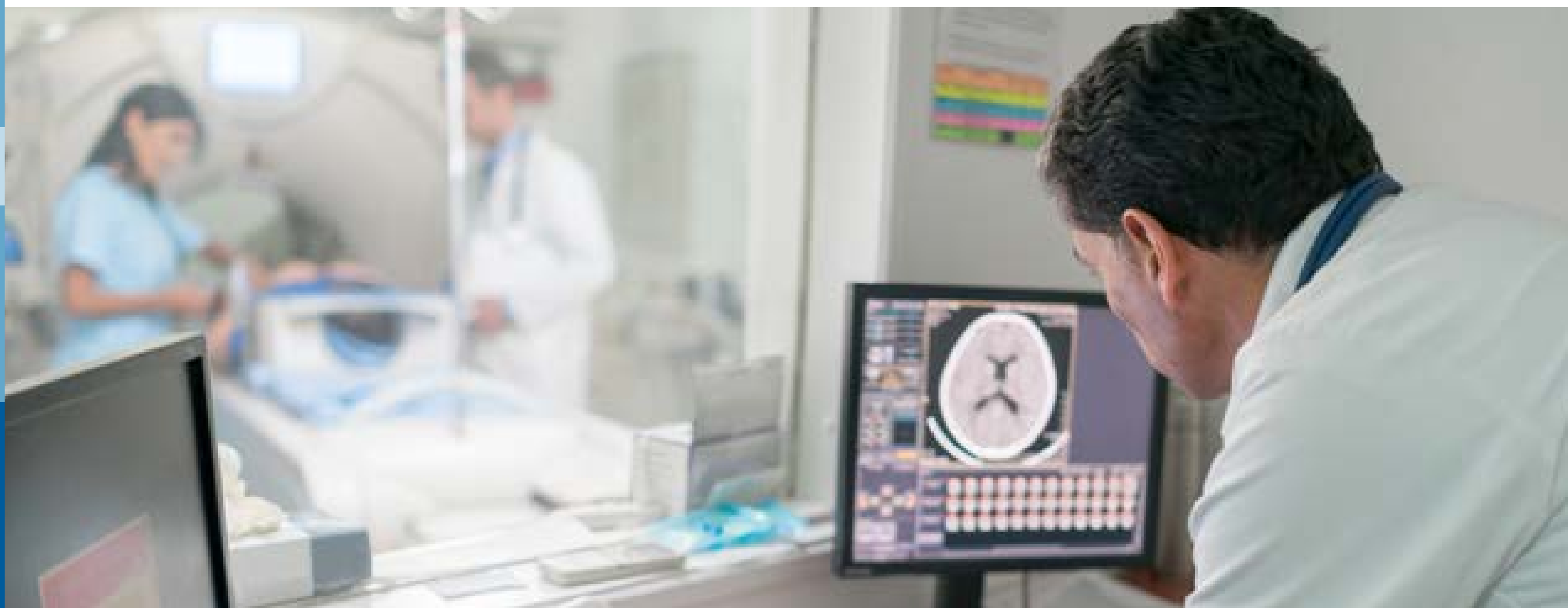
The steps to submit authorization requests to eviCore won't change. You'll follow the typical process of logging in to the eviCore portal at **www.evicore.com**, initiating a request for Clinical Certification for Radiation Therapy and entering information about the member.

For breast, prostate and non-small-cell lung cancer, the system will prompt you to answer the CDS clinical questions. After answering the questions, you'll be presented with a list of treatment regimens. There's also an option to enter a custom treatment regimen.

eviCore manages authorizations for radiation oncology for most Blue Cross' PPO fully insured groups and for Medicare Plus Blue℠ PPO, BCN HMO℠ and BCN Advantage℠ members.

For more information, see the **Blue Cross eviCore-Managed Procedures** or the **BCN eviCore-Managed Procedures** pages of the **ereferrals.bcbsm.com** website.

See related article on **Page 4** titled, "We're revising our policy on hypofractionation for breast and prostate cancer as part of our radiation oncology program managed by eviCore healthcare."



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New and updated questionnaires available in the e-referral system

In June, new and updated questionnaires started opening in the e-referral system for certain procedures. We added and updated preview questionnaires on the **ereferrals.bcbsm.com** website as they were released.

We use our authorization criteria and medical policies and your answers to the questionnaires when making utilization management determinations on your authorization requests.

New questionnaires

On June 14, 2020, we replaced the *Pregnancy termination 1 — Medically necessary or elective* questionnaire with the following two questionnaires for adult BCN HMO℠ members:

- *Pregnancy termination 1 — Medically necessary.* Applicable procedure codes are: *01966, *59100, *59840, *59841, *59850, *59851, *59852, *59855, *59856, *59857, *59866, S0190, S0191, S0199, S2260, S2265, S2266 and S2267.
- *Pregnancy termination 3 — Elective.* Applicable procedure codes are: *01966, *59100, *59840, *59841, *59850, *59851, *59852, *59855, *59856, *59857, *59866, S0190, S0191, S0199, S2260, S2265, S2266 and S2267.

Updated questionnaire

On June 28, 2020, we updated the *Vascular embolization or occlusion (TACE/RFA)* questionnaire for BCN HMO℠, BCN Advantage℠ and Medicare Plus Blue℠ PPO members.

Preview questionnaires

For all these services, you can access preview questionnaires at **ereferrals.bcbsm.com**. The preview questionnaires show the questions you'll need to answer in the e-referral system so you can you prepare your answers ahead of time.

To find the preview questionnaires:

- **For BCN:** Click BCN and then click **Authorization Requirements & Criteria**. Scroll down and look under the "Authorization criteria and preview questionnaires" heading.
- **For Medicare Plus Blue:** Click *Blue Cross* and then click **Authorization Requirements & Criteria**. In the "Medicare Plus Blue PPO members" section, look under the "Authorization criteria and preview questionnaires — Medicare Plus Blue PPO" heading.

Authorization criteria and medical policies

The pertinent authorization criteria and medical policies are also available on the Authorization Requirements & Criteria pages.

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TurningPoint musculoskeletal authorization program to expand in January

We'll add Blue Cross Blue Shield of Michigan commercial members to the TurningPoint Healthcare Solutions, LCC musculoskeletal program for spine, pain management and joint replacement surgeries and related procedures for dates of service on or after Jan. 1, 2021. At that time, the program will also expand to include pain management procedures for Blue Care Network commercial, BCN Advantage℠ and Medicare Plus Blue℠ members.

In addition, spinal procedures for Medicare Plus Blue members will transition from being managed by eviCore healthcare® to being managed by TurningPoint.

Providers can submit authorization requests for the expanded procedures starting Dec. 1, 2020, for dates of service on or after Jan. 1, 2021.

Background

As reported in the May-June ***BCN Provider News***, health care providers should submit authorization requests through TurningPoint for musculoskeletal surgical procedures with a date of service on or after July 1, 2020, for BCN commercial, Medicare Plus Blue and BCN Advantage members. This includes spine and joint replacement surgeries and related procedures.

However, lumbar spinal fusion surgeries for Medicare Plus Blue members will continue to be managed by eviCore through 2020. You can find the codes for these procedures in the *Lumbar spinal fusion surgery procedures requiring authorization by eviCore* table in the *Procedures that require authorization by eviCore healthcare* document. The document is located at **ereferrals.bcbsm.com**. Click on *Blue Cross* and then on *eviCore-Managed Procedures*.

For more information

- See the Musculoskeletal Services webpages for **Blue Cross** and **BCN** on the **ereferrals.bcbsm.com** website.
- Find procedure codes for orthopedic, pain management and spinal procedures managed by TurningPoint on **ereferrals.bcbsm.com** as follows:
  - **Orthopedic**
  - **Pain management**
  - **Spinal**
- Refer to the ***Frequently asked questions for providers*** document on our **ereferrals.bcbsm.com** website.

Please see Musculoskeletal , continued on Page 34

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Register for webinars

We're offering webinar training for providers and facilities for musculoskeletal services managed by TurningPoint.

Use the links below to register.

Provider training

Date	Time	Registration
Nov. 10, 2020	10 to 11:30 a.m.	Click here to register
Nov. 10, 2020	12 to 1:30 p.m.	Click here to register
Nov. 12,2020	2 to 3:30 p.m.	Click here to register
Nov. 17, 2020	2 to 3:30 p.m.	Click here to register
Nov. 18, 2020	10 to 11:30 a.m.	Click here to register
Dec. 2, 2020	10 to 11:30 a.m.	Click here to register
Dec. 3, 2020	2 to 3:30 p.m.	Click here to register
Dec. 8, 2020	12 to 1:30 p.m.	Click here to register
Dec. 10, 2020	10 to 11:30 a.m.	Click here to register
Dec. 16, 2020	12 to 1:30 p.m.	Click here to register
Jan. 5, 2021	10 to 11:30 a.m.	Click here to register
Jan. 6, 2021	12 to 1:30 p.m.	Click here to register
Jan. 14, 2021	2 to 3:30 p.m.	Click here to register

Facility training

Date	Time	Registration
Nov. 10, 2020	2 to 3:30 p.m.	Click here to register
Nov. 12, 2020	12 to 1:30 p.m.	Click here to register
Nov. 18, 2020	2 to 3:30 p.m.	Click here to register
Dec. 3, 2020	10 to 11:30 a.m.	Click here to register
Dec. 9, 2020	12 to 1:30 p.m.	Click here to register
Dec. 15, 2020	2 to 3:30 p.m.	Click here to register
Jan. 5, 2021	2 to 3:30 p.m.	Click here to register
Jan. 12, 2021	12 to 1:30 p.m.	Click here to register

Portal training

Date	Time	Registration
Jan. 7, 2021	10 to 11 a.m.	Click here to register
Jan. 13, 2021	2 to 3 p.m.	Click here to register

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Determinations on requests for inpatient acute care admissions are based on InterQual criteria, not on the two-midnight rule

The Utilization Management department for Blue Cross and Blue Care Network makes determinations on authorization requests for inpatient acute care admissions based on InterQual® criteria, not on the two-midnight rule.

This applies to admissions of members covered by all our lines of business.

We're clarifying this because we recently received some questions from providers about the two-midnight rule.

Providers should do the following:

- Refer to the InterQual criteria for the type of admission and to the associated Blue Cross and BCN Local Rules.

  Note: The Local Rules are available on the **ereferrals.bcbsm.com** website, on the **Blue Cross Authorization Requirements & Criteria** page and the **BCN Authorization Requirements & Criteria** page.
- Disregard any information about the two-midnight rule that we may have published in past communications.

We're updating the provider manuals to include a statement clarifying that we do not use the two-midnight rule in making determinations on authorization requests for inpatient acute care admissions.

Reminder: 1-866-527-1326 fax number out of service as of Oct. 1

The fax number 1-866-527-1326 will be taken out of service starting Oct. 1, 2020.

Currently, some providers are using that fax number to submit authorization requests for acute inpatient admissions for BCN Advantage members.

If you're using the 1-866-527-1326 fax number, stop faxing these requests now and instead submit them using these methods:

- **Michigan providers:** Submit these requests via the e-referral system. When the e-referral system is not available, do one of these:
  - For non-urgent requests, wait for the system to become available again.
  - For urgent requests, call BCN Utilization Management at 1-800-392-2512 (during business hours) or 1-800-851-3904 (after business hours).
- **Non-Michigan providers without access to the e-referral system:** Call these requests in to BCN Utilization Management at 1-800-392-2512 (during business hours) or 1-800-851-3904 (after business hours).

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Commercial SNF authorization requests to be submitted through the e-referral system starting later this year

Later this year, we'll require skilled nursing facilities to submit authorization requests for our commercial members through the e-referral system and not by fax. This requirement will apply to requests for admissions and requests for additional SNF days.

Sign up now to use the e-referral system

To prepare for this change, it's important that SNFs sign up **now** for access to the e-referral system. Don't wait to sign up, as it may take some time to get access.

You'll also need to learn how to use the e-referral system so you're comfortable with it when this change goes into effect.

Everything you need to know is on our **ereferrals.bcbsm.com** website:

- To sign up for the e-referral system: Follow the instructions on the **Sign Up or Change a User** page.
- To learn how to use the e-referral system: Refer to the **Training Tools** page, where you'll find the **e-referral User Guide** and **Online self-paced learning modules**.

More information about the change

Currently, SNFs are completing a form and submitting it by fax. When the new requirement goes into effect later this year, you'll still need to complete the form, but you'll attach it to the request in the e-referral system instead of faxing it.

This is for members covered by our commercial plans:

- Blue Cross' PPO
- BCN HMO℠

Watch for more news about this change

We'll communicate more details about this change in the coming weeks. Watch for web-DENIS messages as well as news items on our **ereferrals.bcbsm.com** website.

We're revising our policy on hypofractionation for breast and prostate cancer as part of our radiation oncology program managed by eviCore healthcare

Blue Cross Blue Shield of Michigan and Blue Care Network have revised the radiation oncology program managed through eviCore healthcare to limit coverage to hypofractionation (a shorter, equally effective regimen) for many breast and prostate cancers, effective for requests submitted on or after Sept. 21. The changes align with evidence-based guidelines including the National Comprehensive Cancer Network, or NCCN.

See full article on **Page 4** for details.

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What to do when the e-referral system is down

We take the e-referral system out of operation on a monthly basis while we perform maintenance. During those times, you won't be able to use it to submit referrals or authorization requests, to upload clinical documentation, to check the status of an authorization request or to do anything else you typically do in the e-referral system.

When e-referral is down for maintenance, follow these instructions:

- **For non-urgent authorization requests:** Please wait and submit these when the e-referral system is available again.
- **For urgent requests** that need to be processed within 24 hours, call or fax as outlined below.

Service	Line of business	What to do
Acute inpatient admissions	Blue Cross' PPO (commercial)	Fax to 1-800-482-1713 anytime. Note: Faxes received after business hours will be processed the next business day. After business hours: Call 1-800-851-3904
	Medicare Plus Blue℠ PPO	Fax to 1-866-464-8223 anytime. Note: Faxes received after business hours will be processed the next business day. After business hours: Call 1-800-851-3904
	BCN HMO℠ (commercial) BCN Advantage	During business hours: Call 1-800-392-2512. After business hours: Call 1-800-851-3904
Post-acute admissions and concurrent reviews	BCN HMO℠ (commercial)	Fax to 1-866-534-9994 anytime. Note: Faxes received after business hours will be processed the next business day.
Behavioral health services	Medicare Plus Blue℠	Call 1-888-803-4960 anytime.
	BCN HMO℠ (commercial)	Call 1-800-482-5982 anytime
	BCN Advantage℠	Call 1-800-431-1059 anytime

You can find this information on our **ereferrals.bcbsm.com** website. Scroll down the left side of any page on the website and click **e-referral system planned downtimes and what to do**.

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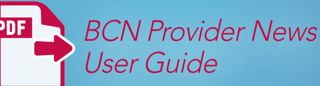
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Blue Care Network to offer 20 individual Marketplace products in 2021

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®.

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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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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.

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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.

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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^{SM} 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.

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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℠

*CPT codes, descriptions and two-digit modifiers only are copyright 2019 American Medical Association. All rights reserved.

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℠

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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.

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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.

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Online Training

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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.*

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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.

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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

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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

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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.

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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**.

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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.

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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.

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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

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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.

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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

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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.

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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).

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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**

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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.

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.

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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.

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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

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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.

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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.

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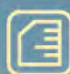

Quality improvement program information available upon request

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.

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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.

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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

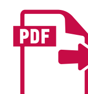
Pharmacies that administer vaccines paid through the member's medical benefits need to instruct their vendors to update their billing software for our covered codes. If you don't do so, the pharmacy technician may get a front-end rejection and the technician may, in error, tell the member that the vaccine 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.



Vaccine affiliation program

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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.

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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℠)**

***CPT codes, descriptions and two-digit modifiers only are copyright 2019 American Medical Association. All rights reserved.**

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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[SM] or BCN HMO[SM] 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.

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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®

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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.

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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

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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.

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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.

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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

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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.

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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.

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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.

***CPT codes, descriptions and two-digit modifiers only are copyright 2019 American Medical Association. All rights reserved.**

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**.

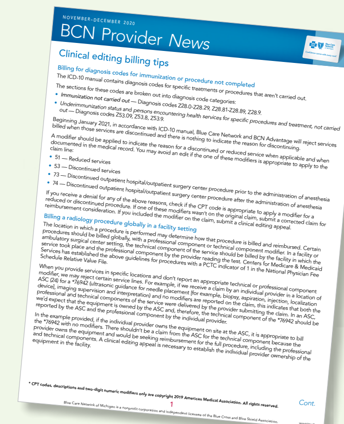
For more information, see the *Patient testing* section of our COVID-19 webpages on our public website at **bcbsm.com/coronavirus** or within Provider Secured Services by clicking on Coronavirus (COVID-19).

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



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Use our online resources to understand billing guidelines

Blue Care Network provides an array of clinical editing and billing resources to help providers bill to avoid clinical edits or denials. Online resources can help you understand how a claim may process.

Our clinical editing involves moving a claim through multiple rules and logic as well as application of payment rules. Claims have different rules applied based on multiple criteria, including provider specialty, location, frequency of the service, medical policies and benefits.

Log in to Provider Secured Services. Then go to *BCN Provider Publications and Resources* to find the following:

- The link to the Billing/Claims page is listed under the Popular links heading. On that page, you'll find clinical editing resources.
- A link to the Claims chapter of the *BCN Provider Manual* is on the Billing/Claims page.
- You can also click to open the *Medical Policy Manual*, *Clinical Practice Guidelines* and *Clinical Quality Corner* pages. Those links are found under the *Other resources* heading in the left navigation.

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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

*CPT codes, descriptions and two-digit modifiers only are copyright 2019 American Medical Association. All rights reserved.

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.

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CLAIM DENIED

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**.

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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

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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**

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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.

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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

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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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