JANUARY–FEBRUARY 2021

BCN Provider News

BCN Provider News User Guide

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.

Please see Physical, continued on Page 2

Get ready for Availity — Select an administrator

Blue Cross Blue Shield of Michigan and Blue Care Network will move to the Availity® provider portal later in 2021. 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 currently using Availity, here's some information to help you prepare for the transition.

Choose a primary administrator

If your organization (office, practice or facility) doesn't currently participate with Availity, you'll need to select someone on your team to serve as the Availity primary administrator. The person selected for this role must be at least 18 years old. The primary administrator will handle access for other users, which will speed up their enrollment process. Every organization is required to have one primary administrator.

Select someone who knows each team member's access

Please see Availity, continued on Page 3

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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:

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

We've changed frequency for preventive screenings to a calendar year

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.

Preventive screenings for BCN Advantage members continue to follow Centers for Medicare & Medicaid Services guidelines.

For details, see article in the **Sept-Oct issue** (Page 1).

Editor
Cindy Palese
bcnprovidernews@bcbsm.com

Provider Communications
Catherine Vera-Burgos, Manager
Elizabeth Donoghue Colvin
Jennifer Fry
Tracy Petipren
Deb Stacy

Market Communications Publications
Joseph Coots

Contributors
William Beecroft, M.D.; Brittney Lewis; Camillya Christian-Smith; Amy Frady; Jody Gembarski; William Pompos; Jacquelyn Redding

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needs, or create an internal process for the primary administrator to review and confirm access needs. The goal is to make sure team members have access only to the roles and permissions they need to do their jobs.

A primary administrator who controls access helps safeguard patient information, maintains compliance with federal privacy and security laws and reduces opportunities for fraud and abuse. This ensures that your biller can status claims, your referral coordinator can submit authorization requests and the Availity experience is streamlined to focus on the tools these team members need.

And, your primary administrator will be able to add team members or change access needs with just a few keystrokes. This will replace having to fax a form for every change.

The primary administrator can have help

While each organization can only have one primary administrator who has access to all administrative functions, you can also delegate others to handle specific roles. They include:

- **Administrator assistant** — This individual can make changes on behalf of the organization, but not on behalf of users. An example could be enrolling the organization in electronic funds transfer.
- **User administrator** — This individual can make changes on behalf of users, but not the organization. This includes adding or deleting users and changing user roles.

Please see Availity, continued on Page 4

Get ready for Availity — Technical requirements

Blue Cross Blue Shield of Michigan and Blue Care Network will move to the Availity® provider portal later in 2021. We want your organization to have the best experience when using Availity. For a smooth transition, you should have the following:

- A high-speed internet connection
- Google Chrome as your browser (Chrome is the preferred browser, but Microsoft Edge, version 79 or higher, and Firefox® are also supported. Internet Explorer®, version 11.0 or higher, is supported but not recommended.)
- The ability to enable pop-up windows, allow JavaScript and allow images to load automatically
- 1024 x 768 pixels or greater screen resolution
- Up-to-date antivirus software
- The latest version of Adobe® Reader, to view PDF documents

Tip: The latest Availity technical requirements are available on the **Availity website**. Scroll down and click on the *Requirements* tab.

Network Operations

Availity *continued from Page 3*

- **Administrator reports** — This individual can pull Availity reports on behalf of the organization, such as user activity reports or transaction reports.

Start thinking about the administrator structure that will work best for your organization, so you'll be able to register in the coming months. Availity will make the administration tasks easy with training, forums and reports.

Questions?

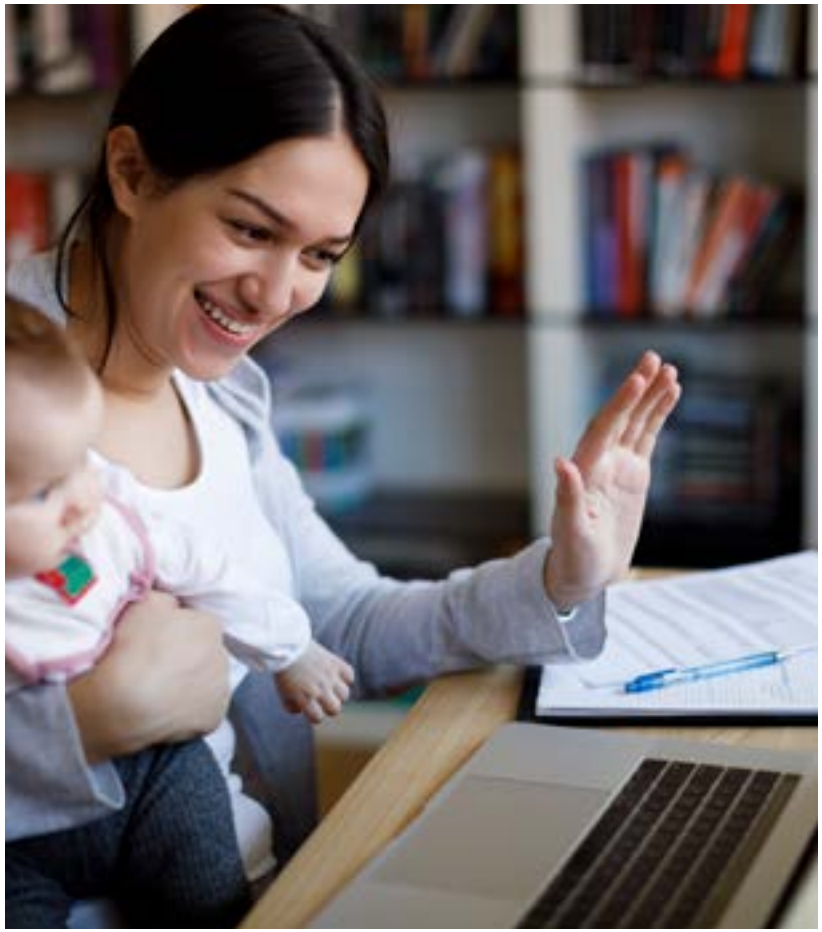
We have a ***Frequently Asked Questions*** document about our move to Availity. If you have a question, check here first to see if it's already been answered. If it hasn't, you can submit your question to *ProviderPortalQuestions@bcbsm.com* so we can consider adding it to the FAQ document. If you need immediate assistance or have a question specific to a certain member or situation, use our website resources or contact Provider Inquiry.

Web resources:

- Log in as a provider at **bcbsm.com**.
- Find prior authorization information for Michigan providers at **ereferrals.bcbsm.com**.
- Find prior authorization information for non-Michigan providers and medical policy information by going to **bcbsm.com/providers** and clicking on ***Quick Links***.

Provider Inquiry numbers are available at **bcbsm.com/providers**. Click on ***Contact Us***. Then, click on the type of provider you are; then click *Provider Inquiry*.

Call the Blue Cross Web Support Help Desk at 1-877-258-3932 if you have problems with the current Blue Cross provider portal.



Previous articles about Availity

We're providing a series of articles focusing on our move to Availity for our provider portal. Here are the articles we've already published, in case you missed them:

- New, secure provider website coming in 2021 (**September – October 2020 issue**)
- Availity multi-payer provider portal brings advantages to providers (**November-December 2020 issue**)

Network Operations

Ascension to be network provider for Blue HPN in Southeast Michigan

As published in the **October *Record***, Blue Cross Blue Shield of Michigan will offer health plans that use a new network called Blue High Performance Network℠, or Blue HPN℠. Starting in January 2021, Ascension will be the network provider for Blue HPN in Southeast Michigan.

Blue Cross health plans with Blue HPN are EPO plan types, which means services are covered within the Blue HPN network. Members who have health plans with Blue HPN in Southeast Michigan can see certain contracted Ascension health care providers for services and will only have to pay the plan's out-of-pocket expenses. They will also be able to see HPN providers throughout the country, when they go out of state. If they see a non-Ascension health care provider, they'll be responsible for the costs (except for emergency services and urgent care).

You'll know that a member has selected the Blue HPN plan by their Blue Cross ID card or in web-DENIS when you check eligibility.

One important item to note on the card is the plan type. You'll see the letters 'EPO' in that area. EPO plan types require members to stay within the network for their plan and don't allow for out-of-network coverage (with some exceptions).

If you see "HPN" in the suitcase on the member ID card, you need to be part of the Blue HPN network to serve that member.

We're here for you — virtually

Blue Cross Blue Shield of Michigan and Blue Care Network's provider consultants are here to serve our provider community.

We recognize this has been a challenging year. Although we've been unable to meet with you in person for the last several months, consultants continue to work hard to assist providers virtually.

We're still here to help meet your education and training needs, and to help clarify medical policy and contract information. We encourage you to use our self-service tools and provider inquiry phone numbers when you need help with claims. When your issue isn't resolved through these channels, **contact** your consultant and provide the interaction number given to you by the provider inquiry representative.

We offer individualized training as needed, but we also offer many topics on our provider training site.

To learn about what we offer to all providers, log on to Provider Secured Services at **bcbsm.com**.

For Blue Cross

1. Click on *BCBSM Provider Publications and Resources*.
2. Click on *BCBSM Newsletters and Resources*.
3. Click on *Provider Training in the left navigation*.

For BCN

1. Click on *BCN Provider Publications and Resources*.
2. Click on *Learning opportunities*.

While we continue to encourage virtual visits, we'll consider an in-person visit if your need is urgent. Call your consultant to request a visit so we can share our safety requirements.

See our **flyer** for Blue Cross and BCN contact information and the role of your provider consultant.

Network Operations

How to request BCN fee schedules

We've set up a new mailbox, feeschedule@bcbsm.com, for providers to request copies of Blue Care Network fee schedules. Fee schedules are reviewed and updated annually.

When you email us, you'll need the following information:

- A copy of your signed licensing agreement (You can request a copy of the licensing agreement from customer service or by calling Provider Inquiry at 1-800-344-8525. There's a link to a recent licensing agreement in the Claims chapter of the *BCN Provider Manual*, in the section titled, "Pricing and fees.")
- Type 2 NPI
- Tax ID number
- Primary practice address
- Specialty
- Medical Care Group affiliation

If you have questions about the fee schedule, contact your provider consultant.

Note: BCN only provides fee schedules to providers who participate on our network. If you are not currently contracted and would like to become a participating provider, go to **bcbsm.com/providers** and click *Join our network*, or contact Provider Enrollment at 1-800-822-2761.

Blue Care Network celebrates latest results awarded from the National Committee for Quality Assurance

Blue Care Network received a commendable status for its commercial HMO and Medicare HMO product lines, and an accredited status for the HMO Marketplace Exchange product line (for this category the products receive accredited or not accredited), scoring 50 out of 50 points from National Committee for Quality Assurance.

The score combined the 50 points for the 2020 NCQA standards with previous HEDIS (Healthcare Effectiveness Data and Information Set) and CAHPS (Consumer Assessment of Healthcare Providers and Systems) scores, which are also used as part of the NCQA measures.

An NCQA accreditation shows our customers and members how we're improving operational efficiencies; satisfying state requirements and employer needs; keeping members healthy; and demonstrating our commitment to quality.

"This year BCN received 50 out of 50 points from NCQA for the standards, which is a major accomplishment," said Belinda Bolton, director, Quality Management. "I'm so grateful for this team. For the past three years, they have performed above and beyond expectations to ensure a successful survey outcome."

After the survey team finished, they applauded the Quality Management team and the entire organization on an excellent survey based on a variety of tasks, including a strong and knowledgeable staff; well-organized files; and for demonstrating an outstanding response to the COVID crisis to ensure continuity of care, just to name a few.

For 2022, the Quality Management team is diligently working toward survey accreditation preparation for the PPO lines of business.

Network Operations

New provider contract management system will require providers to type their names before adding electronic signatures

Blue Cross Blue Shield of Michigan and Blue Care Network are moving to a new contract management system before the end of 2020. We'll continue to send agreements to provider offices by email for their signature using DocuSign. However, before signing, the provider must type in his or her name. This is especially important for larger group practices using the same email address who regularly add new providers.

If you don't type your name before signing, the contract won't automatically populate the provider name and the document will need to be resigned.

Learn to conduct a physical exam using telehealth

Blue Cross Blue Shield of Michigan is offering training to help providers do an effective virtual physical examination. The training is conducted by Gretchen C. Goltz, D.O., C.P.E. She's a medical director at Blue Cross and Blue Care Network.

Dr. Goltz says it's possible to do a relatively thorough physical exam with audio and visual telemedicine.

In the recorded webinar, Dr. Goltz covers the following parts of the physical exam:

- Head, eyes, ears, nose, throat
- Skin
- Cardiopulmonary
- Abdominal and genitourinary
- Musculoskeletal
- Neurological

Click on the link to see the **video.**

Online Training

Sign up for 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 information on the upcoming training webinars:

Webinar name	Date and time	Registration
Blue Cross 201 – Claims Basics – Professional	Wednesday, Feb. 3, 2021 10 to 11 a.m.	**Click here** to register
Blue Cross 201 – Claims Basics – Professional	Wednesday, Feb. 3, 2021 2 to 3 p.m.	**Click here** to register
Autism Overview	Thursday, Feb. 4, 2021 10 to 11 a.m.	**Click here** to register
Autism Overview	Thursday, Feb. 4, 2021 2 to 3 p.m.	**Click here** to register
Autism Overview	Tuesday, Feb. 10, 2021 10 to 11 a.m	**Click here** to register
Autism Overview	Tuesday, Feb. 10, 2021 2 to 3 p.m.	**Click here** to register
Blue Cross 201 – Claims Basics – Professional	Tuesday, March 2, 2021 10 to 11 a.m.	**Click here** to register
Blue Cross 201 – Claims Basics – Professional	Tuesday, March 2, 2021 2 to 3 p.m.	**Click here** to register

The Blue Cross 201 webinar provides an in-depth learning opportunity 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.

The Autism Overview webinar reviews current processes related to delivering services for members with autism.

Recordings of previous webinars are available on Provider Secured Services on the Blue Cross Provider Publications and Resources or BCN Provider Publications and Resources pages as follows.

Please see Webinar, continued on Page 9

Network Operations

Webinar *continued from Page 8*

Blue Cross Provider Publications and Resources

1. Log in to Provider Secured Services at **bcbsm.com**.
2. Click *BCBSM Provider Publications and Resources*.
3. Click *BCBSM Newsletters and Resources*.
4. Click *Provider Training*.
5. In the Featured Links section of the page, check out 2020 Provider Training Webinars.

You can also get more information about online training, presentations and videos by clicking on the E-Learning icon at the top of the page.

BCN Provider Publications and Resources

1. Log in to Provider Secured Services at **bcbsm.com**.
2. Go to *BCN Provider Publications and Resources*.
3. Under Other Resources, click on *Learning Opportunities*.
4. Find the most recent webinars under *2020 Provider Training Webinars*

As additional training webinars become available, we'll provide notices through web-DENIS, *The Record* and *BCN Provider News*.

Reminder: 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.

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.

See the full article in the **November-December 2020** issue (Page 10) for details.

Professional associations can help office staff

If you're a biller, a referral coordinator, an office manager or provide general office assistance in a medical environment, you may want to consider the benefits of joining a professional association. These organizations focus on the type of work you do and often provide:

- Education and communication including conferences, webinars and forums focused on your job skills
- Networking so you can consult with others on common concerns
- Certification opportunities or job resources to help you move forward in your career

As a service to you, we're providing contact information for some local and national groups you may want to explore further. Please note that Blue Cross Blue Shield of Michigan and Blue Care Network do not endorse any specific professional association, have not reviewed their websites and are not responsible for their content.

Association	Michigan Revenue Cycle Association (MRCA)	Healthcare Financial Management Association (HFMA)	Michigan Medical Group Management Association (MiMGMA)	Michigan Medical Billers Association (MMBA)
About our association	Our mission is to provide ongoing mentorship, communication and education to and for our organization members and others in support of the health care revenue cycle; strengthen the role of health care revenue cycle professionals to promote recognition for professional excellence, promote ethics and quality processes while maintaining fiscal responsibility.	Membership gives you access to industry news, education resources (such as access to HFMA's education portal, online programs, webinars and other education opportunities). There are also a number of certifications related to health care finance which are included with the cost of membership.	We offer members a variety of benefits, including educational conferences, monthly member webinars and on- demand educational opportunities, regular updates on legislative and reimbursement issues affecting practices, as well opportunities for ACMPE and AAPC CE credits.	We offer education on changes in insurance, treatments and billing for medical providers.
Target Audience	Those involved in medical claims revenue cycle.	Health care finance colleagues in health systems, insurance organizations, vendor/technology companies and students at universities interested in pursuing careers in healthcare finance	Ambulatory medical practice executives, clinicians and management staff	Medical practices of all specialties and facilities Coders, billers, providers and billing organizations
Educational opportunities	Monthly webinars	Recorded webinars and programs are available to members online. The following upcoming chapter event is also scheduled on Jan. 20, 2021 1:00-3:00 p.m. Eastern time: Be a Hero, HFMA Michigan Great Lakes 2021 Women in Healthcare Leadership Event	Monthly webinars for members only. A spring conference is planned for April 29-30th at the Soaring Eagle Casino. The fall Conference is scheduled for Sept. 30-Oct. 1 at Shanty Creek Resort. Third Party Payer Day 2021 is Nov. 5, 2021 at the Soaring Eagle Casino.	Six chapters across the state with in person and virtual meetings; we offering CEUs for meetings with a wide variety of speakers and topics Annual Expo in East Lansing May 18, 2021
For additional Information	Visit our website https://www.mrcaonline.org/ or contact Membership Chair Renee Sheneman at Renee.Sheneman@mclaren.org	Visit our website: hfmaemc.com (chapter website) and HFMA.org (national website) or contact Membership Director Ariana Raymond at Ariana.raymond@trinity-health.org or Chapter President Nancy Smith at smithnly@mercyhealth.com. There is a 30-day free trial membership available.	Contact info@mimgma.org or call 1-800-314-7602. Executive Director Debra O'Shea, CMPE can be reached at doshea@epoxyhealth.com. Memberships are available for: 1) practice members 2) dual membership option with National MGMA and 3) faculty, student and affiliates.	Contact info@mmbaonline.org Annual membership renewal effective January to December each year.

CareCentrix to manage authorizations for home health care for Medicare Advantage members

Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with CareCentrix® to manage authorization of home health care for Medicare Advantage members.

Providers will need to request prior authorization from CareCentrix for Medicare Plus Blue℠ PPO and BCN Advantage℠ members for home health care, for dates of service on or after March 1, 2021.

CareCentrix will authorize and support the coordination of home health care services such as skilled nursing and physical, occupational and speech therapies.

Submitting prior authorization requests

Primary care providers, acute care providers, post-acute care providers and home health care agencies will be able to submit requests online through the CareCentrix portal, by phone, by fax and through AllScripts®.

How this benefits your patients

This home health care program is designed to:

- Reduce the length of stay in inpatient facilities
- Lower the chance of hospital readmission
- Assist with the transition from hospital to home
- Provide a home-based center of care

Claims and appeals

Home health agencies will continue to submit claims, claims questions and appeals to Blue Cross Blue Shield of Michigan.

If providers don't obtain authorization for home health care from CareCentrix, claims may be denied.

Next steps

In future newsletter articles and web-DENIS messages, we'll provide more information about CareCentrix and this change, including:

- How to access the portal and request prior authorization
- How to sign up for training webinars
- How to access resources and support

BCN Advantage

CMS approves next generation sequencing for certain cancer patients covered by Medicare Advantage plans

The Centers for Medicare & Medicaid Services has determined next generation sequencing is a covered service as a diagnostic laboratory test for patients with germline (inherited) ovarian or breast cancer when performed in a CLIA-certified laboratory, ordered by a treating physician and when specific requirements are met.

The CMS decision is retroactive to Jan. 27, 2020, and affects all Medicare Advantage plans, including Medicare Plus Blue PPO℠ and BCN Advantage℠. The implementation date for claims processing is November 13, 2020.

Next generation sequencing is one technique that can measure one or more genetic variations as a laboratory diagnostic test, such as when used as a companion in vitro diagnostic test.

The decision memo is available on the **CMS website**.

Reminder: Medicare Advantage members transitioning to a new diabetic management program

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

See the full article in the November-December ***BCN Provider News*** (Page 15).

Medicare Part B medical specialty drug prior authorization list is changing in January 2021

For dates of service on or after Jan. 1, 2021, the following CAR-T medications will be managed by Blue Cross Blue Shield of Michigan and Blue Care Network under the medical benefit for Medicare Plus Blue℠ PPO and BCN Advantage℠ members. (For dates of service before Jan. 1, 2021, CAR-T cell therapy is covered under Original Medicare.)

- Yescarta® (axicabtagene ciloleucel), HCPCS code Q2041
- Kymriah® (tisagenlecleucel), HCPCS code Q2042
- Tecartus™ (brexucabtagene autoleucel), HCPCS code J9999

You must submit prior authorization requests for outpatient CAR-T therapy drugs before providing the service.

Submit prior authorization requests, **including all relevant clinical documentation**, using one of these methods:

- Enter the request in the NovoLogix® online tool. For more information about entering requests in NovoLogix, see the NovoLogix section below.
- Fax the request to the Pharmacy Part B Help Desk at 1-866-392-6465.

Note: Prior authorization for CAR-T drugs is **not** managed by AIM Specialty Health®.

If you have questions about this, please email MASRX@bcbsm.com.

We're also adding a medication to the *Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue℠ PPO and BCN Advantage℠ members.* The following specialty medication will require prior authorization through NovoLogix for dates of service on or after Jan. 1, 2021, when the drug 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 (place of service 11, 12, 19, 22 and 24):

- Viltepso™ (viltolarsen), HCPCS codes J3490, J3590

How to bill

For Medicare Plus Blue and BCN Advantage, we require authorization for all outpatient places of service 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

Submit authorization through NovoLogix

For these drugs, submit authorization requests through NovoLogix. It offers real-time status checks and immediate approvals for certain medications. 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 for Medicare Plus Blue PPO and BCN Advantage members.***

BCN Advantage

Get ready for annual visits for your Medicare Advantage patients

In the new year, you'll start seeing new and existing BCN Advantage℠ patients for their Welcome to Medicare visits, annual wellness visits or annual 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 annual physical exams.
- Existing BCN Advantage members should begin scheduling their annual wellness visit and the more comprehensive annual physical exam.

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 annual 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.
- Provide education on preventive services and prescription of appropriate services.
- Create a screening schedule (checklist) for appropriate preventive services.
- Give flu and pneumococcal shots, and referrals for other care, if needed.

Please see Annual Visits, continued on Page 15

Annual Visits *continued from Page 14*

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
- 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 and family history, and perform a head-to-toe assessment with a hands-on examination to assess your patient's health and 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 or established patient
*99386 (40-64 years old)
*99387 (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.

Please see Annual Visits, continued on Page 16

Annual Visits *continued from Page 15*

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
  - o FOBT yearly
  - o Sigmoidoscopy every five years
  - o Colonoscopy every 10 years
  - o Cologuard every three years
- Breast cancer screening
  - o Mammography every two years
- Osteoporosis screening
  - o Bone mineral density testing for women older than 65 and men older than 70
  - o Recommended every two to 10 years, depending on risk factors
  - o Medicare pays for the screening every two years; more often if medically necessary

Comprehensive diabetes care

- o A1c blood sugar screening to diagnose diabetes — every three years if test is normal; once diagnosed, two to four times per year to monitor treatment response
- o Urine microalbumin screening — yearly
- o 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.

Patient Care

Help patients get annual health screenings

As the new year approaches, 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 partnership in making HEDIS 2021 (measurement year 2020) a success.

As part of our joint effort in making this happen, here's a checklist to help patients take care of their heath.

- Get an early start with patients in 2021. Get 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 test, if needed (age 50 to 75, colonoscopy every 10 years). For patients that refuse a colonoscopy, suggest they complete an FOBT or FIT-DNA test.
- For all females between age 50 and 74, order a mammogram (if they haven't completed one in the last 24 months) and cervical cancer screening age 21 to 64 (if they haven't had one in three 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 and immunizations.
- Schedule a depression assessment.
- Childhood and adolescent immunizations: Check immunization record on MCIR and schedule visits to have complete and timely immunizations.
- Adult immunizations: Check immunization record 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 Clinical Data Operations HEDIS message line at 1-855-228-8543.

Patient Care

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 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
- 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.

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 *Medical Policy Manual*. Recent updates to the medical policies include:

Noncovered services

- Home monitoring device for age-related macular degeneration
- Gene expression profiling for cutaneous melanoma

Covered services

- Genetic testing — Noninvasive prenatal screening for fetal aneuploides, microdeletions and twin zygosity using cell-free fetal DNA
- Amniotic membrane and amniotic fluid
- Intravitreal and punctum corticosteroid implants
- Transcatheter aortic valve implantation for aortic stenosis
- Home cardiorespiratory monitoring — Pediatric
- Intensity-modulated radiation therapy, or IMRT: Central nervous system tumors
- Sleep disorders, diagnosis and medical management
- Transcatheter arterial chemoembolization of hepatic tumors, or TACE
- Urinary biomarkers for bladder cancer
- Genetic testing — BRAF mutation in selecting melanoma patients for targeted therapy
- Implantable cardioverter defibrillator, or ICD, including subcutaneous ICD
- Prostatic urethral lift procedure for the treatment of BPH

Medical Policy Updates

Behavioral Health

We've made changes to BCN's Behavioral Health Incentive Program

Blue Care Network is making changes to some of the incentive opportunities in the 2021 Behavioral Health Incentive Program.

- The engagement phase of the HEDIS measure, Alcohol and Other Substance Use Disorders, will be payable to psychiatrists along with the initiation phase, which was added for 2020.
- Psychiatrists who deliver medication-assisted treatment to patients diagnosed with opioid use disorder will receive an incentive based on each patient treated with naltrexone or buprenorphine. (Methadone isn't part of this incentive opportunity.)
- Psychiatrists who participate with a primary care practice to offer the Psychiatric Consult Collaborative Care Model, will be eligible for a per-practice bonus of $2,500 when they contract with primary care providers or physician organizations.

We're discontinuing the incentive for the acute phase of Antidepressant Medication Management but will continue to offer an incentive for the continuation phase.

Log in to Provider Secured Services at **bcbsm.com** to review the program brochure and flyer for details.

- Go to BCN Provider Publications and Resources.
- Click *Behavioral Health* under Other resources in the left-hand navigation.
- The BHIP booklet and program flyer are listed under the Behavioral Health Incentive Program heading.

Guidelines for billing collaborative care

The Collaborative Care Model, also known as CoCM, is a benefit for all our members, including seniors and Blue Care Network members, who see a primary care provider who uses this model. There are no member cost-sharing requirements for the use of CoCM.

Keep in mind that there are some specific billing requirements when using this model. Neither the behavioral health care manager nor the psychiatrist submits claims for CoCM services. The PCP bills for services provided by the care team over a calendar-month service period.

See details outlined in the article on **Page 33** in the Billing section.

Behavioral Health

Quality corner: Antidepressant medication management

What is the antidepressant medication management measure, according to the Healthcare Effectiveness Data and Information Set guidelines?

The percentage of members 18 years or older with a diagnosis of major depression who are newly treated with antidepressant medication, and who remained on the medication for at least:

- 84 days for the acute treatment phase
- 180 days for the continuous treatment phase

Why is it important?

Major depressive disorder[1]:

- Can impair daily activities, as well as disrupt eating habits, sleep patterns and concentration
- Affects nearly 15 million adults in the United States
- Results in lost work productivity
- Can lead to suicide or attempted suicide

How can I ensure my patients adhere?

Know the common barriers to adherence[2]:

- Regimen complexity
- Medication beliefs
- Cost

Educating your patients is very important. Advise them on when and how antidepressants should be taken, and how long they can expect to take them. Be prepared for questions about cost as well. Please remember that the members pay the least for drugs on the lowest tier of their drug list. Drugs on higher tiers cost the member more and may require prior authorization.

References

1 http://www.qualitymeasures.ahrq.gov/content.aspx?id=48934&search=antidepressant+medication+management

2 http://adhereforhealth.org/wp-content/uploads/pdf/RAND_TR765_AReviewofBarrierstoMedicationAdherenceAFrameworkforDrivingPolicyOptions.pdf

We send reminders to patients to adhere to ADHD follow-up visits

We occasionally 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 medication for at least 210 days, they should have two follow-up visits within nine months after the initiation phase.

We also send letters to remind physicians to schedule the follow-up visits as noted in 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 PDF below for HEDIS hints for patient education and coding tips.

HEDIS hints for patient education and coding tips

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:

The footnote for InterQual's Substance *Use Disorders — Inpatient Rehabilitation — Episode Day 1 — Clinical Findings — Intoxication* say that the intoxication effects are due to "recent ingestion" of substance(s)." Does this mean that the member must have been intoxicated at the time of admission to inpatient rehabilitation or (if stepping down from) inpatient detoxification, or does it mean that the member generally exhibits the intoxication symptoms when they've used or are intoxicated?

For example, if a member is stepping down from inpatient detoxification to inpatient rehabilitation level of care, not having used in three to four days but generally demonstrates the symptoms of intoxication when using, does this count toward the criteria point?

Answer:

The criteria point in question means that the patient must have used just before or been intoxicated at the time of admission to the current level of care (inpatient rehabilitation).

Question:

For InterQual's *Adult/Geriatric Psychiatry — Partial Hospital Program — Episode Week 1 — Admission — Functional Impairment — Severe and change in baseline within last month — Job or school performance impaired — Suspended or terminated* criteria point, can this include Family Medical Leave Act time to enter treatment to address behavioral or emotional issues, especially if not a punitive measure from the employer?

For example, if the member's job was not at risk due to performance problems related to behavioral or emotional issues, but he or she takes FMLA time to enter treatment, would this count toward the criteria point?

Answer:

Yes, FMLA can be used to meet this criteria point. Criteria point "Rapid deterioration in functional ability" may also be appropriate in this example, as the member had to leave work to seek treatment.

HEDIS 2020 results

Due to the COVID-19 pandemic, the Centers for Medicare & Medicaid Services suspended the requirement for HEDIS® reporting for Medicare and Marketplace products that are typically due June 15, 2020, for the 2019 measurement year. The National Committee for Quality Assurance continued to require reporting for commercial plans but allowed the use of HEDIS 2019 reported results for hybrid measures.

HEDIS is the most widely used set of performance measures in the managed care industry, and is used by the NCQA for accreditation. It's also 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 also used by CMS for their star ratings.

Blue Care Network noted the following areas of improvement in 2020 (measurement year 2019):

Commercial

- Weight assessment and counseling for nutrition and physical activity for children/adolescents — Physical activity counseling
- Antidepressant medication management — Effective acute and continuation phase treatment
- Avoidance of antibiotic treatment in adults with acute bronchitis/ bronchiolitis
- Breast cancer screening
- Childhood immunizations — Combo 10
- Follow-up after emergency department visit for mental illness — 7 and 30 day
- Follow-up after emergency department visit for alcohol and other drug abuse or dependence — 7 and 30 day
- Use of imaging studies for low back pain
- Use of opioid from multiple prescribers and pharmacies

- Follow-up care for children prescribed ADHD medication — Continuation and maintenance phase
- Medication management for people with asthma – Medication compliance 75%
- Pharmacotherapy management of COPD exacerbation — Bronchodilators and systemic corticosteroid
- Prenatal and postpartum care — Postpartum care
- Use of first-line psychosocial care for children and adolescents on antipsychotics
- Statin therapy for patients with cardiovascular disease — Therapy and adherence
- Statin therapy for patients with diabetes — Therapy and adherence
- Non-recommended cervical cancer screening in adolescent females
- Plan all-cause readmission
- Emergency department utilization
- Well-child visits in the third, fourth, fifth and sixth years of life

Please see HEDIS results, continued on Page 23

Quality Counts

HEDIS results *continued from Page 22*

Thank you to all our affiliated practitioners for providing quality care to our members and allowing access 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 actively involved in activities throughout the year that positively affect 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 summit meetings

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 Clinical Data Operations at 1-855-228-8543.

2020 HEDIS results

Help patients get annual health screenings

As the new year approaches, 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 partnership in making HEDIS 2020 a success.

As part of our joint effort in making this happen, we're providing a checklist to help patients take care of their heath. See article on **Page 17** for the checklist.

We cover Skyrizi and Tegsedi under the pharmacy benefit for Blue Cross' PPO and BCN HMO members

We've changed how we cover Skyrizi® and Tegsedi® for Blue Cross' PPO (commercial) and BCN HMO℠ (commercial) members, effective Oct. 8, 2020.

Blue Cross Blue Shield of Michigan's PPO and Blue Care Network HMO plans are no longer covering the following medications under the medical benefit. Instead, they're covered under the pharmacy benefit.

- Skyrizi (risankizumab-rzaa), HCPCS codes C9399, J3590
- Tegsedi (inotersen), HCPCS codes C9399, J3490

Coverage for these drugs has moved to the pharmacy benefit because the drugs can be safely and conveniently self-administered in the member's home.

These drugs will continue to require prior authorization and are available through pharmacies that dispense specialty drugs, including AllianceRx Walgreens Prime Specialty Pharmacy.

We've contacted members affected by this change and advised them to talk to their doctors about prescribing these medications for purchase from a pharmacy.

Providers who administer these medications to their patients on or after Oct. 8, 2020, will be responsible for the cost.

Both drugs require prior authorization

There are no changes to the management of these therapies.

- Both Skyrizi and Tegsedi continue to require prior authorization. For information about submitting prior authorization requests, continue reading.
- For Skyrizi, quantity limits continue to apply.
- For Tegsedi, documentation requirements continue to apply.

Submitting prior authorization requests

Providers can submit prior authorization requests for these drugs as follows:

- **Electronically:** Through CoverMyMeds® or another free ePA tool, such as Surescripts® or ExpressPAth®. See **Save time and submit your prior authorization requests electronically for pharmacy benefit drugs** for more information.
- **By phone:** Call 1-800-437-3803.
- **By fax:** Call the Pharmacy Clinical Help Desk at 1-800-437-3803 to obtain the pertinent medication request form, which you can then submit by fax.

Please see Pharmacy Benefits, continued on Page 25

Pharmacy Benefits *continued from Page 24*

- **For Blue Cross' PPO members:** Fax the medication request form to 1-866-601-4425.
- **For BCN HMO members**: Fax the medication request form to 1-877-442-3778.

- **By written request:** Mail a written request to:
  Blue Cross Blue Shield of Michigan
  Attention: Pharmacy Services
  Mail Code 512
  600 E. Lafayette Blvd.
  Detroit, MI 48226-2998

List of requirements

To view requirements for Skyrizi, Tegsedi and other drugs covered under the pharmacy benefit, see the Blue Cross and BCN **Prior authorization and step therapy coverage criteria** document. This document is available from the following pages on the **ereferrals.bcbsm.com** website.

- **Blue Cross Pharmacy Benefit Drugs**
- **BCN Pharmacy Benefit Drugs**

For a list of requirements related to drugs covered under the medical benefit, see the ***Blue Cross and BCN utilization management medical drug list for Blue Cross PPO (commercial) and BCN HMO (commercial) members*** document.

Quarterly update: Requirements changed for some commercial medical benefit drugs

During July, August and September 2020, we updated authorization requirements, site-of-care requirements, or both, for BCN HMO℠ members, for the following medical drugs:

HCPCS code	Brand name	Generic name
J3490*	Viltepso™	viltolarsen
J3590*	Tecartus™	brexucabtagene
J3590*	Uplizna™	inebilizumab-cdon

* Will become a unique code

For a detailed list of requirements, see the **Blue Cross and BCN utilization management medical drug list**. This list is available on the **Blue Cross Medical Benefit Drugs** 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 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.

We added more vaccines to the pharmacy benefit

We added the following Hepatitis B vaccines to the pharmacy benefit for eligible Blue Cross Blue Shield of Michigan and Blue Care Network commercial non-Medicare members, starting Dec. 1, 2020:

- Energix™-B
- Heplisav-B®
- Recombivax HB®

This allows participating pharmacies to bill through the pharmacy claims processing system.

The program covers the same vaccines offered under the Vaccine Affiliation program. These vaccines are now billed under the medical benefit. Listed below are the vaccines and age requirements covered under the pharmacy benefits plan:

Vaccine	Common name	Age requirements
Influenza virus	Flu	None
Havrix®	Hepatitis A	None
Vaqta®	Hepatitis A	None
Twinrix®	Hepatitis A and B	None
Energix™-B (effective 12/1/20)	**Hepatitis B**	**None**
Heplisav-B® (effective 12/1/20)	**Hepatitis B**	**None**
Recombivax HB® (effective 12/1/20)	**Hepatitis B**	**None**

Vaccine	Common name	Age requirements
Gardasil®9	HPV	9 to 45 years old
M-M-R® II	Measles, mumps, rubella	None
Menveo®	Meningitis	None
Menactra®	Meningitis	None
Menomune®	Meningitis	None
Trumenba®	Meningococcal B	None
Bexsero®	Meningococcal B	None
Ipol®	Polio	None
Pneumovax 23	Pneumonia	None
Pneumococcal (PCV7)	Pneumonia	None
Prevnar 13®	Pneumonia	65 and older
Shingrix®	Shingles	50 and older
Boostrix®	Tetanus, diphtheria, whooping cough	None
Adacel®	Tetanus, diphtheria, whooping cough	None
TDVax®	Tetanus, diphtheria booster	None
Tenivac®	Tetanus, diphtheria booster	None
Varivax®	Varicella (chickenpox)	None

Please see Vaccines, continued on Page 27

Pharmacy News

Vaccines, *continued from Page 26*

Vaccines for Blue Cross members can be processed under both pharmacy benefits and medical plans, but only one plan can be billed per claim. Both plans require a qualified administrator at a Blue Cross participating pharmacy or medical office to give the vaccine.

Qualified pharmacists giving the vaccine can bill the member's pharmacy benefits plan or the member's medical plan when the pharmacy participates in the medical Vaccine Affiliation program.

Participating medical offices giving the vaccine should bill the member's medical plan.

Most Blue Cross commercial members with prescription drug coverage are eligible. Most of the vaccines will be covered with no cost share to members if their benefits meet the coverage criteria.

Grandfathered and retiree opt-out groups won't be part of this program. These groups will maintain their current vaccine coverage under their medical benefit.

Most Blue Cross and BCN members can search for a participating retail pharmacy by logging in to their member account at **bcbsm.com**. After logging in:

- Hover the mouse over *My Coverage* in the blue bar at the top of the page.
- Select *Prescription* from the drop-down menu.

Scroll down to *Where to go for care* and click on *Find a pharmacy*. The link will take members directly to Express Scripts®.

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

See full article on **Page 13** for details.

Billing Bulletin

Michigan law prohibits 'surprise billing'

As of Oct. 22, 2020, Michigan state law prohibits surprise billing by nonparticipating professional providers in Michigan for emergency services and some non-emergency services provided on and after this date. Surprise billing is already prohibited for participating providers.

"Surprise billing" refers to instances where a member unknowingly receives care from a nonparticipating provider and later receives an unexpected bill for the difference between the insurer's payment and what the provider charges.

Nonparticipating professional providers in Michigan will no longer be able to balance bill members in the following scenarios outlined in the law:

- Covered emergency services at a participating or nonparticipating health facility
- Covered non-emergency services at a participating health facility when at least one of the following events occurs:
  - o The patient doesn't have the ability or opportunity to choose a participating provider
  - o The nonparticipating provider doesn't provide the required advanced written disclosure notice to the member of the service's estimated costs and notice of the right to seek care from a participating provider (see **Public Act 235**)
- A health care service at a participating health facility for a patient who was a admitted to the hospital within 72 hours after receiving a health care service in the hospital's emergency room

For the above scenarios, the law defines the benchmark rate that these nonparticipating providers must now accept as payment in full. The benchmark rate is defined as the greater of the following (excluding any in-network cost sharing):

- The median amount negotiated by the patient's carrier for the region and provider specialty
- 150% of the Medicare fee-for-service amount listed on the fee schedule for the health care service provided

Members are responsible for any in-network cost-sharing requirements.

If you have questions, contact Provider Inquiry at the appropriate number below:

- Blue Cross Blue Shield of Michigan
  - o Physicians and other professional providers of care: 1-800-344-8525
  - o Hospital and facility providers: 1-800-249-5103
- Blue Care Network
  - o Professional providers: 1-800-344-8525
  - o Ancillary and facility providers: 1-800-249-5103

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 the performed procedure is correctly reported to us.

This issue's tips include:

- Billing for monthly monitoring and management codes
- Clinical editing appeal submission reminders

Clinical editing billing tips

Facilities can't bill for separate labs when using point-of-care testing for blood gas analysis

When blood analysis is completed by point-of-care testing in an inpatient hospital setting, Blue Cross Blue Shield of Michigan and Blue Care Network will only pay for the primary charge, per time and date of service, that the blood was analyzed, but not for other associated or separately billed labs. Separate labs should be zero priced when billed and will be considered a provider write off.

This policy is effective Jan. 1, 2021, for Blue Cross' PPO members, Medicare Plus Blue℠ PPO, BCN HMO℠ (commercial) and BCN Advantage℠.

Background

Blood gas analysis performed by point-of-care testing, or utilization of a blood gas analyzer, is prescribed by a physician, or a non-physician practitioner, to provide quick laboratory testing using one sample of blood to achieve multiple test results within minutes and can affect the treatment and management of the patient. This billing policy isn't intended to affect provider decision-making or patient care. Providers are expected to apply medical judgment when caring for all members.

The following is a list of common point-of-care testing or blood gas analyzer devices that result an array of labs, and are covered by this billing policy:

- Abbott handheld I-Stat Machine
- epoc® blood analysis system
- Radiometer

The following is a list of commonly associated, but separately billed labs. These include, but are not limited to:

- Electrolytes (for example, sodium, potassium, chloride)
- Lactate/lactic acid
- Ionized calcium
- Creatinine and urea nitrogen
- Hemoglobin and hematocrit
- Glucose

Coverage decisions announced for additional COVID-19 testing codes

The American Medical Association announced four new CPT* codes for COVID-19 that were effective Aug. 10, 2020.

Blue Cross Blue Shield of Michigan and Blue Care Network are not covering these codes for our PPO commercial and BCN HMO℠ commercial plans. However, they are covered by our Medicare Advantage plans — Medicare Plus Blue℠ PPO and BCN Advantage℠. The codes are: *0225U, *0226U, *86408 and *86409.

These codes have been added to our **COVID-19 patient testing recommendations for physicians** document. You can find this document on our public website at **bcbsm.com/coronavirus** and through Provider Secured Services at **bcbsm.com**.

Billing Bulletin

Blue Cross doesn't reimburse for drugs that are experimental, starting in January

Blue Cross Blue Shield of Michigan and Blue Care Network won't reimburse providers for experimental and investigational drugs. This payment policy is effective Jan. 1, 2021 and applies to all claims reported for Blue Cross' PPO, Medicare Plus Blue℠ PPO, BCN HMO℠ (commercial) and BCN Advantage℠.

When you bill these types of drugs on a UB-04 for inpatient services, use the correct revenue code and modifiers necessary for experimental drug use. Use revenue code 0256 — experimental drugs, and the appropriate Advance Beneficiary Notice of Noncoverage modifier (GA, GX, GY, GZ).

Health care providers may not bill members for such services unless, prior to the services, all of these requirements are met:

- You provide the member with a cost estimate of the service.
- You have the member confirm in writing that he or she assumes financial responsibility for the service.
- The member understands that Blue Cross won't reimburse the provider for the service.

Facilities should prorate daily respiratory therapy services, starting Jan. 1

Blue Cross Blue Shield of Michigan and Blue Care Network will require facilities to prorate daily respiratory therapy services by hours used, not to exceed 24 hours in a single day. This billing rule is effective Jan 1, 2021, for members of Blue Cross' PPO, Medicare Plus Blue℠ PPO, BCN HMO℠ (commercial) and BCN Advantage. It applies to an inpatient setting only.

The following is a list of general respiratory therapy services applicable to this billing policy:

- All types of ventilators
- Continuous positive airway pressure (CPAP)
- Bilevel positive airway pressure (BIPAP)
- All types of oxygen

Billing example

On a single day of service, a patient is on the ventilator for five hours and then is weaned to CPAP for the remaining 19 hours of the day. Previously, services were billed at a daily rate regardless of hours used. New billing should reflect only those hours used for each modality.

Background

Respiratory therapy services are services prescribed by a physician or a nonphysician practitioner for the assessment and diagnostic evaluation, treatment, management and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function. This billing policy isn't intended to affect physician decision-making; providers are expected to apply medical judgment when caring for all members.

Billing Bulletin

Reminder about billing for COVID-19 testing

With the increase in COVID-19 cases that we're seeing across Michigan and the United States, we want to remind our health care providers about Blue Cross Blue Shield of Michigan and Blue Care Network's policy when it comes to COVID-19 testing.

Blue Cross and BCN will cover the cost of member COVID-19 testing that:

- Is ordered by a qualified health professional who determines testing is medically appropriate using judgment in accordance with accepted standards of current medical practice
- Has met the necessary regulatory approval through the FDA or falls within one of the other categories of tests required to be covered by the Families First or CARES Acts.

The test orders must show medical necessity. The only exception is for patients with Medicare Advantage coverage who are allowed one COVID-19 test without an order from a health professional in accordance with the Centers for Medicare & Medicaid Services policy.

Blue Cross and BCN cover preoperative COVID-19 testing for procedures conducted in hospital operating rooms and ambulatory surgical facilities. Aerosol-generating procedures are also appropriate for preoperative COVID-19 testing regardless of the location performed, such as oral surgery in an office setting.

It's important to note that Blue Cross and BCN policy does not cover workplace or screening tests. This includes testing to:

- Participate in sports
- Return to work or school
- Qualify for admission to armed services, residential facilities, for example
- Engage in research
- Accommodate requests for routine testing due to general concerns or a desire to get tested prior to family gatherings, such as vacations

If a patient wants to get testing that their health plan won't cover, you can direct them to **Michigan.gov/coronavirus** to find a site that offers free COVID-19 testing.

For more information, please see the **COVID-19 patient testing recommendations** document. It's available on our public website at **bcbsm.com/coronavirus** and by logging in as a provider at **bcbsm.com** and clicking on *Coronavirus (COVID-19)*.

Sleep studies may receive a clinical edit

In accordance with the Centers for Medicare & Medicaid, a patient may be entitled to a comprehensive sleep evaluation within a year prior to participating in a sleep study. Blue Care Network supports the appropriate monitoring of those patients. If you receive an edit you believe is incorrect, please submit a clinical editing appeal.

As a reminder, Blue Care Network has a medical policy for sleep studies that includes CPT and HCPCS codes *95782, *95783, *95800, *95805, *95806, *95807, *95808, *95810, *95811, E0486, G0398, G0399, *95801, A7047, E0485, E1399, and G0400.

Please follow the guidelines and preauthorization requirements outlined in the medical policy.

Billing Bulletin

New clinical editing resource helps you correct billing errors

We've posted a new billing tips resource, titled *Clinical Edits: What You Need to Do and What Documentation is Needed*, in the Provider Secured Services area of **bcbsm.com**. It's expected to provide a clearer understanding of the clinical edits you may encounter and how to resolve them.

To find it, follow these steps:

1. After logging in to Provider Secured Services at **bcbsm.com**, click *BCN Provider Publications and Resources.*
2. Click *Billing/Claims* under Popular links in the left-hand navigation.
3. Under Clinical Editing Resources, click *Clinical edits: What you need to do and what documentation is needed.*

Once you open the document, you can use the keyword search function (Ctrl + F) to search for keywords found on your voucher. Here's a screenshot of a portion of the new resource:

Description	What next?	Appeal Documentation
Assistant Surgeon Policy – Surgeon who assists with surgical procedure. Not all procedures need an assistant so additional reimbursement for the surgical assistants is denied	No further action since this is reimbursement policy based on American College of Surgeons guidelines.	Operative response indicating the need for the surgical assistance. The work the assistant surgeon performed should be documented in the surgical record.
Anesthesia Not Eligible – An anesthesiologist bills for non-anesthesia procedures. The daim line is denied.	No further action since this is reimbursement policy. Anesthesia service is not necessary for the procedure performed.	Complete documentation of anesthesia service provided. Appeal only if the procedure performed requires anesthesia service.

The document provides a description of our clinical editing policies. We follow nationally recognized rules and guidelines from the Centers for Medicare & Medicaid Services, current procedural terminology codes and guidance from professional practitioner associations and societies. **Note**: The rules aren't all-encompassing and are intended to provide additional guidance and understanding of clinical edits.

The document also outlines your options for correcting billing errors. We offer advice on how to proceed to correct a claim or submit an appeal and specify the required appeal documentation.

In addition to *Clinical Edits: What You Need to Do and What Documentation is Needed*, you'll find another useful document on the site: *EX codes: Recommendations Regarding Appeal or Resubmission (BCN).* It offers a description of EX codes and recommendations on whether you should appeal or resubmit.

Keep in mind that there are many online medical billing and coding resources that can help you understand correct coding guidelines. Accurate claim submission and medical record documentation are crucial to correct reimbursement.

As a reminder, clinical editing is an integral part of our payment policy and you'll need to use the established guidelines for resolving medical and benefit policy questions.

Guidelines for billing collaborative care

The Collaborative Care Model, also known as CoCM, is a benefit for all our members, including seniors and Blue Care Network members, who see a primary care physician who uses this model. There are no member cost-sharing requirements for the use of CoCM.

As you may have read in a **September *Record* article**, this integrated behavioral care model allows a primary care physician to more effectively treat patients with behavioral health conditions, such as depression and anxiety.

This model requires three provider types, working together as a team and focusing on the following responsibilities:

- A primary care physician, who retains responsibility for patient treatment plans and billing.
- A behavioral health care manager, who works closely with the patient, administers screening assessments, conducts weekly systematic case reviews with a consulting psychiatrist and serves as a liaison between the PCP and the consulting psychiatrist.
- A consulting psychiatrist, who consults with the care manager each week to review the patient's response to treatment and their behavioral screening results. The psychiatrist doesn't meet with the patient as part of this model.

Keep in mind that there are some specific billing requirements when using this model. Neither the behavioral health care manager nor the psychiatrist submit claims for CoCM services. The primary care physician bills for services provided by the care team over a calendar-month service period.

Billing basics

- Bill per member, per calendar month.
- For each month, bill for the time spent by all clinical team members but don't duplicate shared time. For example, if the care manager and psychiatrist meet for 10 minutes, you would bill for 10 minutes in total, not 10 minutes for the care manager and another 10 minutes for the psychiatrist.
- There must be a separate initiating billable visit with the PCP prior to billing CoCM codes for patients not seen within one year. This visit includes establishing a relationship with the patient, assessing the patient prior to referral, and obtaining patient consent to consult with specialists. (Consent may be verbal or written but must be documented in the electronic health record.)
- CoCM services may be billed alone or with a claim for another billable visit; however, CoCM services cannot be billed in the same calendar month as general behavioral health integration.
- Can bill both CoCM services and provider-delivered care management claims if both types of services are rendered.

Billing codes for commercial members:

Provider location	Code	Month	Time threshold
Any location	*99492	Initial month	36 to 70 minutes
	*99493	Subsequent month(s)	31 to 60 minutes
	*99494	Add-on code	16 to 30 minutes

Billing codes for patients with Medicare, a Medicare Advantage plan or Medicaid:

Provider location	Code	Month	Time threshold
Non-FQHC/RHC	*99492	Initial month	36 to 70 minutes
	*99493	Subsequent month(s)	31 to 60 minutes
	*99494	Add-on code	16 to 30 minutes
FQHC/RHC	G0512	Initial month	70 minutes
		Subsequent month(s)	60 minutes

Although CoCM has been a Blue Cross and BCN benefit since 2017, we're working to expand its use through training and support opportunities, as well as with incentives. Contact your physician organization if your practice is interested in learning more about training opportunities or incentives for using this model.

Evaluation and management changes for 2021

Changes will be effective in CPT for reporting requirements, beginning Jan. 1, 2021. These changes will affect the appropriate level of office evaluation and management codes. Blue Care Network is prepared for the changes and want to make sure providers are educated on the updated guidelines. The following highlights some of the major components that make up the evaluation and management service.

An E&M should be reported based on the level of medical decision-making or the total time for E&M services performed on the date of the encounter.

Medical decision-making will still be assigned levels of straightforward, low, moderate and high. As defined by the American Medical Association, these levels are based on three elements:

- The number and complexity of problems that are addressed during the encounter
- The amount or complexity of data to be reviewed and analyzed
- The risk of complications, morbidity, or mortality of patient management decisions made at the visit, associated with the patient's problems, the diagnostic procedures and treatments

There are clearly defined guidelines that describe each of these elements in detail to determine the level for the encounter.

Under the new evaluation and management guidelines, time may be used to select the code level regardless of how much of that time was spent with counseling or coordination of care. The new guidelines define the time by the service descriptors. The physician or other qualified health care professional time includes the following activities defined by AMA, when performed:

- Preparing to see the patient (review of tests)
- Obtaining or reviewing separately obtained history
- Performing a medically appropriate examination or evaluation
- Counseling and educating the patient, family or caregiver
- Ordering medications, tests or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient, family or caregiver
- Care coordination (not separately reported)

E/M	Total time
*99201	Deleted
*99202	15 to 29 minutes
*99203	30 to 44 minutes
*99204	45 to 59 minutes
*99205	60 to 74 minutes (for services greater than 75 minutes, see prolonged services)
*99211	Minimal
*99212	10 to 19 minutes
*99213	20 to 29 minutes
*99214	30 to 39 minutes
*99215	40 to 54 minutes (for services greater than 55 minutes, see prolonged services)

The evaluation and management changes don't affect other rules for E&M reporting, for example, an E&M the same day as a minor or major procedure, during a post-op period or decision-making for surgery. Please review all the changes related to E&M services in preparation for the upcoming year.

We've updated questionnaires in the e-referral system

We use our authorization criteria, our medical policies and your answers to the questionnaires in the e-referral system when making utilization management determinations on your authorization requests.

In September and October:

- We updated six questionnaires in the e-referral system.
- We removed one questionnaire from the e-referral system.

When we update or remove questionnaires, we also update or remove the corresponding preview questionnaires on the **ereferrals.bcbsm.com** website.

Updated questionnaires

- **Endoscopy, upper gastrointestinal, for gastroesophageal reflux disease:** On Sept. 27, we updated the list of procedure codes for which providers must complete this questionnaire for BCN HMO℠ and BCN Advantage℠ members.

  Starting Sept. 27, providers must complete this questionnaire for these procedure codes: *43191, *43192, *43193, *43195, *43196, *43197, *43198, *43200, *43201, *43202, *43214, *43231, *43233, *43235, *43237, *43238, *43239, *43241, *43242, *43248, *43249, *43250, *43253, and *43259

  Providers no longer need to complete the questionnaire for these procedure codes: *43180 and *43254.
- **Sacral nerve neuromodulation/stimulation:** On Oct. 11, we updated this questionnaire for Medicare Plus Blue℠ PPO, BCN HMO and BCN Advantage members.
- **Breast implant management:** On Oct. 25, we updated this questionnaire for BCN HMO and BCN Advantage members.
- **Breast reconstruction:** On Oct. 25, we updated this questionnaire for BCN HMO and BCN Advantage members.
- **Breast reduction:** On Oct. 25, we updated this questionnaire for BCN HMO and BCN Advantage members.
- **Orthognathic surgery:** On Oct. 25, we updated this questionnaire for BCN HMO and BCN Advantage members.

Removed questionnaire

On Sept. 27, we removed the **Lumbar spine surgery, minimally invasive** questionnaire for BCN Advantage members. The e-referral system now automatically approves requests for code G0276.

Preview questionnaires

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.

Authorization criteria and medical policies

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

Reminder: Providers must submit authorization requests to TurningPoint for musculoskeletal procedures for most members

As we reported in the November-December issue of ***BCN Provider News*** (Page 46), TurningPoint Healthcare Solutions LLC has expanded its surgical quality and safety management program for dates of service on or after Jan. 1, 2021.

You now need to submit authorization requests for orthopedic, pain management and spinal procedures to TurningPoint for the following groups and members:

- Blue Cross' PPO — All fully insured groups and select self-funded groups
- Medicare Plus Blue℠ PPO members
- BCN HMO℠ members
- BCN Advantage℠ members

Some important reminders

- 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, include only the procedure codes TurningPoint authorized on claims for musculoskeletal procedures.
- For procedures that are affected by the Jan. 1 program expansion, TurningPoint began accepting authorization requests on Dec. 1, 2020.
- You have until April 30, 2021, to submit retroactive authorization requests to eviCore healthcare® for:
  - Spinal procedures for Blue Cross' PPO fully insured groups and Medicare Plus Blue members for dates of service before Jan. 1
  - Pain management procedures for Blue Cross' fully insured groups with PPO coverage, select PPO self-funded groups with Blue Cross coverage, all Medicare Plus Blue members, all BCN HMO members and all BCN Advantage members for dates of service prior to Jan. 1

Webinar training

We'll continue to offer webinar training for providers, facilities and clinical staff. Use the links below to register for webinars.

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
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
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

Where to find more information

For more information about TurningPoint, see the following pages on the **ereferrals.bcbsm.com** website:

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

To view the lists of codes for which TurningPoint manages authorizations, see the ***Musculoskeletal procedure codes that require authorization by TurningPoint*** document.

For detailed information, see the ***Musculoskeletal procedure authorizations: Frequently asked questions for providers*** document.

Reminder: 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 refer to the article in the **November-December 2020** issue (Page 44) for more information.

Inpatient medical hospital peer-to-peer review request process changing for Blue Cross and BCN members

Effective Jan. 4, 2021, Blue Cross Blue Shield of Michigan will no longer accept peer-to-peer requests for Medicare Plus Blue℠ members regarding inpatient medical hospital admission denials.

Facilities are encouraged to follow the two-level provider appeal process for Medicare Plus Blue to reevaluate the denial decision on an inpatient admission request. See the Contracted MI Provider Acute Inpatient Admission Appeals section in the **Medicare Plus Blue℠ PPO Manual.**

BCN commercial, BCN Advantage℠ and Blue Cross' commercial PPO are still accepting peer-to-peer review requests. For those members, facilities must submit peer-to-peer review requests within seven days of the date the authorization request was denied. We're updating the document **How to request a peer-to-peer review with a Blue Cross or BCN medical director** to reflect the changes in the process for all lines of business. This document can be found on our **ereferrals.bcbsm.com** website on these webpages:

- **BCN Authorization Requirements & Criteria** webpage – look under the "Referral and authorization information" heading
- **Blue Cross Authorization Requirements & Criteria** webpage – in both the Blue Cross' PPO and Medicare Plus Blue PPO sections of the page

Before submitting prior authorization requests for inpatient hospital admissions, Blue Cross and BCN encourage hospitals to provide all clinical documentation needed to validate medical necessity criteria.

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