MARCH-APRIL 2021

BCN Provider News

Blue Care Network of Michigan
Confidence comes with every card.®

BCN Provider News User Guide

We're providing $0 cost sharing for COVID-19 vaccine coverage

Blue Cross Blue Shield of Michigan and Blue Care Network are waiving all copays, deductibles and coinsurance for administration of COVID-19 vaccines to all commercial members during the government's multi-phased approach to vaccine distribution. Medicare is covering the vaccine costs for Medicare members.

To assist you, we've created a new document to support provider offices preparing for COVID-19 vaccines. The ***COVID-19 vaccine information for providers*** document includes guidelines on distribution, coverage, billing, reporting and more using the most current information available.

We also encourage health care providers to review their list of patients to determine which ones are now eligible to receive the vaccine, and to consider reaching out to assist them in their efforts to obtain a vaccine.

You can find the *COVID-19 vaccine information for providers* document referenced above on the *Coronavirus information updates for providers* link on the on the *BCBSM Newsletters and Resources* and *BCN Provider Publications and Resources* pages of web-DENIS under COVID-19 vaccine information. It's also on our public website at **bcbsm.com/coronavirus**.

For more information about our decision to provide COVID-19 vaccine coverage at 0% cost sharing, read the Blue Cross **news release**.

Feedback | Subscribe

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

Inside this issue…

Network Operations

BCN Provider *News*

Feedback

Availity will bring new online search and favoriting capabilities

What you need to know

- Our new provider portal will offer new search and favoriting capabilities.
- You can set up favorites to take you directly to your frequently used applications.
- Read our Frequently Asked Questions documents for more information. The link is provided in this article.

Availity will bring new online search and favoriting capabilities

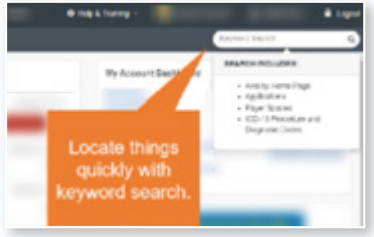
When Blue Cross Blue Shield of Michigan and Blue Care Network move to the Availity® provider portal later in 2021, you'll notice some updated features that will help you find what you need faster. Here's a preview of the two capabilities that will be available on Availity.

Search

Availity has a keyword search field in the upper right corner of the page. Here are some of the items you can find using the search feature:

- Specific content either available to all or posted within Payer Spaces (areas with content specific to a certain health plan, such as Blue Cross Blue Shield of Michigan and Blue Care Network)
- An application
- Key help topics, tips and quick links to Availity training
- Diagnosis and procedure codes (you can find them by code or a portion of the code name)

The search feature isn't case sensitive, but you'll need to spell the word correctly for the system to find it. So, if you remember seeing a resource or an announcement, but don't remember where it was, type in a keyword and Availity will help you find it.



Favoriting

Throughout the Availity portal, you'll see hearts next to the applications and other resources. You can click on the heart if you want to identify that item as one of your favorites. They'll be added to the *My Favorites* dropdown at the top of the screen. You choose what you want shown in that dropdown. It can be an application or a specific document. Then, each time you log in to Availity, you can go to *My Favorites* to quickly find the information you need.

In addition, Availity looks at the applications you use the most and lists them on the home page in the *My Top Applications* area. Here's a sample of what you might see based on your usage history.

Please see Availity, continued on Page 3

Editor
Cindy Palese
bcnprovidernews@bcbsm.com

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

Market Communications Publications
Colleen McIver

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

BCBSM and BCN maintain **BCBSM.com**, **ahealthiermichigan.org**, **mibluesperspective.com**, **valuepartnerships.com** and **theunadvertisedbrand.com**. The Blues do not control any other websites referenced in this publication or endorse their general content.

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.

No portion of this publication may be copied without the express written permission of Blue Care Network of Michigan, except that BCN-participating health care providers may make copies for their personal use. In no event may any portion of this publication be copied or reprinted and used for commercial purposes by any party other than BCN.

Availity, *continued from Page 2*

Questions?

If you have questions about the move to Availity, check our ***Frequently Asked Questions*** document first. If your question isn't answered there, submit it 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*.

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**)
- Many online tools will continue after move to Availity in 2021 (**November-December 2020 issue**)
- Get ready for Availity — Select an administrator (**January-February 2021 issue**)

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

No-cost COVID-19 treatment extended through Sept. 30, 2021

As the pandemic continues, Blue Cross Blue Shield of Michigan and Blue Care Network want to ensure members can get the care they need during these difficult times. We are extending the time frame for waiving the member cost share for COVID-19 treatment through Sept. 30, 2021.

The coverage applies to Blue Cross, BCN, Medicare Plus Blue℠, BCN Advantage℠ and Medigap plans.

We'll also continue to cover physician-approved testing and associated services for the duration of the public health emergency, as required by federal guidelines.

For more information, see our **news release**.

You can read about changes we've implemented for COVID-19 at **bcbsm.com/coronavirus** or log in to Provider Secured Services and click on *Coronavirus (COVID-19)*.

For up-to-date changes, see our **Temporary changes due to the COVID-19 pandemic document**.

Note: Some commercial self-funded groups are extending the waiver of member cost share. In addition, the Michigan Education Special Services Association, known as MESSA, and some Medicare Advantage groups have a different end date for the waiver of member cost share. Providers are encouraged to submit claims to Blue Cross and BCN and wait for the voucher before charging member cost share, if applicable.

Clinical review decisions are based solely on appropriateness of care

Utilization decisions regarding care and service 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.

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.

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 1-800-675-7278. (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.

Network Operations

How to request a member transfer

In some circumstances, a primary care provider 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 provider 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 15**.

Online Training

Sign up for training webinars

Providers and staff can sign up for two webinars in March. The webinars are designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

The Blue Cross 201 webinar series provides an in-depth learning opportunity and builds on information shared in our *Blue Cross 101: Understanding the Basics* webinar. This new webinar reviews the processes and tools available when submitting claims.

Here's information on the upcoming training webinars:

Webinar name	Date and time	Registration
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.

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.

Blue Cross Provider Publications and Resources

1. Log in to Provider Secured Services.
2. Click on *BCBSM Provider Publications and Resources*.
3. Click on *BCBSM Newsletters and Resources*.
4. Click on *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.
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*.

Blue Cross offers additional mileage reimbursement for ground ambulance providers in 2021

During the first quarter of 2021, Blue Cross Blue Shield of Michigan and Blue Care Network are offering ground ambulance providers an opportunity to become eligible for additional reimbursement for mileage.

Ground ambulance providers who participate under the *BCBSM and BCN Ambulance Provider Participation Agreement* will be eligible for additional reimbursement associated with HCPCS code A0425. Reimbursement will depend on the number of providers who sign the agreement. This additional reimbursement is in addition to the 2.25% overall ambulance fee schedule increase for 2021.

The program will be reassessed every 12 months.

To receive this additional reimbursement, follow these steps:

1. Sign the joint *BCBSM and BCN Ambulance Provider Participation Agreement* if you haven't already done so.
   - The signing period runs from Jan. 1 to March 31, 2021, for initial qualification.
2. Receive an additional percentage reimbursement for mileage.
   - The percentage will depend on the number of providers who sign the joint agreement (see table below).
   - The appropriate additional reimbursement percentage will be applied to code A0425 beginning on April 1, 2021.

Provider participation	Additional percentage for mileage
If providers currently participate under the joint ambulance contract or sign it between Jan. 1 and March 31, 2021	5%
If all participating Blue Cross commercial providers participate under the combined agreement (allowing Blue Cross to retire the individual provider agreement)	15%
If the percentage of providers who sign the joint contract equals 90%, thereby expanding the number of participating providers.	20%

Network Operations

New Blue Cross, BCN members to be issued alphanumeric subscriber IDs in February

Blue Cross Blue Shield of Michigan and Blue Care Network will issue alphanumeric subscriber IDs to new members, starting Feb. 27,2021. This will apply to all new Blue Cross and BCN members. We announced this change last year, but had delayed the implementation date.

Blue Cross will use the letter M after the prefix to begin the alphanumeric ID, followed by eight numbers. For example, a new subscriber ID could look like this: XYZM91234567. When you see one of these ID cards, use the last nine characters of the ID card to check in web-DENIS for benefits and eligibility.

The alphanumeric subscriber IDs (de-identified IDs, which appear on subscribers' member 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.

There are currently no plans to change subscriber IDs for existing members.

We're migrating to a new platform for electronic transmissions

Blue Cross Blue Shield of Michigan is moving to a new SFTP file transfer platform, Edifecs, for your electronic transmissions. We posted a web-DENIS message on Feb. 9 with information you need to know. Watch for updated messages for information on actions you'll need to take.

Questions can be sent to:
EDIMigration@bcbsm.com

Optum to handle credit recovery efforts for Blue Cross Blue Shield and Blue Care Network

Blue Cross Blue Shield of Michigan and Blue Care Network has retained Optum® to identify and recover credit balance overpayments on our behalf, effective Jan. 1, 2021.

Optum, a professional health care consulting firm, conducts periodic claim audits at provider locations. Reviews involve patient accounting records, not medical records. Claim recoveries will be handled through claims offset, not check refunds.

Previously, these reviews may have been conducted by Conduent, formerly known as CDR Associates. Any review initiated by Conduent that is in progress will be completed by Conduent with an estimated completion date of February 2021.

Claims data will be available through a web-based tool for providers to submit credit balance recoveries to the overpayment management tool.

BCN Advantage

Annual wellness visit included in telehealth visits available to Medicare Advantage patients

Blue Cross and Blue Shield of Michigan and Blue Care Network encourage providers to remind Medicare Advantage patients of their option to complete visits using telehealth.

Remember that for all telehealth visits, the documentation in the office note must include specific information:

- Type of telehealth contact (for example, visual, audio, email, portal)
- Type of video service (Skype, Zoom, BlueJeans)
- Location of patient and provider
- Patient informed consent documented (for example, the patient understands and accepts the privacy and security risks of telehealth medicine)

The following may also be documented through telehealth, telephone, e-visits, and virtual check-ins:

- Patient self-reported blood pressure readings from any digital device
- Advanced illness and frailty exclusions

In addition, Medicare Advantage patients can also complete a free annual wellness visit as:

- A traditional face-to-face visit in your office
- An online telehealth visit using a smartphone, computer or tablet with audio and video capability
- A telephone-only visit for patients who don't have video capability

The CPT codes are:

- G0402: Welcome to Medicare Visit
- G0438: Annual wellness visit, initial
- G0439: Annual wellness visit, subsequent

For more information, view the *Controlling Blood Pressure* tip sheet and the *Advanced Illness and Frailty Exclusions Guide* PDFs.

Controlling Blood Pressure

Advanced Illness and Frailty Exclusions Guide

BCN Advantage

Reminder: Check eligibility and benefits to determine cost sharing for telehealth services

As a reminder, effective Jan. 1, 2021, member cost share for Medicare-covered telehealth services is no longer automatically waived due to the public health emergency. Cost share is now applied based on the patient's plan coverage guidelines. Please check the member's eligibility and benefits to determine if cost share applies.

Refer to the **Medicare-covered telehealth procedure codes** list for the billable services allowed.

Submit prior authorization requests for nonpreferred filgrastim products using NovoLogix, starting April 1

For courses of treatment that start on or after April 1, 2021, submit all prior authorization requests for nonpreferred filgrastim products using the NovoLogix® online tool.

See full article on **Page 24**.

Gain insights from CAHPS research on improving the patient experience

The Centers for Medicare & Medicaid Services can help providers better understand their Medicare patients' needs and expectations through research from the Consumer Assessment of Healthcare Providers and Systems, or CAHPS®, survey. CMS annually compiles findings about improving the patient experience and understanding health outcomes.

You can access reports, articles and case studies through the **Agency for Healthcare Research and Quality (AHRQ): Research on Improving the Patient Experience**.

Read the ***CAHPS survey tip sheet*** to learn more about why this annual survey is important, how it's conducted, what questions are asked and ways you can successfully address care opportunities for patients.

We've changed the date CareCentrix will start managing prior authorizations for home health care for Medicare Advantage members to June 1

As reported in the December 2020 issue of ***The Record*** and in the January-February 2021 issue of ***BCN Provider News***, Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with CareCentrix® to manage authorizations for home health care services for Medicare Plus Blue℠ and BCN Advantage℠ members.

We're delaying the date on which CareCentrix will begin managing authorizations. CareCentrix will manage authorizations for home health care services for episodes of care starting on or after **June 1, 2021**.

For episodes of care that start before June 1, 2021, you don't need to submit prior authorization requests for home health care services.

BCN Advantage

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

BCN Advantage 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℠ and BCN Advantage HMO℠ 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

Patient Care/ Quality

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

- Miscellaneous genetic and molecular diagnostic tests
- Molecular testing for chronic heart failure and heart transplant
- Radiofrequency ablation of basivertebral nerve for low back pain

Covered services

- Balloon dilation of the eustachian tube (BDET)
- Genetic testing for BRCA1 or BRCA2 for hereditary breast/ovarian cancer syndrome and other high-risk cancers
- Genetic testing-whole exome and whole genome sequencing for diagnosis of genetic disorders
- Genetic testing-molecular analysis for targeted therapy or immunotherapy of non-small-cell lung cancer
- Charged particle (proton or helium ion) radiotherapy for neoplastic conditions
- Lymphedema surgical treatments

PDF *Medical Policy Updates*

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 Blue Care Network, its services, practitioners or providers, and member rights and responsibilities
- Receive language assistance and information about their care in a manner that is understandable to them
- Receive considerate and courteous care with respect and recognition of their dignity and right to privacy
- Participate with practitioners in decision-making about their health care
- Candidly discuss appropriate, medically necessary treatment options for their health conditions, regardless of cost or benefit coverage
- Voice concerns or complaints about their health care and file appeals about the health plan, benefit determinations, service or quality of care received by contacting Customer Service or submitting a formal written grievance through the Member Grievance program
- Receive medically necessary care as outlined in their *Member Handbook* and *Certificate of Coverage* and riders
- Make recommendations regarding members' rights and responsibilities policies

Members have a responsibility to:

- Supply information (to the extent possible) complete and accurate information Blue Care Network and providers need in order to provide care
- Comply with the 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

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 and the health plans QI program are available to all Blue Care Network primary care physicians, primary care groups and specialists upon request.

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.

Helping patients with medication management

Medication adherence can be challenging for patients with a chronic illness, such as asthma, cardiovascular disease, diabetes or hypertension. Unfortunately, not all patients take their medication as prescribed and may be reluctant to discuss their reasons with their doctor.

A complete and accurate medication list maintained by patients is the foundation for addressing medication management issues, according to the Agency for Healthcare Research and Quality. Keeping a medication list may help identify behaviors that put some patients at risk for overdosing, underdosing or missing doses.

Following are several online resources to help patients keep track of their prescribed and over-the-counter medications:

- **My Medication Record** is a one-page form by The National Council on Aging.
- **Personal Medicine List** is a four-page form by the Institute for Safe Medication Practices.

My Medicine Record is a four-page form by the Food and Drug Administration.

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 up 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

Crisis care is important for our members

Blue Care Network and BCN Advantage℠ have expanded their crisis care services by adding a contracted provider — Hegira Health/Community Outreach for Psychiatric Emergencies (COPE) — which offers behavioral health, mobile crisis services, an observation unit and two crisis residential facilities in Canton and Detroit.

We previously announced the addition of crisis assessment and placement services from Common Ground in the **November-December 2019** issue.

These behavioral health providers offer services that complement the programs we've always provided. We continue to offer inpatient hospital, crisis residential inpatient, psychiatric residential inpatient services partial hospital (outpatient) and, for some members, intensive outpatient services, in addition to traditional outpatient services and psychiatric evaluation and treatment

Recognizing that the emergency room isn't always the best option for crisis care, these providers can quickly do an initial assessment, triage the member and frequently begin treatment while in the facility. The goal is to place the member in the right level of care at the right time using a provider who specializes in behavioral health urgent or emergent evaluation and placement.

Primary care providers and specialists can refer members who need behavioral health assistance. Call 1-734-721-0200 to reach Hegira. Members can either walk in or call ahead to arrange an evaluation. To refer patients to Common Ground for an assessment, call 1-248-456-1991.

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 with a BCN behavioral health physician reviewer after normal business hours, 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.

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 make sure that providers and health plans understand the application of the criteria and Local Rules, BCN provides clarification from Change Healthcare on various topics.

Question:

In regard to InterQual criteria point 'Child/Adolescent – Inpatient – Episode Day 2-13 and 14-X – Symptoms improving or expected to improve… – Finding present within last 24 hours – Non-suicidal self-injury within last 48 hours – New onset within last 24 hours', does "new onset" mean that (to the best of the knowledge of the provider) the member has never self-injured before, or does it mean that they had self-injured prior to admission, and then had done so again after admission/within 24 hours of the review?

Answer:

The sub-criteria of "New onset within last 24 hours" refers to a new issue that has taken place within 24 hours. The issue of worsening is addressed in the previous sub-criteria point "Increased frequency or intensity" of self-injury occurring prior to admission.

So, the "New onset within last 24 hours" would mean the self-injury is new behavior from the member, rather than a reoccurrence of self-injury that took place prior to admission.

Changes coming to site-of-care requirements for Blue Cross commercial and BCN commercial pediatric members, starting March

Beginning March 1, 2021, site-of-care exemptions will no longer apply to pediatric Blue Cross commercial members and pediatric Blue Care Network commercial members for some drugs covered under the medical benefit.

This means all drugs that have site-of-care requirements for adult commercial members will have the same site-of-care requirements for pediatric commercial members.

For these drugs:

- Pediatric members who begin therapy at a hospital outpatient location **before March 1** are authorized to continue treatment at the current location through Aug. 31, 2021. This will provide continuity of care and give members time to work with their providers during the transition period.
- Pediatric members who begin therapy **on or after March 1** must have an authorization that includes a site-of-care approval. Members should talk to their doctors before March 1 to arrange to receive infusion services at one of the following locations:
  - Doctor's office or other health care provider's office
  - Ambulatory infusion center
  - The member's home

Additional information

- Pediatric members who begin therapy on or after March 1 will be authorized to receive the first dose at a hospital outpatient facility.
- If a member needs treatment in a hospital outpatient setting, the provider must submit clinical documentation to establish medical necessity; the plan will review the documentation and make a determination.

Pediatric members are defined as one of the following:

- 15 years old or younger, regardless of weight
- 16 to 18 years old and weigh 50 kg or less

More about the authorization requirements

- These authorization requirements apply only to groups that currently participate in the 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.

What you need to know

- All drugs that have site-of-care requirements for adult commercial members will also apply to pediatric commercial members, starting March 1.
- Pediatric members who begin therapy **on or after March 1** must have an authorization that includes a site-of-care approval.
- Submit authorization requests through the NovoLogix® online tool.

Please see Site-of-care requirements continued on Page 17

Site-of-care requirements, *continued from Page 16*

How to submit authorization requests

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

To learn how to submit requests through NovoLogix, go to **ereferrals.bcbsm.com** and do the following:

- **For BCN commercial members:** Click *BCN* and then click **Medical Benefit Drugs**. In the BCN HMO (commercial) column, see the "How to submit authorization requests electronically using NovoLogix" section.
- **For Blue Cross commercial members:** Click *Blue Cross* and then click **Medical Benefit Drugs**. In the Blue Cross PPO (commercial) column, see the "How to submit authorization requests electronically using NovoLogix" section.

Lists of requirements

To view requirements for these drugs, see the following drug lists:

- Standard commercial medical drug program: **Blue Cross and BCN utilization management medical drug list for Blue Cross PPO (commercial) and BCN HMO (commercial) members** document
- UAW Retiree Medical Benefits Trust non-Medicare members: **Medical Drug Management with Blue Cross for UAW Retiree Medical Benefit Trust PPO non-Medicare members**
- Blue Cross and Blue Shield Federal Employee Program® non-Medicare members: **Utilization management medical drug list for Blue Cross and Blue Shield Federal Employee Program® non-Medicare members**

What you need to know

- Members can get select diabetes monitoring products through participating pharmacies or through durable medical equipment providers.
- The supplier may vary depending on the member's plan.

We've expanded access to diabetes monitoring products for commercial members

Diabetes monitoring products, such as glucometers and test strips, lancets, continuous glucose monitors and insulin delivery devices, were added to the pharmacy benefit on Jan. 1 for Blue Cross commercial and Blue Care Network commercial members.

Members can obtain diabetes monitoring products or supplies through participating pharmacies or through durable medical equipment providers, as outlined below.

Through participating pharmacies

Select glucometers and continuous glucose monitors are available through members' pharmacy benefit with no cost sharing.

Other diabetes supplies are covered according to the drug list for the member's plan; the appropriate pharmacy copayment will apply.

Glucometers and continuous glucose monitoring products that are available with no cost sharing include:

- OneTouch Verio Reflect®
- OneTouch Verio Flex®
- OneTouch Ultra® 2
- Contour®
- Contour Next
- Contour Next One
- Contour Next EZ
- Dexcom G5™ receivers and transmitters
- Dexcom G6™ receivers and transmitters

Please see diabetes monitoring products continued on Page 18

Diabetes monitoring products, *continued from Page 17*

Through durable medical equipment providers

Members can also obtain diabetes monitoring products through a DME provider. The steps to locate DME providers vary depending on a member's plan:

- **Blue Cross commercial fully insured groups:** These members must obtain their diabetes monitoring products through a Northwood Inc. network provider starting Jan. 1. To find a Northwood network provider, members can do one of the following:
  - Log in to their Blue Cross member account (through **bcbsm.com** or our mobile app) and click on *Find a Doctor*.
  - Go to **bcbsm.com/dmesupplies** and click on *Find a Doctor*.

  A Northwood icon appears next to each Northwood network provider.
- **Blue Cross commercial self-funded groups:** To find a network provider, members can log in to their secure member account (through **bcbsm.com** or our mobile app) and click on *Find a Doctor*.
- **BCN commercial members:** To find a J&B Medical Supply network provider, members can do one of the following:
  - Log in to their secure member account (through **bcbsm.com** or our mobile app) and click on *Doctors & Hospitals*. They can then click on the *durable medical equipment* link.
  - Call J&B Medical Supply at 1-888-896-6233.

What this change means

This change affects members as follows:

- **Blue Cross commercial fully insured groups:** For these groups and members, we've moved to one provider, Northwood, beginning Jan. 1, 2021.

  If members use a provider in the Northwood network, their medical copayment, cost sharing, coinsurance or deductible won't change.

  However, if members use a provider outside the Northwood network on or after Jan. 1, they may pay a higher copay, cost sharing, coinsurance or deductible. Members can obtain diabetes supplies and prescriptions from a participating network pharmacy or from a provider through the Northwood network.
- **Blue Cross commercial self-funded groups:** There's no change to how members obtain durable medical equipment. Members can continue to get diabetes supplies from the DME provider they're using now under the pharmacy benefit.
- **BCN commercial members:** J&B Medical Supply is the DME provider for BCN commercial members; there won't be a negative effect on members who currently receive diabetes monitoring supplies under the medical benefit. This change simply expands access by allowing members to get diabetes supplies and prescriptions from participating network pharmacies, in addition to the durable medical equipment providers they're using now.

Waste avoidance program expansion starts March 1 for commercial members

To minimize drug waste, reduce unnecessary drug exposure and decrease the risk of adverse events, we're expanding our waste avoidance program to include additional drugs, effective March 1, 2021.

This change affects Blue Cross Blue Shield of Michigan commercial and Blue Care Network commercial members who receive these drugs:

- Onpattro®, HCPCS code J0222
- Orencia®,* HCPCS code J0129
- Stelara®, HCPCS code J3357
- Stelara IV®,* HCPCS code J3358
- Soliris®, HCPCS code J1300
- Ultomiris®, HCPCS code J1303

*In addition to Blue Cross commercial and BCN commercial members, the dosing strategy change for this drug applies to UAW Retiree Medical Benefits Trust non-Medicare members.

When this change takes effect, dosing for these therapies will be based on weight and will be specific to:

- The dosing guidelines of the U. S. Food and Drug Administration and the manufacturer
- Current medical best practices

This change will apply to members who start therapy and members whose authorizations are renewed on or after March 1. Members whose current authorizations for these drugs extend past March 1, 2021, can continue at their current dose until their authorization expires.

This change **doesn't** apply to:

- Blue Cross and Blue Shield Federal Employee Program® members
- BCN Advantage℠ members
- Medicare Plus Blue℠ members

Lists of requirements

To view the requirements for these drugs, see the following drug lists:

- Standard commercial medical drug program: **Blue Cross and BCN utilization management medical drug list for Blue Cross PPO (commercial) and BCN HMO (commercial) members** document
- UAW Retiree Medical Benefits Trust non-Medicare members: **Medical Drug Management with Blue Cross for UAW Retiree Medical Benefit Trust PPO non-Medicare members**
- FEP non-Medicare members: **Utilization management medical drug list for Blue Cross and Blue Shield Federal Employee Program® non-Medicare members**

We're updating these drug lists with information about the change in dosing strategy.

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 Blue Cross commercial and BCN commercial members.

During October, November and December 2020, we made changes to prior authorization requirements, site-of-care requirements or both for BCN commercial members for the following medical benefit drugs:

HCPCS code	Brand name	Generic name
J0596	Ruconest®	c-1 inhibitor recombinant
J0597	Berinert®	c-1 esterase
J0598	Cinryze®	c-1 esterase
J1290	Kalbitor®	ecallantide
J1442	Neupogen®	filgrastim
J1447	Granix®	tbo-filgrastim
J1744	Firazyr®	icatibant
J1744	Icatibant	icatibant hcl

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

These 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.

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

Changes coming to preferred products for drugs covered under the medical benefit for most members, starting April 1, 2021

For dates of service on or after April 1, 2021, we're designating certain medications as preferred products. This change will affect most Blue Cross Blue Shield of Michigan commercial, and all Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠ members.

Here's what you need to know when prescribing these products:

- **Preferred products vary based on members' health care plans.** Be sure to read this entire article. It includes changes that apply to most members, changes that apply only to most commercial members and changes that apply only to Medicare Advantage members.
- **For members who start treatment on or after April 1:** Prescribe preferred products when possible. The "Submitting requests for prior authorization" section of this article describes how to submit requests for preferred products and — for members who can't receive preferred products — how to submit requests for nonpreferred products.
- **For members who receive nonpreferred products for bevacizumab, trastuzumab, and rituximab, for courses of treatment that start before April 1:** These members can continue treatment using the nonpreferred product until their authorizations expire. We'll reach out to **commercial members** who receive these nonpreferred products and encourage them to discuss treatment options with you.

Note: For commercial members, the requirements outlined in this article:

- Apply only to groups that participate in the standard commercial Medical Drug Prior Authorization Program for drugs covered under the medical benefit
- Don't apply to members covered by the Blue Cross and Blue Shield Federal Employee Program® or the Michigan Education Special Services Association or to UAW Retiree Medical Benefits Trust non-Medicare members

Please see Changes coming to preferred products, continued on Page 22

Changes coming to preferred products, *continued from Page 21*

Preferred and nonpreferred products for most members

We're designating the following products as preferred and nonpreferred for: Blue Cross commercial fully insured groups, Blue Cross commercial members with individual coverage, Medicare Plus Blue members, BCN commercial members and BCN Advantage members.

Medication	Preferred products	Nonpreferred product
bevacizumab (reference product: Avastin®)	• Mvasi™ (bevacizumab-awwb), HCPCS code Q5107 • Zirabev® (bevacizumab-bvzr), HCPCS code Q5118	• Avastin® (bevacizumab), HCPCS code J9035
rituximab (reference product: Rituxan®)	• Ruxience™ (rituximab-pvvr), HCPCS code Q5119 • Riabni™ (rituximab-arrx), HCPCS code J3590 (will become a unique code)	• Rituxan® (rituximab), HCPCS code J9312 • Truxima® (rituximab-abbs), HCPCS code Q5115
trastuzumab (reference product: Herceptin®)	• Kanjinti™ (trastuzumab-anns), HCPCS code Q5117 • Trazimera™ (trastuzumab-qyyp), HCPCS code Q5116	• Herceptin® (trastuzumab), HCPCS code J9355 • Herzuma® (trastuzumab-pkrb), HCPCS code Q5113 • Ogivri® (trastuzumab-dkst), HCPCS code Q5114 • Ontruzant® (trastuzumab-dttb), HCPCS code Q5112

Additional preferred and nonpreferred products for most commercial members

We're designating the following products as preferred and nonpreferred for Blue Cross commercial fully insured groups, Blue Cross commercial members with individual coverage and BCN commercial members.

Medication	Preferred products	Nonpreferred product
pegfilgrastim (reference product: Neulasta®)	• Neulasta® / Neulasta Onpro® (pegfilgrastim), HCPCS code J2505 • Nyvepria™ (pegfilgrastim-apgf), HCPCS code J3590	• Fulphila® (pegfilgrastim-jmdb), HCPCS code Q5108 • Udenyca® (pegfilgrastim-cbqv), HCPCS code Q5111 • Ziextenzo™ (pegfilgrastim-bmez), HCPCS code Q5120

Additional preferred and nonpreferred products for Medicare Advantage members

We're designating the following products as preferred and nonpreferred for Medicare Plus Blue members and BCN Advantage members.

Medication	Preferred products	Nonpreferred product
pegfilgrastim (reference product: Neulasta®)	• Neulasta® / Neulasta Onpro® (pegfilgrastim), HCPCS code J2505 • Udenyca® (pegfilgrastim-cbqv), HCPCS code Q5111	• Fulphila® (pegfilgrastim-jmdb), HCPCS code Q5108 • Ziextenzo™ (pegfilgrastim-bmez), HCPCS code Q5120 • Nyvepria™ (pegfilgrastim-apgf), HCPCS code J3590

Please see Changes coming to preferred products, continued on Page 23

Pharmacy News

Changes coming to preferred products, *continued from Page 22*

Submitting requests for prior authorization

Here's how to submit prior authorization requests for preferred products and for nonpreferred products.

- **For select preferred products:** These products require prior authorization through AIM Specialty Health. Submit the request through the **AIM *Provider Portal*** or by calling the AIM Contact Center at 1-844-377-1278. For information about registering for and accessing the portal, see the **Frequently asked questions** page on the AIM website.
- **For nonpreferred products — for members who must take nonpreferred products:** These products have authorization requirements. Submit the prior authorization request through the NovoLogix online tool. NovoLogix 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.

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

Lists of requirements

See the following lists to view requirements for these products:

For commercial members, see:

- **Standard commercial medical drug program: Blue Cross and BCN utilization management medical drug list for Blue Cross PPO (commercial) and BCN HMO (commercial) members document**
- **Medical oncology drug program: Medical oncology prior authorization list for Blue Cross PPO' (commercial) fully insured and BCN HMO (commercial) members**

For Medicare Advantage members, see the **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 April 1, 2021.

Submit prior authorization requests for nonpreferred filgrastim products using NovoLogix, starting April 1

For courses of treatment that start on or after April 1, 2021, submit all prior authorization requests for nonpreferred filgrastim products using the NovoLogix® online tool.

This is a change for some requests:

- BCN commercial, Medicare Plus Blue and BCN Advantage members:
  - For courses of treatment that start Oct. 1, 2020, through March 31, 2021, submit these requests to AIM Specialty Health®. We communicated this in provider alerts and newsletter articles as early as July 2020.
  - For courses of treatment that start on or after April 1, 2021, submit these requests using the NovoLogix online tool.
- For Blue Cross fully insured commercial members, for courses of treatment that start on or after Oct. 1, 2020, you're already submitting these requests using the NovoLogix online tool; this will not change.

Note: For commercial members, the requirements outlined in this article:

- Apply only to groups that participate in the standard commercial Medical Drug Prior Authorization Program for drugs covered under the medical benefit
- Don't apply to members covered by the Blue Cross and Blue Shield Federal Employee Program®, the Michigan Education Special Services Association or UAW Retiree Medical Benefits Trust non-Medicare members

As a reminder, we communicated the preferred and nonpreferred products for filgrastim (reference product: Neupogen®) in July 2020 provider alerts. These designations were effective for courses of treatment that started on or after Oct. 1, 2020.

For the details on the preferred and nonpreferred filgrastim products, refer to these news articles:

- **Effective Oct. 1, Nivestym and Zarxio are preferred filgrastim products**, in the August 2020 issue of *The Record*
- **Effective Oct. 1, Nivestym and Zarxio are the preferred filgrastim products for all Blue Cross and BCN commercial and Medicare Advantage members**, Page 24 of the September-October 2020 issue of *BCN Provider News*

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

Medical benefit specialty drug prior authorization list changing in April for most members

We're adding prior authorization requirements for some drugs covered under the medical benefit, starting in April. Providers must request prior authorization through AIM Specialty Health®.

April 15 changes

For dates of service on or after April 15, 2021, the following drug will require prior authorization for UAW Retiree Medical Benefits Trust PPO non-Medicare members:

- Kanjinti™ (trastuzumab-anns), HCPCS code Q5117

April 22 changes

For dates of service on or after April 22, 2021, the following drugs will require prior authorization for Blue Cross commercial fully insured members and for BCN commercial, Medicare Plus Blue℠ and BCN Advantage℠ members:

- Danyelza® (naxitamab-gqgk), HCPCS codes J3490, J3590, J9999, C9399
- Margenza™ (margetuximab-cmkb), HCPCS codes J3490, J3590, J9999, C9399

These requirements don't apply to:

- Blue Cross and Blue Shield Federal Employee Program® members
- Michigan Education Special Services Association members

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:

- Blue Cross commercial fully insured and BCN commercial: **Blue Cross and BCN utilization management medical drug list** and the **Medical Oncology Program list**
- UAW Retiree Medical Benefits Trust non-Medicare members: **Medical Drug Management with Blue Cross for UAW Retiree Medical Benefit Trust PPO non-Medicare members**
- Medicare Advantage: **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**

We'll update these lists to reflect these changes before the effective dates.

Update for the Preferred Drug List changes, effective Jan. 1

We published an article in the **November-December 2020** issue that detailed changes to the Preferred Drug List, effective Jan.1, 2021. We're making an update to the exclusion information. **Cimzia® and Kevzara® remain on the Preferred Drug List**. These drugs aren't excluded.

The following is a list of all drug list changes for Jan. 1, 2021:

What you need to know

- Cimzia® and Kevzara® remain on the Preferred Drug List.
- Some drugs on the Preferred Drug List won't be covered
- Some drugs on the Preferred Drug List have quantity limits.

Changes to the Preferred Drug List

The following are changes to the Preferred Drug List that were effective Jan. 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®
Cosentyxv®	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®

Please see Preferred Drug List changes, continued on Page 27

Preferred Drug List changes, *continued from Page 26*

Drugs that won't be covered	Common use/drug class	Preferred alternatives
Ecoza®, Xolegel®	Topical antifungal	Loprox®, Naftin®, Nizoral®, Oxistat®, Spectazole®
Elestrin®	Estrogen	Divigel®
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
Lastacaft®, Pazeo®	Ophthalmic anti-allergy	Elestat®, Opticrom®, Optivar®, Pataday®, Zerviate®
Moviprep® (brand)	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®

Please see Preferred Drug List changes, continued on Page 28

Preferred Drug List changes, *continued from Page 27*

Drugs that won't be covered	Common use/drug class	Preferred alternatives
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.

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

The brand-name drugs that 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	Acularv, Bromdayv, Ocufenv, Voltarenv ophthalmic solution
Oraceav	Anti-infective	Adoxa®, Doryx®, Minocin®, tetracycline, Vibramycin®
Qbrexzav	Hyperhidrosis	Antiperspirant products are available over the counter

Drugs on the Preferred Drug List that will have quantity limits

These drugs 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

Please see Preferred Drug List changes, continued on Page 29

Preferred Drug List changes, *continued from Page 28*

Drug		PPO and HMO	
		Preferred Drug List	New quantity limit
	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®**	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

Changes to the Clinical, Custom and Custom Select Drug Lists

The following are changes to the Clinical, Custom and Custom Select Drug Lists that were 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 aren't 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 aren't 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®

Please see Preferred Drug List changes, continued on Page 30

Preferred Drug List changes, *continued from Page 29*

Drugs that won't be covered	Common use/drug class	Preferred alternatives
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.

Drugs on the Custom Drug List that have a higher copayment

The brand-name drugs that 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)

Please see Preferred Drug List changes, continued on Page 31

Preferred Drug List changes, *continued from Page 30*

Nonpreferred drugs that will have a higher copayment	Common use/drug class	Preferred alternatives
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 aren't 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)
ProAir® Respiclick®, Ventolin HFA®, albuterol sulfate HFA[1] (authorized generic for Ventolin HFA®)	Bronchospasm	ProAir HFA®, Proventil HFA®
Soma®	Muscle relaxant	Flexeril®, Norflex®, Robaxin®, Parafon Forte DSC®, Zanaflex®
Sovaldi® tablet	Hepatitis C	Epclusa®, Zepatier®

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

Please see Preferred Drug List changes, continued on Page 32

Preferred Drug List changes, *continued from Page 31*

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

These drugs 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

Please see Preferred Drug List changes, continued on Page 33

Preferred Drug List changes, *continued from Page 32*

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	
Sancuso®3 (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

Some drugs aren't payable when administered by a health care professional, starting April 1

For dates of service on or after April 1, 2021, the medications listed in this article won't be payable by Blue Cross Blue Shield of Michigan and Blue Care Network when administered by a physician or other health care professional.

This change affects Blue Cross commercial and Blue Care Network commercial members.

These drugs are now payable under either the medical benefit or the pharmacy benefit. Starting April 1, these drugs are payable only under the pharmacy benefit.

We're making this change because the drugs listed in this article can safely and conveniently be self-administered in the member's home and don't require administration by a health care professional.

Please see Some drugs aren't payable, continued on Page 34

Some drugs aren't payable, *continued from Page 33*

Drugs affected by this change

Here are the drugs that are subject to this change:

- Actimmune® (interferon gamma-1b), HCPCS code J9216
- Akynzeo® (netupitant / palonosetron), HCPCS code J8655
- Arcalyst® (rilonacept), HCPCS code J2793
- Banophen™ / Ormir™ / Pharbedryl™ (diphenhydramine), HCPCS code Q0163
- Emend® (aprepitant), HCPCS code J8501
- Imitrex® (sumatriptan succinate), HCPCS code J3030
- Granisetron HCl® (granisetron hydrochloride), HCPCS code Q0166 / S0091
- Marinol® / Syndros® (dronabinol), HCPCS code Q0167
- Megestrol acetate®, HCPCS code S0179
- Pegasys® (peginterferon alfa-2a), HCPCS code S0145
- Pegintron® (peginterferon alfa-2b) HCPCS code S0148
- Promethazine HCl® (phenadoz), HCPCS code Q0169
- Regranex® (becaplermin), HCPCS code S0157
- Sensipar® (cinacalcet), HCPCS code J0604
- Varubi® (rolapitant), HCPCS code J8670
- Zofran® / Zuplenz® (ondansetron), HCPCS code Q0162 / S0119

There are currently no other changes that apply to the management of these therapies.

Lists of requirements

To view requirements for 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.

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

Zostavax vaccine discontinued by the manufacturer

Merck, the manufacturer of Zostavax® vaccine, has announced that it is discontinuing the manufacturing of this vaccine and it will no longer be available for use in the United States. All remaining product has an expiration date of November 2020. Zostavax is used for the prevention of shingles in adults 60 and older. This discontinuation is due to business reasons, not to the medication's safety or efficacy.

Starting Dec. 1, 2020, Blue Cross Blue Shield of Michigan and Blue Care Network commercial pharmacy are no longer covering Zostavax vaccine.

Blue Cross and Blue Care Network will continue to offer Shingrix® vaccine for the prevention of shingles in adults 50 and older.

Blue Cross Blue Shield of Michigan and Blue Care Network partner with OptumRx for pharmacy benefit management services

A new partnership between Blue Cross Blue Shield of Michigan, Blue Care Network and OptumRx will provide members, providers and employers with prescription drug benefit services designed to improve the pharmacy experience, drive better health outcomes and lower costs. Beginning in 2022, OptumRx will support Blue Cross in managing pharmacy benefit services for group customers and members.

As a leading pharmacy care services provider, OptumRx will augment Blue Cross' existing programs, bringing new tools and digital technology designed to better manage overall drug spend and increase member engagement in pharmacy treatment. The OptumRx integrated health and wellness service platform complements the integrated benefit solutions with Blue Cross. Through this partnership, OptumRx will support administration of pharmacy claims, manage rebate contracting with pharmaceutical manufacturers, provide mail-order dispensing and manage Blue Cross' pharmacy networks.

"Holding the line on steadily increasing pharmacy costs and ensuring members have access to the prescriptions they need are top priorities for Blue Cross," said Daniel J. Loepp, president and CEO of Blue Cross Blue Shield of Michigan. "We're confident our partnership with OptumRx will help us move closer to reaching those goals through affordable, innovative solutions that improve care within our communities."

This collaboration advances Blue Cross' commitment to providing members with convenient and affordable access to prescription medications through a comprehensive retail and home delivery pharmacy network with no disruption to current members. Leveraging OptumRx's expertise, negotiated contracts and network of more than 68,000 pharmacies, these efforts will expand access and significantly improve prescription drug pricing and rebates to offer members and group customers more value and cost savings on their pharmacy benefits.

OptumRx will provide enhanced customer service technology integrated with member communications to ensure a smooth exchange of information. An updated website and new mobile app will also place individualized coverage details at each member's fingertips for quick and convenient access to costs and benefit information.

Blue Cross will continue to work closely with its current pharmacy benefit provider, Express Scripts Inc., to ensure a successful and seamless transition. Changes will take effect January 1, 2022, for commercial individual and group members, and January 1, 2023, for Medicare individual and group members.

Billing Bulletin

New ICD-10-CM/PCS COVID-19 diagnosis and procedure codes now available

The Centers for Medicare & Medicaid Services, in conjunction with the Centers for Disease Control and Prevention and the National Center for Health Statistics, has released a January ICD-10-CM/PCS code update, which will be effective with dates of service on or after Jan. 1, 2021. The update was released in response to the national emergency that was declared due to the COVID-19 outbreak.

It includes six new ICD-10-CM (diagnosis) codes and 21 ICD-10-PCS (inpatient procedure) codes to capture COVID-19 diagnoses and inpatient procedures for COVID-19. We've created a **document** listing the new codes.

For more information, visit the **ICD-10 section** of the CMS website:

- From the home page, click on *2021 ICD-10-CMS* or *2021 ICD-10 PCS*.
- In the *Downloads* section of the page, you can select *Coding Guidelines*, *Code Descriptions* or other key information you may need.

None of the information included herein is intended to be legal advice and as such it remains the provider's responsibility to comply with all applicable state and federal laws and regulations.

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:

- Anesthesia with pain management procedures
- Arthrodesis of SI joint may receive a clinical edit

Clinical editing billing tips

Clinical editing updates coming in June to outpatient claims

Starting in June, Blue Care Network and BCN Advantage℠ will be updating clinical edits applied to outpatient claims. We're expanding the edits to continue promoting correct coding to outpatient claims and maintain alignment with national coding guidelines.

BCN Advantage medical and payment policies will continue to comply with:

- National coverage determinations
- General coverage guidelines included in original Medicare manuals and instructions
- Written coverage decisions of the local Medicare administrative contractor

These expanded edits will continue to integrate appropriate local and national coverage determination guidelines. Some of the enhancements include, but are not limited to:

- CCI edits
- Evaluation and management services
- Radiology services

As with the application of all our clinical edits, the guidelines and regulations of these sources should be followed:

- Centers for Medicare and Medicaid Services' medical policies
- American Medical Association CPT coding guidelines
- National bundling edits, including the Correct Coding Initiative
- Modifier usage
- Global surgery period
- Add-on code usage

The appeal process won't change. Providers should continue to submit clinical editing appeals on the *Clinical Editing Appeal Form* with the necessary supporting documentation. Fax one appeal at a time to avoid processing delays.

We'll provide updates as the June enhancements draw closer.

New and updated questionnaires available 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.

Starting Nov. 22, 2020, new and updated questionnaires opened in the e-referral system for certain procedures. Preview questionnaires are available on the **ereferrals.bcbsm.com** website.

What you need to know

- We've added one and updated several questionnaires in the e-referral system.
- Preview questionnaires are on the Authorization Requirements & Criteria page in **ereferrals.bcbsm.com**.

Updated and new questionnaires

We've updated the following questionnaires in December:

- Biofeedback (non-behavioral health) for BCN commercial members
- Biofeedback (non-behavioral health) for BCN Advantage members

For both questionnaires:

- You'll need to complete them for procedure codes *90901 and *90912.
- You'll no longer need to complete them for procedure code *90911.

In addition, we made these updates in November:

A new *Ventricular assist devices* questionnaire opens in the e-referral system for adult BCN Advantage℠ members for these procedure codes: *33990 and *33991.

We've updated and renamed the *Mastectomy for male gynecomastia* questionnaire for Blue Care Network commercial and BCN Advantage members. The new name for the questionnaire is *Surgical treatment for male gynecomastia*.

We updated the *Artificial heart, total* questionnaire.

- This questionnaire will open only for BCN commercial members. You'll no longer need to complete this questionnaire for BCN Advantage members.
- You'll need to complete this questionnaire for these procedure codes: *0051T, *0052T, *0053T, *33927, *33928, *33929, *33975, *33976, *33979, *33981, *33982, *33983, *33990, *33991.
- You'll no longer need to complete this questionnaire for these procedure codes: *33992, *33993.

Preview questionnaires

You can access preview questionnaires at **ereferrals.bcbsm.com**. This can help you prepare your answers in advance.

To find the preview questionnaires, click *BCN* and then click **Authorization Requirements & Criteria**. Scroll down and look under the "Authorization criteria and preview questionnaires" heading.

Authorization criteria and medical policies

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

***CPT codes, descriptions and two-digit modifiers only are copyright 2020 American Medical Association. All rights reserved.**

Referral Roundup

Update: CareCentrix will start managing prior authorizations for home health care for Medicare Advantage members June 1

We're delaying the date on which CareCentrix will begin managing authorizations. CareCentrix will manage authorizations for home health care services for episodes of care starting on or after **June 1, 2021**.

For episodes of care for Medicare Plus Blue℠ and BCN Advantage℠ members that start before June 1, 2021, you don't need to submit prior authorization requests for home health care services.

See the January-February issue of ***BCN Provider News*** for details.

Procedure codes *71271 and *33208 don't require authorization for most members

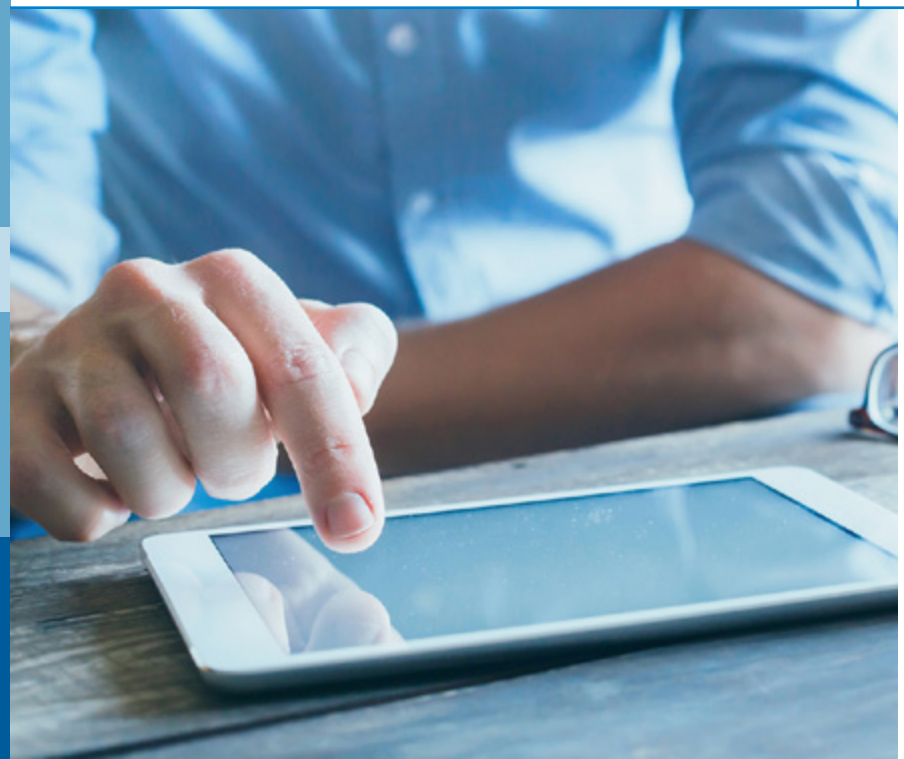
Services associated with radiology procedure code *71271 and cardiology procedure code *33208 don't require authorization for these members:

- BCN commercial
- BCN Advantage℠
- Medicare Plus Blue℠

These codes have been removed from the document ***Procedures that require prior authorization by AIM Specialty Health: Cardiology, radiology (high technology) and sleep studies (in lab)***.

We'll reprocess and pay any claims related to these procedure codes that were denied for lack of authorization.

***CPT codes, descriptions and two-digit modifiers only are copyright 2020 American Medical Association. All rights reserved.**



Check for messages in e-referral to finalize your pending requests

You can help us complete the processing and improve the turnaround time of your requests for authorization by checking the e-referral system for messages and responding quickly. We may reach out to you using the Case Communication feature in e-referral for additional information, including clinical documentation, that we need to process your requests.

Refer to the e-referral **user guide** sections regarding Case Communication for instructions.

Index

BCN Provider *News*

Feedback

INDEX: March-April 2021