MAY-JUNE 2021

BCN Provider News

BCN Provider News User Guide

Qualified providers invited to apply for designation in BDC Substance Use Treatment program

Qualified providers are urged to apply for national designation as a Blue Distinction Center for Substance Use Treatment and Recovery. As reported in a November-December 2020 ***BCN Provider News*** article, this is our newest designation.

Three Michigan providers have applied for and received this designation thus far.

This designation recognizes providers that have demonstrated expertise in delivering quality specialty care in this area safely, effectively and cost efficiently. All providers who apply for it must offer programs for opioid use disorder, including medication-assisted treatment as needed.

Providers can obtain detailed information about BDC program criteria through the Blue Cross and Blue Shield Association **website**.

The BDC Substance Use Treatment program designation provides value to health care providers in various ways:

- It differentiates you among your peers locally and nationally.
- It gives consumers and referring physicians the information they need to select a provider recognized for delivering quality, cost-efficient care. (See "Did you know" sidebar article for more information.)
- To better manage cost and quality of care, some employers are developing plans that encourage employees to use designated providers that demonstrate their ability to provide high-quality, cost-efficient care.

Please see BDC, continued on Page 2

Did you know?

- Less than half of Americans have a high level of confidence that they could find quality information to aid their search for quality care, according to the Associated Press-NORC Center for Public Affairs Research.
- Consumers are more likely to select a higher-quality, lower-cost provider than a high-cost provider when quality and cost information are shown in tandem, according to a report published in *Health Affairs*, a health care journal.

Inside this issue…

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Network Operations

BDC, *continued from Page 1*

Whether a provider meets program selection criteria or not, every provider evaluated receives a customized report providing useful insights about their performance.

Finding a BDC provider

Consumers and referring physicians can locate designated providers through the **Blue Distinction Center Finder.** Designations are also identified on the Find a Doctor search tool, which can be accessed from the home page of **bcbsm.com**.

To apply for designation

If you're interested in applying for this designation, send an email to Michelle Williams at **MWilliams3@bcbsm.com**.

Reminder: Blue Elect Plus members don't need referrals

Providers should be aware that members enrolled in Blue Care Network's Blue Elect Plus℠ POS plan don't need referrals to see a specialist.

When a patient calls a specialist for an appointment, your staff needs to verify whether the member has BCN HMO℠ or Blue Elect Plus POS coverage. BCN members can have HMO or POS benefits; it's an important distinction.

Blue Elect Plus is a point-of-service plan and doesn't require referrals to see a specialist, either in or out of network. The ID card prefix is the same prefix that's on the ID card for HMO coverage. But the plastic ID card specifically indicates "POS" coverage. In addition, language on the back of the member ID card notes that referrals aren't required for Blue Elect Plus. By contrast, the virtual ID card doesn't indicate that the member is in a point-of-service plan. Therefore, it's important to check web-DENIS for eligibility and benefits.

For Blue Elect Plus, some services, including most preventive care, are only covered when received from an in-network provider. Providers should also be aware that some services require prior approval.

See the **Blue Elect Plus** page of **ereferrals.bcbsm.com** for more information. or watch our Blue Elect Plus **video**.

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Blue Care Network pays providers same rates for telehealth and in-office visits

What you need to know

- We've updated our telehealth payment policy to pay the same for telehealth and in-office visits.
- We've updated our policies to include asynchronous visits and remote patient monitoring.

Blue Care Network is paying providers the same rates for telehealth visits that we pay for in-office visits, effective Jan. 1. This applies to BCN HMO℠ commercial members. The policy brings us in line with Blue Cross Blue Shield of Michigan; we've paid telemedicine visits at parity for PPO members since 2016.

Any services billed with place of service code 02 (telehealth) will pay the same if they were billed with place of service code 11 (in the office).

We're also making this change to support the use of telehealth when it's appropriate for patient care.

BCN Advantage℠ follows Centers for Medicare & Medicaid Services reimbursement guidelines for telehealth services

As a reminder, services are appropriate for telehealth when:

- A physician, in consultation with the patient, determines that significant progress to established treatment goals can be attained through telehealth.
- The service falls within the physician's scope of practice.
- The physician can provide medical record documentation supporting what is submitted for payment.

Telehealth includes asynchronous visits and remote patient monitoring

In addition, we've updated the medical policy to include store and forward services.. These updates are part of the telemedicine services policy that was updated Nov. 1, 2020. A new policy on remote patient monitoring was effective Jan. 1, 2021.

Store and forward services, also known as asynchronous visits, are telehealth visits that aren't held in real time. This can be used by:

— Practitioners requesting a consultation with a consulting specialist outside the patient encounter (This is particularly useful for radiology, ophthalmology and dermatology.)

— Patient-to-clinician interactions where the patient submits images to the physician who reviews, interprets and responds at a later time

Remote patient monitoring is defined as the use of digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and clinical management recommendations.

See Medical policy updates, **Page 21** for more information about remote patient monitoring.

Network Operations

Important information about our concierge medicine policy

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

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

About concierge medicine

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

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

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

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

Providers may charge a concierge fee if:

- Patients aren't required to pay the concierge fee to become or continue to be a patient in the practice.

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

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

Network Operations

eviCore will stop mailing Practice Profile Summaries and category information for outpatient physical therapy services

Beginning with July 2021 data, eviCore will no longer mail paper copies of the *Practice Profile Summary*, which includes information about your assigned category, to health care providers. Instead, eviCore will post category updates on the first business day of February and August each year beginning in August 2021.

Follow these steps to access your *Practice Profile Summary* and obtain your category:

1. Access eviCore's provider portal and select *Practitioner Performance Summary* from the main menu.
2. You may be prompted to select the health plan (select either Blue Cross or BCN) and enter your NPI.
3. Click on the *View PPS* button to review your PPS.
4. To find out your assigned category, click on the *UM Category* tab in the top left corner.

If you believe there are circumstances adversely affecting your utilization data, you may still request reconsideration within 15 days of eviCore's notification. Initiate your reconsideration request within the *UM Category* window.

Additional information is available on the **evicore.com** website as follows:

1. From the ***Implementation Resources* page** of **evicore.com**, click on the *Solution Resources* tab.
2. Click on *Musculoskeletal*.
3. Click on *Practitioner Performance Summary & Utilization Management Categories Training Presentation*.

You can also contact Provider and Client Services at 1-800-646-0418 for more information.

The move to Availity expected in late 2021 or early 2022

We're delaying the move to the Availity® provider portal to ensure our transition provides you with the features you want and the accuracy and dependability you deserve.. We're still working to have Blue Cross Blue Shield of Michigan and Blue Care Network content available in Availity this year, but a full transition is likely to move into 2022.

To help support this change, we plan to have both our current portal (bcbsm.com Provider Secured Services, including web-DENIS) and Availity functioning with Blue Cross and BCN information for a period of time.

We'll provide more information as we get closer to the implementation date. We appreciate your patience as we work to improve our online services for you.

Questions?

If you have questions about the move to Availity, please check our ***Frequently Asked Questions* document** first. If your question isn't answered there, submit it to ProviderPortalQuestions@bcbsm.com so we can consider updating the FAQ document.

New provider training website coming in 2021

To enhance the training experience for health care providers and staff, we're launching a new provider training website this year.

The new site will allow users to easily locate training resources, including recorded webinars, videos, e-Learning modules and supporting training documents. Future articles will share details on requesting access and how to navigate the website to locate training courses and track progress.

Online Training

Sign up for new webinars and check our on-demand training

We're continuing our 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 that review the processes and tools available when submitting facility claims:

Webinar name	Date and time	Registration
Claims Basics – Facility	Wednesday, May 19, 10 to 11 a.m.	**Click here** to register.
Claims Basics – Facility	Wednesday, May 19, 2 to 3 p.m.	**Click here** to register.
Claims Basics – Facility	Tuesday, May 25, 10 to 11 a.m.	**Click here** to register.
Claims Basics – Facility	Tuesday, May 25, 2 to 3 p.m.	**Click here** to register.

We've also posted recordings of webinars previously delivered this year. In addition, video and eLearning modules are available on specific topics.

Here is a list of the newest resources that are available:

- Autism Services Overview: This recorded webinar reviews current processes related to providing services to members with autism.
- A new document offers links for training modules and resources for newly contracted athletic trainers.
- Blue High-Performance Network e-Learning: This video gives an overview of the new Blue High-Performance Network to help providers care for patients. Note: This is only on the *Blue Cross Provider Training* page.

Recordings of previous webinars are available on web-DENIS. Look on the B*lue Cross Provider Publications* and *Resources* or *BCN Provider Publications* and *Resources* pages as follows.

Please see Training, continued on Page 7

Network Operations

Training, *continued from Page 6*

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 *Provider Event Presentations* section of the page, check out *2021 Provider Training Webinars*.
6. To find video and eLearning modules, click on the E-Learning (Online training, presentations and videos) link under Quick access at the top of the page.

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*.

Register for one or more of the upcoming provider symposiums, using the links included in this article.

Virtual provider symposiums to focus on patient experience, HEDIS, documentation and coding

We've scheduled this year's provider symposiums virtually throughout May and June for physicians, office staff and coders. The dates are listed below. You may register for one or more topics by clicking the registration links.

These sessions are for physicians and office staff responsible for closing gaps in care related to quality measures and creating a positive patient experience:

Topic	Date and time	Registration Link
HEDIS® measures (details and exclusions), Consumer Assessment of Healthcare Providers and Systems Survey, and Health Outcomes Survey	Tuesday, May 4 Noon to 2 p.m.	To register, click **here**.
HEDIS® measures (details and exclusions), Consumer Assessment of Healthcare Providers and Systems Survey, and Health Outcomes Survey	Wednesday, May 12 8 to 10 a.m.	To register, click **here**.
HEDIS® measures (details and exclusions), Consumer Assessment of Healthcare Providers and Systems Survey, and Health Outcomes Survey	Thursday, May 20 Noon to 2 p.m.	To register, click **here**.
HEDIS® measures (details and exclusions), Consumer Assessment of Healthcare Providers and Systems Survey, and Health Outcomes Survey	Tuesday, June 8 8 to 10 a.m.	To register, click **here**.
HEDIS® measures (details and exclusions), Consumer Assessment of Healthcare Providers and Systems Survey, and Health Outcomes Survey	Wednesday, June 16 Noon to 2 p.m.	To register, click **here**.
HEDIS® measures (details and exclusions), Consumer Assessment of Healthcare Providers and Systems Survey, and Health Outcomes Survey	Thursday, June 24 8 to 10 a.m.	To register, click **here**.

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Topic	Date and time	Registration Link
Patient experience	Tuesday, May 4 8 to 10 a.m.	To register, click **here**.
Patient experience	Wednesday, May 5 Noon to 2 p.m.	To register, click **here**.
Patient experience	Wednesday, May 12 Noon to 2 p.m..	To register, click **here**.
Patient experience	Thursday, May 20 8 to 10 a.m.	To register, click **here**.
Patient experience	Tuesday, June 8 Noon to 2 p.m.	To register, click **here**.
Patient experience	Wednesday, June 16 8 to 10 a.m.	To register, click **here**.

These sessions are for physicians, coders, billers and administrative staff:

Topic	Date and time	Registration Link
Updates on telehealth, and CPT, ICD-10-CM and evaluation and management codes	Thursday, May 6 8 to 9 a.m.	To register, click **here**.
Updates on telehealth, and CPT, ICD-10-CM and evaluation and management codes	Tuesday, May 11 Noon to 1 p.m.	To register, click **here**.
Updates on telehealth, and CPT, ICD-10-CM and evaluation and management codes	Wednesday, May 19 8 to 9 a.m.	To register, click **here**.
Updates on telehealth, and CPT, ICD-10-CM and evaluation and management codes	Thursday, June 10 Noon to 1 p.m.	To register, click **here**.
Updates on telehealth, and CPT, ICD-10-CM and evaluation and management codes	Tuesday, June 15 8 to 9 a.m.	To register, click **here**.
Updates on telehealth, and CPT, ICD-10-CM and evaluation and management codes	Wednesday, June 23 Noon to 1 p.m.	To register, click **here**.

Physicians, physician assistants, nurse practitioners, nurses and coders can receive continuing education credits for attending the sessions.

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

Providers must comply with access and availability guidelines

Blue Care Network has established standards for access to care. Providers are required to comply with the following standards when a member requests an appointment

Access to primary care	• Regular and routine care — within 30 business days • Urgent care — within 48 hours • After-hours care — 24 hours, seven days a week
Access to behavioral health care	• Life-threatening emergency — within one hour or a policy to direct members to nearest emergency services • Not life-threatening emergency — within six hours • Urgent care — within 48 hours • Initial visit for routine care — within 10 business days • Follow-up routine care — within 30 business days of request
Access to specialty care	High-volume/high-impact specialists including, but not limited to: OB-GYN and oncologists • Regular and routine care — within 30 business days • Urgent care — within 48 hours

For more information, please refer to the "Access to Care" chapter in the *BCN Provider Manual*.

To find the manual:

- Log in to *Provider Secured Services*.
- Go to *BCN Provider Publications & Resources*
- Click provider manual under *Publications*.

BCN Advantage

Additional medications will require prior authorization for Medicare Advantage members, starting June 22

For dates of service on or after June 22, 2021, the following medications will require prior authorization through the NovoLogix® online tool:

- Oxlumo™ (lumasiran), HCPCS code C9074
- Evkeeza™ (evinacumab-dgnb), HCPCS codes C9399, J3490, J3590
- Nulibry™ (fosdenopterin), HCPCS codes C9399, J3490, J3590

This affects Medicare Plus Blue℠ and BCN Advantage℠ members.

Places of service that require authorization

For Medicare Advantage members, we require authorization for these drugs when they're administered by a health care professional in a provider office, at the member's home, in an off-campus or on-campus outpatient hospital or in an ambulatory surgical center (sites of care 11, 12, 19, 22 and 24) and billed as follows:

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

Important reminder

Submit authorization requests for these drugs 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, see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**.

BCN Advantage

More Medicare Part B covered drugs are now available at retail pharmacies

Beginning May 13, pharmacies can begin billing BCN Advantage℠ directly for certain drugs approved for coverage under the Medicare Part B benefit for members enrolled in plans without prescription coverage. BCN Advantage plans with prescription coverage already include this benefit.

Previously, many retail pharmacies were unable to bill Part B medications directly to the medical benefit and often charged members in full for these drugs. This required members to submit reimbursement forms to Blue Care Network. For Medicare Plus Blue℠ members, this change became effective in April.

Cost sharing for these drugs still applies according to the member's plan.

The table below lists the medication types and how they'll be processed.

Drug type	What's new	Additional Info
Nebulizer solutions	Will automatically process under Part B if member lives at home and pharmacy uses the correct BIN/PCN/RxGroup ID.	For members residing in a **long-term care or skilled nursing facility,** these drugs are covered under Part D. The pharmacy should bill using the member's Part D plan ID card.
Select oral cancer medications	Will automatically process under Part B; prior authorization is not required if pharmacy uses correct BIN/PCN/ RxGroup ID.	These drugs are always covered under Part B and should not be billed to Part D plans.

View the **list** of Medicare Part B drugs available at point of service for Medicare Advantage members.

How to submit appeals for BCN Advantage members

Providers who need to submit appeals for denied authorization requests for Medicare Plus Blue℠ and BCN Advantage℠ inpatient acute care admissions (non behavioral health) should follow the process described in the provider manuals. Blue Cross and BCN also provide instructions in the denial letters they send providers.

For BCN Advantage members, providers can find instructions in the **BCN Advantage chapter** of the *BCN Provider Manual*. Click the TOC entry for BCN Advantage provider appeals. The provider appeals process for BCN Advantage members is governed by Medicare regulations.

Advanced illness and frailty exclusions allowed for HEDIS star measures

The National Committee for Quality Assurance allows patients to be excluded from select Healthcare Effectiveness Data and Information Set, or HEDIS®, star quality measures due to advanced illness and frailty. The NCQA **acknowledges** that measured services most likely would not benefit patients who are in declining health.

Providers may submit claims with advanced illness and frailty codes to exclude patients from select measures. Using these codes also reduces medical record requests for HEDIS data collection purposes.

Read the *Advanced Illness and Frailty Exclusions for HEDIS Star Measures Guide* for a description of the advanced illness and frailty exclusion criteria and a list with some of the appropriate HEDIS-approved billing codes.

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

Provider Star Measure Tip Sheet Advanced Illness

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

Comparing a patient's current and discharge medication list can reduce the chances of adverse drug events, especially for patients taking multiple medications. .

The Medication Reconciliation Post-Discharge, or MRP, HEDIS® star measure assesses patients ages 18 and older with Medicare coverage in the measurement year whose medications were reconciled on the date of discharge through 30 days after discharge (a total of 31 days).

During medication reconciliation, changes in the medication list should be reviewed and documented. Medication reconciliation also allows for documentation of the most accurate list of patient medications, allergies and adverse drug reactions.

View the Medication Reconciliation Post-Discharge tip sheet to learn more about when the process should be completed, information to include in medical records, CPT® codes to include in claims and tips for talking with patients about this important topic.

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

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

Medication Reconciliation Post-Discharge tip sheet

BCN Advantage

Breyanzi requires prior authorization for Medicare Advantage members

We require authorization for the CAR-T medication Breyanzi® (lisocabtagene maraleucel), HCPCS code J9999, when administered at on-campus or off-campus outpatient hospital (site of care 19 or 22). This applies to Medicare Plus Blue℠ and BCN Advantage℠ members.

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

Important reminder

Submit authorization requests for Breyanzi through the NovoLogix® online tool. 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.***

We're calling members to remind them to refill maintenance medications

We've been calling BCN Advantage members who have at least one chronic health condition and are near or past their medication refill date.

These calls remind members to refill their maintenance medications for diabetes, hypertension and cholesterol. If eligible, these members will also be able to switch to a 90-day supply of their medications. Please discuss with your patients whether a 90-day supply is right for them.

We also mail an "unable to reach" letter to members we couldn't reach by phone. The call campaign will continue through December 2021.

BCN Advantage

We made changes to our Telehealth procedure codes for COVID-19 chart

We've updated our ***Telehealth procedure codes for COVID-19*** document to refer to the Centers for Medicare & Medicaid Services' ***Covered Telehealth Services for PHE for the COVID-19 pandemic*** list for the billable services allowed for our Medicare Advantage members.

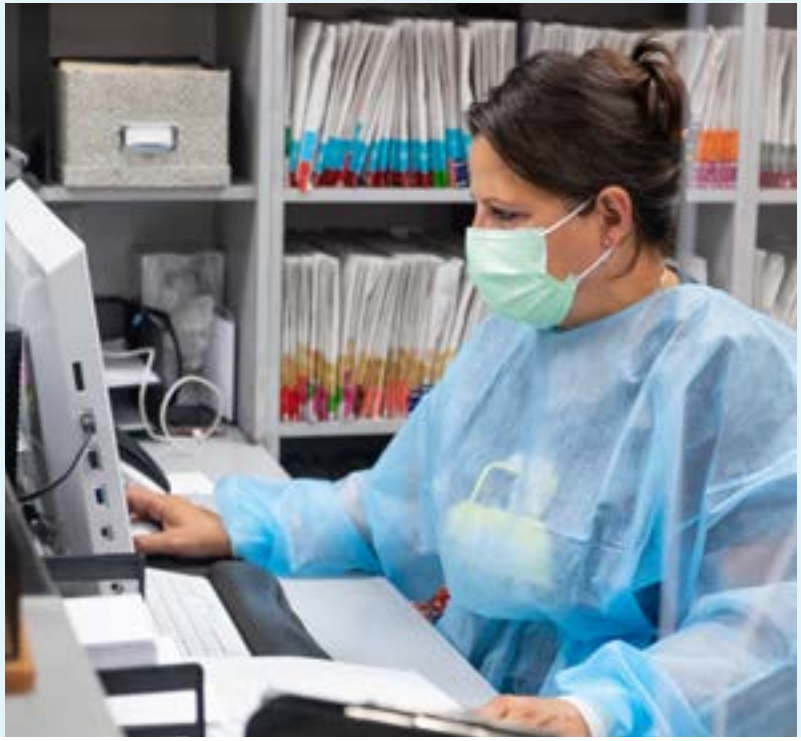
To save you the time of having to download the ZIP file from the CMS link above, we provide a PDF of the Medicare covered telehealth services **list** on our website. We review this list monthly and will provide any updates from CMS as necessary. For the most recent Medicare covered telehealth services, refer to the **list** on CMS' website.

You'll find the PDF and the following informative documents in the *Telehealth* section of our COVID-19 webpages on our public website at **bcbsm.com/coronavirus** and through Provider Secured Services:

- ***Medicare covered telehealth services for the COVID-19 PHE***
- ***Telemedicine Medical Policy***
- ***Telehealth for medical providers***
- ***Telehealth for behavioral health providers***

Medicare Advantage cost sharing reminder

Effective Jan. 1, 2021, member cost share for Medicare covered telehealth services during the COVID-19 public health emergency is no longer automatically waived. Cost share is now applied based on the patient's plan coverage guidelines. Check each member's eligibility and benefits to determine if cost share applies.



Don't use F codes when requesting authorization for inpatient medical admissions

When requesting authorization for acute care inpatient medical (non behavioral health) admissions, select a medical ICD-10 diagnosis code in the e-referral system — one that doesn't begin with F.

If you select an ICD-10 diagnosis code that begins with F, the processing of your request will be delayed.

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

BCN Advantage

Pilot program with naviHealth supports Medicare Advantage members after hospital discharge

Blue Cross Blue Shield of Michigan and Blue Care Network have started working with naviHealth to pilot the company's Patient Navigation Program. The program provides non-clinical support to Medicare Plus Blue℠ and BCN Advantage℠ members for discharge needs after their acute hospital stay through their transition home.

The Patient Navigation program will be provided to select members admitted to select hospitals in the Detroit area. The pilot will run through July, at which time an evaluation will be completed to determine whether the program should become permanent.

The goal of the program is to reduce readmissions.

This program has no cost share to members and is a component of the existing clinical partnership with naviHealth.

naviHealth's patient navigation team won't provide medical care or make clinical recommendations and doesn't replace care they're receiving through any other case management programs.

Patient navigators support members by:

- Engaging members during their hospital stay and supporting them through phone calls for 30 days from post discharge to home
- Identifying social barriers that may affect medical outcomes and connecting members with appropriate resources
- Helping to coordinate physician appointments
- Connecting members with appropriate Blue Cross and BCN clinical programs and resources

Blue Cross and BCN patient experience survey launches in June

Blue Cross Blue Shield of Michigan and Blue Care Network are launching a new Medicare Advantage member survey in June 2021 to assess patient experience. Our research shows positive member experiences at the point of care drive strong provider relationships and affect health outcome perceptions. And member perceptions are a crucial component of Centers for Medicare & Medicaid Services star ratings of health plans. Strong star performance allows us to deliver affordable Medicare Advantage benefits to your patients.

The nationally recognized Clinician and Group Consumer Assessment of Healthcare Providers and Systems, or CG-CAHPS, survey protocol will be used to gather patient feedback about specific care experiences with providers and their office staff. Key survey topics include provider communication, care coordination and access to care.

Approximately 7% of Medicare Plus Blue℠ and BCN Advantage℠ members will be randomly invited to take the survey annually. These members will be eligible for the survey if our claims data indicate they have had a care experience within the past 45 days with a primary care provider or one of five coordinated care specialists:

- Cardiologists
- Endocrinologists
- Nephrologists
- Oncologists
- Pulmonologists

Results will allow Blue Cross to monitor patient experience ratings across physician organizations as one of many elements that inform overall performance measurement. We'll also share results with provider organizations, including comparisons to national benchmarks.

A CMS-certified vendor will administer the mailed survey beginning in June 2021, with online and phone completion options. Monthly mailings will then be ongoing.

BCN Advantage

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 the authorization of home health care for Medicare Advantage members.

For episodes of care starting on or after June 1, 2021, providers will need to request prior authorization from CareCentrix for Medicare Plus Blue℠ and BCN Advantage℠ members.

For episodes starting before June 1, 2021, providers need to request prior authorization in the following situations:

- Recertification is needed
- Resumption of care is needed
- Significant change in condition occurs

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

The CareCentrix program will:

- Use evidence-based guidelines, including those from InterQual® and the Centers for Medicare & Medicaid Services, and clinical documentation to make utilization management decisions
- Validate appropriate utilization and enhanced quality of care across home health services
- As needed, assist with coordinating member transitions from hospital to home

What you need to know

- CareCentrix will manage the authorization of home health care for members.
- Register for webinars to learn about obtaining prior authorizations for home health care services, appeal processes and provider support and resources.

Please see Authorizations, continued on Page 18

BCN Advantage

Authorizations, *continued from Page 17*

Submitting prior authorization requests

Home health care agencies will be able to submit prior authorization requests starting on May 28, 2021. They can submit these requests online through the CareCentrix HomeBridge® portal, by phone or by fax.

Registering for webinar training

We're offering training webinars on the home health care program for services managed by CareCentrix. There are training sessions for referring providers and for home health care agencies.

Click a link below to register.

Webinar for referring providers —This session will cover the CareCentrix home health care program and details about members' transitions from hospital to home.

Date	Time	Registration
Tuesday, May 11, 2021	10 to 11 a.m.	Click here to register

Webinars for home health care agencies — These sessions will cover the CareCentrix home health care program; the steps required to obtain prior authorizations for home health care services; intent to deny, peer-to-peer and appeal processes; and provider support and resources.

Date	Time	Registration
Tuesday, May 4, 2021	10 to 11:30 a.m.	Click here to register
Tuesday, May 4, 2021	2 to 3:30 p.m.	Click here to register
Wednesday, May 5, 2021	10 to 11:30 a.m.	Click here to register
Wednesday, May 5, 2021	2 to 3:30 p.m.	Click here to register
Thursday, May 6, 2021	10 to 11:30 a.m.	Click here to register
Thursday, May 6, 2021	2 to 3:30 p.m.	Click here to register
Tuesday, May 11, 2021	2 to 3:30 p.m.	Click here to register
Wednesday, May 12, 2021	10 to 11:30 a.m.	Click here to register
Wednesday, May 12, 2021	2 to 3:30 p.m.	Click here to register
Thursday, May 13, 2021	10 to 11:30 a.m.	Click here to register
Thursday, May 13, 2021	2 to 3:30 p.m.	Click here to register

Learning more about the CareCentrix home health care program

We'll publish a *Home health care: Frequently asked questions for providers* document soon. When it's ready, we'll post a web-DENIS message to let you know.

Addressing implicit bias in health care can improve care delivery

You might have heard that implicit bias plays a role in how health care is delivered in doctor's offices, hospitals and other health care settings. But what exactly is meant by implicit bias?

Implicit bias refers to the attitudes, stereotypes and generalizations that affect our understanding, actions and decisions in an unconscious manner. It often results in prejudices in favor of — or against — a thing, person or group.

"All human beings are wired to have bias, and biases are often based on assumptions and stereotypes that are learned over time," explained Bridget Hurd, vice president of Inclusion and Diversity for Blue Cross Blue Shield of Michigan. "These unrealized or unconscious beliefs can affect our decision-making."

In a health care setting, implicit bias can have dangerous consequences.

"Every medical professional is mission-driven to heal their patient, but research indicates that bias shows in various ways in the delivery of health care — more often implicitly rather than explicitly," said President and CEO Daniel J. Loepp in a recent blog. "It benefits all medical professionals to spend time working to recognize where implicit bias may be present in the delivery of care and developing approaches to address it to the benefit of patients everywhere."

Consider these examples:

- Non-white patients presenting to the emergency room with the same symptoms as white Americans are less likely to receive pain medication, according to an **article** in *Physician's Weekly*.
- An **article** published in the National Academy of Sciences reported that a survey of white medical students in 2016 showed that many had false beliefs about the biological differences between Blacks and whites, leading to different treatment recommendations.
- Early in the COVID-19 pandemic, reports indicated that African-Americans with concerning symptoms weren't tested as often as their white counterparts, according to a **review** of billing information conducted by a biotech data firm.

Creating widespread understanding of these disparities in how health care delivery differs based on implicit bias is the first step in successfully addressing this issue.

That's why Blue Cross is rolling out implicit bias education to health care providers over the next two years. It covers such topics as the science of bias, how it influences behaviors and patient outcomes and how to make efforts to overcome implicit bias.

In September, leaders and staff at 40 physician organizations that participate in the Physician Group Incentive Program were introduced to implicit bias education. Next, it's being rolled out to patient-centered medical home physicians and office staff.

"Creating awareness among physicians and office staff is an important step in building cultural competency and addressing gaps in care that may occur due to biases related to race, ethnicity, gender, sexual orientation, obesity or socioeconomic status," said Hurd, who is leading the new Office of Health and Health Care Disparities.

Practices with PCMH designation will be required to take part in implicit bias educational opportunities this year to continue to receive value-based reimbursement tied to the PCMH designation.

Additionally, Gov. Gretchen Whitmer announced a directive last year that requires medical professionals to go through implicit bias training when obtaining or renewing their licenses.

HEDIS and Star tip sheets updated for 2021

We've updated our HEDIS® tip sheets** for 2021 and posted them on the *Clinical Quality Corner* page of web-DENIS, along with a series of *Star Measure Tips*. The tip sheets were developed to assist health care providers and their staff in their efforts to improve overall health care quality and prevent or control diseases and chronic conditions.

The new 2021 tip sheets that have been posted are up to date as of this publication. As updated versions are produced, we'll post new ones. For example, after the National Committee for Quality Assurance publishes final updates to the 2021 HEDIS specifications, we may need to update the tip sheets again.

The *Star Measure Tips* highlight select measures in the Medicare Star Ratings program. Most of the measures featured in the *Star Measure Tips* are also HEDIS measures. HEDIS is one of the most widely used performance improvement tools in the U.S.

Accessing the tip sheets

These *HEDIS Measure Tip Sheets* and the *Star Measure Tips* are housed on the *Clinical Quality Corner* page of web-DENIS. You can get there by following these steps:

1. From the homepage of web-DENIS, click on *BCBSM Provider Publications and Resources* in the left column. (You can also access them from the *BCN Provider Publications and Resources* section of web-DENIS.)
2. Click on *Newsletters & Resources*.
3. Click on *Clinical Quality Corner* on the left-hand side of the page under Other Resources.

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

Medical record guidelines policies require providers to maintain member records

Blue Cross Blue Shield of Michigan and Blue Care Network have a policy for content of medical records to ensure clinical records are maintained for each of our members and organized in a manner that facilitates easy access for reviewing and reporting purposes. The medical record should be stored or electronically secured to comply with HIPAA regulations.

Content of the medical record should include:

- Member demographics
- Health assessment
- Reason for visit
- Diagnosis
- Documentation of discussion about the following: advanced directives, preventive health and health maintenance, patient education, follow-up plan, consultation review and referred services review

Our medical recordkeeping policies support Centers for Medicare & Medicaid Services and National Committee for Quality Assurance standards and contain elements from the Michigan Quality Improvement Consortium Guidelines.

Quality management coordinators in our Quality Management department conduct medical record reviews of our contracted health providers for a variety of reasons, including, member complaints, identified deficiencies during a site visit, member surveys, suspicion of fraud, waste or abuse, or random reviews to monitor compliance with established standards for adequacy of medical recordkeeping.

The performance expectation is an overall score of at least 80%.

Information regarding screening guidelines can be found on the **MQIC** website.

Blue Care Network promotes coordination of care and exchange of information among practitioners

Blue Care Network collects and analyzes data each year to assess the coordination of care and exchange of information among specialists, behavioral health providers and primary care physicians following inpatient and outpatient consultations. This information is important as we work to improve continuity and coordination of care within our network.

Patient care that isn't coordinated across care settings results in confusion for members, increased risks to patient safety and unnecessary costs due to duplicate testing or procedures. Collaboration among health care providers can also greatly improve member satisfaction.

We can work together to accomplish our goal of 100% coordination of care among all providers by:

- Ensuring that specialists and behavioral health care providers have the correct contact information for the patient's primary care doctor at the time of the visit
- Requesting that specialists and behavioral health providers forward post-visit information to the patient's primary care provider
- Ensuring that primary care physicians forward patients' medical information to the treating behavioral health providers and specialists, if needed
- Asking behavioral health patients to sign an authorization for release of information, or including a note of refusal in the patient's chart if the patient declines to share information

We encourage all heath care providers to take steps to enhance the coordination of care and bidirectional information exchange across the continuum of care among specialists, behavioral health providers and primary care physicians to improve member satisfaction and quality of care.

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:

Covered services

- Balloon ostial dilation for treatment of chronic and recurrent rhinosinusitis
- Genetic testing of CADASIL syndrome
- Remote patient monitoring
- Genetic testing for cystic fibrosis
- Electroretinography, multifocal electroretinography and pattern electroretinography (pERG)
- Pediatric feeding programs
- Obstructive sleep apnea and snoring — surgical treatment
- Wearable cardioverter defibrillators

Medical Policy Updates

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.

The following is intended for Acute Adult Inpatient reviews for the subset General Medical Neurological:

Question:

Can metabolic encephalopathy be considered a new onset neurological disorder?

Answer:

No. The most common causes are underlying infection, acute kidney injury or liver damage. The focus of the review should be related to the underlying cause of the neurological disorder.

- If the cause is infectious, use the most appropriate infection condition specific subset.
- If the cause is secondary to acute kidney injury, the Acute Kidney Injury subset may be the most appropriate.
- If the cause is related to liver damage, hepatic encephalopathy is located under the Gastrointestinal or Biliary subset.

Question:

Could dizziness or vertigo be used to satisfy new onset neurological disorder?

Answer:

No. According to Change Healthcare, dizziness can be a symptom of many disorders, but is not, in and of itself, a neurological disorder. The focus of the review should be related to the underlying cause of the symptom of dizziness.

Question:

Can pain be considered a new onset neurological disorder?

Answer:

No. According to Change Healthcare, pain can be a symptom of many disorders but, in and of itself, is not necessarily a new onset neurological disorder. The focus of the review should be related to the underlying cause of the symptom of pain.

- The Hematology/Oncology subset addresses pain caused by malignancy with a specific bullet point for intractable pain.
- If pain is related to a trauma, the General Trauma subset may be appropriate.
- Severe pain is an observation level criterion point in the General Medical subset.

Neurologic disorder new onset is intended primarily to refer to the four bulleted findings below:

- Ataxia
- Blindness, diplopia, visual field loss
- Nystagmus
- Paresis or paralysis of extremity

Blue Care Network promotes continuity of care in some situations

Continuity of care services are available for the following members:

- Blue Care Network members whose primary care physician, specialist or behavioral health provider voluntarily or involuntarily disaffiliates from BCN
- New Blue Care Network members who require an ongoing course of treatment

Members can't see their current physician if that physician was terminated from BCN for quality reasons. In this instance, the member is required to receive treatment from an in-network provider.

BCN provides continuity of care notification to members at least 30 days prior to the practitioner's termination date.

BCN permits the member to continue treatment in the situations described below provided that the practitioner:

- Continues to accept as payment in full, reimbursement from BCN at rates applicable prior to the termination
- Adheres to BCN standards for maintaining quality health care and provides the necessary medical information related to the care
- Adheres to BCN policies and procedures regarding referral and clinical review requirements

Primary care physicians may offer continuity of care for a member in the situations described in the table below. Specialty providers may offer continuity of care for a member receiving an ongoing course of treatment in the situations described in this table.

Situation	Length of continuity of care
General care	Up to 90 days after the practitioner's termination date
This pregnancy	Through postpartum care directly related to the pregnancy, if the member is in the second or third trimester of pregnancy at the time of the practitioner's disaffiliation
Terminal illness	For the remainder of the member's life for treatment directly related to the terminal illness, if the member was being treated for the terminal illness prior to the practitioner's disaffiliation

An active course of treatment is defined as:

- An ongoing course of treatment for a life-threatening condition: A disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted
- An ongoing course of treatment for serious acute condition: A disease or condition requiring complex ongoing care, which the covered person is currently receiving, such as chemotherapy, postoperative visits or radiation therapy
- An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes
- The second or third trimester of pregnancy, through the postpartum period

A disaffiliating physician who wishes to offer a member continuity of care in accordance with the conditions of payment and BCN policies must notify BCN and the member who desires approval of continuity of care.

Providers may contact BCN's Care Management department at 1-800-392-2512 to arrange for continuity of care services.

Members should contact Customer Service by calling the number on the back of their member ID card.

A nurse provides written notification of the decision to the member and practitioners.

Newly enrolled members must select a primary care physician before requesting continuity of care services and within the first 90 days of their enrollment.

Behavioral Health

Quality Corner: Behavioral health providers have access to MQIC guidelines for behavioral health disorders

Providers looking to provide evidence-based care can consult Michigan Quality Improvement Consortium clinical practice guidelines for various medical and behavioral health disorders, which are updated every two years.

The MQIC committee is comprised of medical directors from a wide variety of insurers and professional organizations across Michigan and is devoted to publishing evidence-based guidelines to improve service delivery and outcomes.

MQIC guidelines include information on the diagnosis and treatment of attention deficit hyperactivity disorder, depression and medical conditions, such as diabetes, that may coexist with behavioral health disorders. The guidelines are intended for both behavioral health and primary care providers to help those practitioners deliver the most effective, evidence-based care.

Here's a list of some of the guidelines available for the specific issues noted above:

ADHD

Diagnosis guidelines

Treatment guidelines

Depression

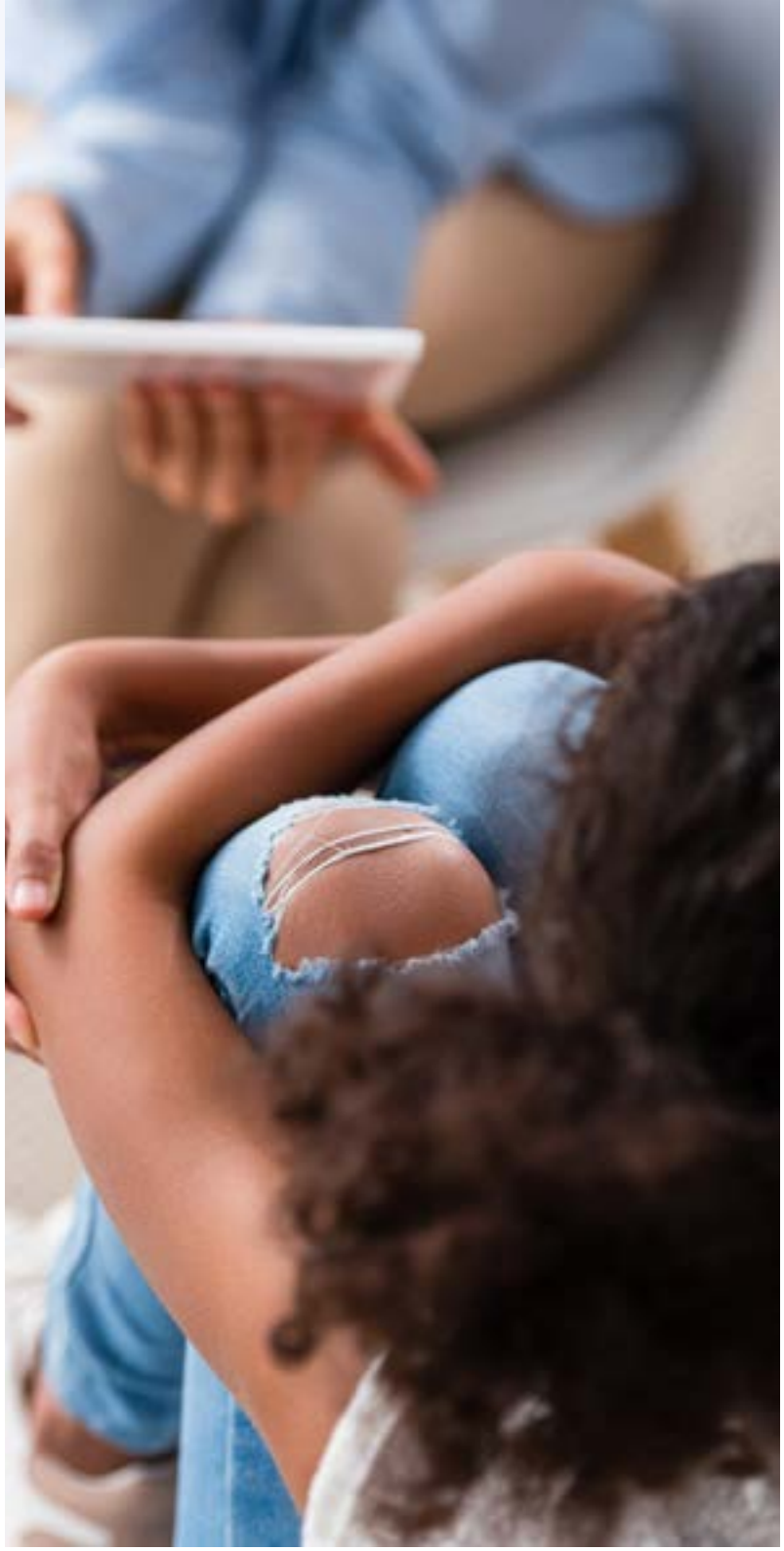
Primary care diagnosis guidelines

Treatment guidance update alert

Diabetes

Diabetes mellitus management guidelines

For updates, join the MQIC mailing list at **mqic**. Or click the *Join Now* link on the site.



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:

Regarding the criteria point for Adult/Geriatric Psychiatry – Episode Day 2-13 – Symptom Improving or Expected to Improve… – Finding within last 24 hours – Suicide – Attempt within last 48 hours, is it the intent of the criteria point that this would apply only to suicide attempts while on the inpatient unit, or would it apply to attempts just prior to admission if it falls under the 48 hour time frame?

For example: If a member is admitted to an inpatient psychiatric unit on Feb. 7, 2021, having attempted suicide that day, and then the facility submits a continuing stay request on Feb. 9, 2021, where the member denies suicidal ideation on that day, but the attempt on Feb. 7 still falls under the 48-hour window, is it the intent of this criteria point that it would be valid to select this criterion, or would the current denial of suicidality override the attempt which led to hospitalization?

Answer:

To apply "Attempt within the last 48 hours", there must be documentation in the patient record that the patient attempted suicide in the past 48 hours. In your example, if the patient attempted suicide on Feb. 7, and this is supported by documentation, it may be used to apply this criterion point despite the denial on Feb. 9, as long as it was within 48 hours.

If the patient later denies it, "Ideation and intent denied but not believable or not reliable" may be appropriate as well. Refer to the notes attached to the criteria points for more information about the intent of the criteria.

Physicians can help patients find appropriate treatment for substance use disorder

Patients have many choices when seeking a treatment center for help with a substance use disorder. Because all treatment centers aren't equal, providers can be a resource for their patients.

According to Substance Abuse and Mental Health Services Administration, or SAMHSA, the recovery process is supported through family and relationships so it's important to find a treatment center that involves caregivers and patients' social support systems.

Because individuals with substance abuse orders have different needs, physicians should counsel patients to look for flexibility in a treatment center. What works for an older adult may not work for an adolescent or teen.

"Individual treatment for substance use disorder is like getting individual treatment for any other medical issue," says Dr. William Beecroft, medical director for Blue Cross Blue Shield of Michigan and Blue Care Network. "Using in-network resources is usually the best option. Blue Cross and BCN have done the legwork to find providers that use evidence-based practices and take a member's individual needs into account when developing a long-term treatment plan."

Recovery Research Institute, a nonprofit research institute of Massachusetts General Hospital, has compiled a list of ***11 indicators of effective treatment***. Feel free to share the information on that website with patients and caregivers.

Blue Cross and BCN cover additional vaccines

To increase access to vaccines and decrease the risk of vaccine-preventable disease outbreaks, Blue Cross Blue Shield of Michigan and Blue Care Network added the following vaccines to its list of covered vaccines, effective March 1.

Vaccine	Common name	Age requirement
ActHIB®	Haemophilus influenzae type B	None
Hiberix®	Haemophilus influenzae type B	None
PedvaxHIB®	Haemophilus influenzae type B	None
ProQuad®	Measles, mumps, rubella and varicella	None
Rotarix®	Rotavirus	None
RotaTeq®	Rotavirus	None
Vaxelis™	Tdap, inactivated poliovirus, haemophilus B, hepatitis B	None
Pediarix®	Tdap, hepatitis B, polio	None
Kinrix®	Tdap, polio	None
Quadracel® Tdap-IPV	Tdap, polio	None
Pentacel®	Tdap, polio, haemophilus influenzae type B	None
Diptheria and tetanus toxoids	Tetanus, diphtheria	None

The following vaccines are covered under eligible members' prescription drug plans. Most Blue Cross commercial (non-Medicare) members with prescription drug coverage are eligible. If a member meets the coverage criteria, the vaccine is covered with no cost share.

Vaccine	Common name	Age requirement
Influenza virus	Flu	Under 9: Two vaccines per 180 days 9 and older: One vaccine per 180 days
ActHIB®	Haemophilus influenzae type B	None
Hiberix®	Haemophilus influenzae type B	None

Please see Vaccines, continued on Page 27

Vaccines, *continued from Page 26*

Vaccine	Common name	Age requirement
PedvaxHIB®	Haemophilus influenzae type B	None
Havrix®	Hepatitis A	None
Vaqta®	Hepatitis A	None
Energix-B®	Hepatitis B	None
Heplisav-B®	Hepatitis B	None
Recombivax HB®	Hepatitis B	None
Twinrix®	Hepatitis A & B	None
Gardasil®9	HPV (Human papillomavirus)	9 to 45 years old
M-M-R® II	Measles, mumps, rubella	None
ProQuad®	Measles, mumps, rubella and varicella	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
Prevnar 13®	Pneumonia	65 and older
Rotarix®	Rotavirus	None
RotaTeq®	Rotavirus	None
Shingrix®	Shingle (Zoster)	50 and older
Boostrix®	Tdap (Tetanus, diphtheria and whooping cough, also known as pertussis)	None
Adacel®	Tdap	None
Vaxelis™	Tdap, inactivated poliovirus, haemophilus B, hepatitis B	None
Pediarix®	Tdap, hepatitis B, polio	None
Kinrix®	Tdap, polio	None
Quadracel® Tdap-IPV	Tdap, polio	None
Pentacel®	Tdap, polio, haemophilus influenzae type B	None
Diptheria and tetanus toxoids	Tetanus, diphtheria	None
Tenivac®	Tetanus, diphtheria	None
TDVax®	Tetanus, diphtheria	None
Varivax®	Varicella (chickenpox)	None

If a member doesn't meet the age requirement, Blue Cross won't cover the vaccine under the prescription drug plan, and the claim will reject.
Vaccines must be administered by certified, trained and qualified registered pharmacists.

Pharmacy News

We're extending quantity limits on medical benefit drugs to BCN commercial members

Starting Aug. 1, 2021, the NovoLogix® online tool will apply daily dose and interval limits to certain medical benefit drugs for Blue Care Network commercial members. BCN will determine the appropriate quantity limit for each member during the prior authorization process.

The drugs affected by this change already have limits for Blue Cross Blue Shield of Michigan commercial members.

To view the quantity limits we currently apply for Blue Cross commercial members, see the ***Blue Cross and BCN utilization management medical drug list for Blue Cross PPO (commercial) and BCN HMO℠ (commercial) members.*** We'll update this list to reflect this change.

For Blue Cross commercial, the quantity limits in the drug list apply only to groups that currently participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit. To view the list of Blue Cross commercial groups that don't participate in the program, see the ***Specialty Pharmacy Prior Authorization Master Opt-in/out Group List***. This list is also available on the ***Blue Cross Medical Benefit Drugs*** page of the ereferrals.bcbsm.com website.

For more information about drugs covered under the medical benefit, see the following pages of our **ereferrals.bcbsm.com** website:

- ***Blue Cross Medical Benefit Drugs***
- ***BCN Medical Benefit Drugs***

Breyanzi requires prior authorization for Medicare Advantage members

We require authorization for the CAR-T medication Breyanzi® (lisocabtagene maraleucel), HCPCS code J9999, when administered at on-campus or off-campus outpatient hospitals (site of care 19 or 22). This applies to Medicare Plus Blue℠ and BCN Advantage℠ members.

See full article in the BCN Advantage section, **Page 14**

More Medicare Part B covered drugs are now available at retail pharmacies

Pharmacies can bill BCN Advantage℠ plans directly for certain drugs approved for coverage under the Medicare Part B benefit, beginning May 13. Previously, many retail pharmacies were unable to bill Part B medications directly to the medical benefit and often charged members in full for these drugs. This required members to submit reimbursement forms to Blue Care Network. For Medicare Plus Blue℠ members, this change became effective in April.

See article on **Page 12** for details.

We've made changes to preferred products for drugs covered under the medical benefit for most members

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, all Medicare Plus Blue℠, all Blue Care Network commercial and all BCN Advantage℠ members.

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

For dates of service on or after April 1:

- **Preferred products vary based on members' health care plans:** Be sure to read this entire article.
- **For members who start treatment on or after April 1:** Prescribe preferred products when possible. See information on how to submit prior authorization requests for both preferred products and nonpreferred products in the "Submitting requests for prior authorization" section later in this article.
- **For members who receive nonpreferred products for bevacizumab, trastuzumab or 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 encourage our **commercial members** who receive these nonpreferred products to discuss treatment options with you.
- **For members who receive nonpreferred products for pegfilgrastim:** These members will need to transition to a preferred product by April 1.
- **For members who receive a bevacizumab product through intravitreal administration on or after April 1:** Prior authorization won't be required for intravitreal administrations for diagnoses associated with ocular conditions. As a reminder, bevacizumab products for intravitreal administration don't currently require prior authorization.

What you need to know

This article previously ran in the March-April issue of BCN Provider News. This version contains some important updates.

- Members who receive nonpreferred products for pegfilgrastim need to transition to a preferred product.
- Bevacizumab products for intravitreal administration don't currently require prior authorization. This won't change.
- Changes were made in the section titled, "Information for Blue Cross commercial members."
- Previous communications incorrectly stated that Ruxience and Riabni require prior authorization.

Information for Blue Cross commercial members

- These requirements apply only to groups that participate in the standard commercial Medical Drug Prior Authorization program for drugs covered under the medical benefit.
- These requirements **don't** apply to members covered by the Blue Cross and Blue Shield Federal Employee Program® or to UAW Retiree Medical Benefits Trust non-Medicare members.
- For Michigan Education Special Services Association and Blue Cross commercial self-funded groups:
  - **For preferred products:** These groups don't participate in the AIM Specialty Health® oncology management program. Therefore, you don't need to request prior authorization for members who have coverage through these groups.
  - **For nonpreferred products:** You'll need to request prior authorization through the NovoLogix® online tool for members who have coverage through these groups.

Please see Preferred Products, continued on Page 30

Preferred Products, *continued from Page 29*

Correction: Previous communications incorrectly listed the Michigan Education Special Services Association as a group to which these requirements don't apply.

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
- BCN Advantage members

Medication	Preferred products	Nonpreferred products
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(1) • Riabni™ (rituximab-arrx), HCPCS code J3590(1),(2)	• 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
filgrastim (reference product: Neupogen®)	• Nivestym® (filgrastim-aafi), HCPCS code Q5110 • Zarxio® (filgrastim-sndz), HCPCS code Q5101	• Neupogen® (filgrastim), HCPCS code J1442(3),(4) • Granix® (tbo-filgrastim), HCPCS code J1447(3),(4)

(1) Preferred rituximab products don't require authorization through AIM Specialty Health.

(2) Will become a unique code.

(3) For 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. For courses of treatment that start on or after April 1, 2021, submit these requests through NovoLogix.

(4) For Blue Cross commercial fully insured members and Blue Cross commercial members with individual coverage: For courses of treatment that start on or after Oct. 1, 2020, you're already submitting these requests through NovoLogix; this will not change.

Please see Preferred Products, continued on Page 31

Preferred Products, *continued from Page 30*

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
- BCN commercial members

Medication	Preferred products	Nonpreferred products
pegfilgrastim (reference product: Neulasta®)	• Neulasta® / Neulasta® Onpro® (pegfilgrastim), HCPCS code J2505 • Nyvepria™ (pegfilgrastim-apgf), HCPCS code Q5122	• 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 and BCN Advantage members.

Medication	Preferred products	Nonpreferred products
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 Q5122

Submitting requests for prior authorization

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

- **For preferred products:** These products require prior authorization through AIM. 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 *AIM ProviderPortal*, see the ***Frequently asked questions* page** on the AIM website.

  Exception: Ruxience and Riabni don't require authorization.

  Correction: Previous communications incorrectly stated that Ruxience and Riabni require prior authorization.

- **Nonpreferred products:** These products have authorization requirements. Submit the prior authorization request through NovoLogix. 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.

Please see Preferred Products, continued on Page 32

Pharmacy News

BCN Provider *News*
Feedback

Preferred Products, *continued from Page 31*

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've updated the requirements lists with the new information.

You'll have easier access to RC Claim Assist, starting in May

Starting May 1, 2021, you'll be able to access RC Claim Assist only through Provider Secured Services.

To do this, log in to **bcbsm.com** as a provider, click the *RC Claim Assist* link in the Provider Secured Services welcome page and follow the prompts.

As a reminder, RC Claim Assist is a web-based resource that's available to Blue Cross Blue Shield of Michigan and Blue Care Network contracted providers who bill for drugs covered under the medical benefit. RC Claim Assist provides an inclusive overview of medical drug products and a calculation tool to identify the correct National Drug Code and CPT codes to bill, along with the correct NDC quantity, unit of measure and HCPCS billable units, according to the package information.

Pharmacy News

Starting June 1, Blue Cross and BCN will cover only preferred hyaluronic acid products for GM, FCA and Ford commercial groups

Blue Cross Blue Shield of Michigan and Blue Care Network will cover select hyaluronic acid products under the medical benefit for General Motors, Fiat Chrysler Automobiles and Ford commercial groups starting June 1, 2021.

There are currently 16 hyaluronic acid products on the market that have been approved by the U.S. Food and Drug Administration. To date, no study has shown one hyaluronic acid product to be superior to another.

Starting June 1, we'll cover the following preferred hyaluronic acid products, listed on the left of the table below, for GM, FCA and Ford commercial groups.

Preferred (covered) hyaluronic acid products	Nonpreferred (noncovered) hyaluronic acid products
Durolane®	Gel-one®
Euflexxa®	GenVisc 850®
Gelsyn-3™	Hyalgan®
Supartz FX™	Hymovis®
	Monovisc®
	Orthovisc®
	Synvisc®
	Synvisc-One® TriVisc®
	Visco-3™
	Synojoynt™
	Triluron™

Nonpreferred hyaluronic acid products, listed on the right of the table, will no longer be covered, starting June 1.

Here are some other things you need to know:

- Members receiving a nonpreferred hyaluronic acid product before June 1 can continue their treatment course until it's complete. However, effective June 1, we encourage providers to talk to their patients about using a preferred hyaluronic acid product for future treatment courses.
- Members who start hyaluronic acid therapy on or after June 1 will be required to use a preferred product.
- We'll notify affected members of these changes and encourage them to discuss treatment options with you.

We started covering select hyaluronic acid products for other Blue Cross commercial and BCN commercial members on Jan. 1, 2020.

Additional medications will require prior authorization for Medicare Advantage members, starting June 22

For dates of service on or after June 22, 2021, the following medications will require prior authorization through the NovoLogix® online tool:

- Oxlumo™ (lumasiran), HCPCS code C9074
- Evkeeza™ (evinacumab-dgnb), HCPCS codes C9399, J3490, J3590
- Nulibry™ (fosdenopterin), HCPCS codes C9399, J3490, J3590

This affects Medicare Plus Blue℠ and BCN Advantage℠ members.

See the full article on **Page 11** for details.

Billing Bulletin

Billing policy and guidelines for intensity modulated radiation therapy

When billing for intensity modulated radiation therapy, or IMRT, the following guidelines should be followed, in accordance with a new Blue Cross Blue Shield of Michigan policy. This policy has been adopted to align billing requirements with industry and Centers for Medicare & Medicaid Services standards.

When an IMRT simulation is performed on the same tumor within 14 days before an IMRT plan, reimbursement of the simulation will be included in the reimbursement whether the simulation is reported on the same or different date of service. In addition, the IMRT policy addresses certain radiation therapy services that may be performed 14 days before, on, or as part of the development of the IMRT plan.

In accordance with the American Medical Association and CMS' National Correct Coding Initiative Policy Manual, Blue Cross considers CPT codes *77014, *77280, *77285, *77290, *77295, *77306 through *77321, *77331 and *77370 as included in the payment for CPT code *77301 (IMRT planning) when performed in the development of the IMRT plan on the same or different dates of service for the same tumor. To report services for a different tumor on a different date of service, use the appropriate modifier to identify that it is separate, distinct and unrelated to the IMRT plan.

IMRT simulation services billed separately and not billed according to the above guidelines will be denied.

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Reminder: Clinical editing updates coming in June to outpatient claims

We mentioned in the last issue that, starting in June 2021, Blue Care Network and BCN Advantage℠ will update clinical edits applied to outpatient claims, starting in June 2021. We're expanding the edits to continue promoting correct coding to outpatient claims.

These improvements help us to continue adapting to changing needs in the health care industry while maintaining alignment with national coding guidelines.

There won't be changes or additions to the current explanation codes. The appeal process also won't change with the expanded edits. Appeals should continue to be submitted on the *Clinical Editing Appeal* form with the necessary supporting documentation. Continue to fax one appeal at a time to avoid processing delays.

Refer to the article March-April ***BCN Provider News*** for more information.

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:

- Vitamin D testing
- Billing an evaluation and management service with foot care

Clinical editing billing tips

Billing Bulletin

Here's more of what you need to know about the respiratory therapy services billing policy

Blue Cross Blue Shield of Michigan and Blue Care Network have updated their provider manuals to include a new policy that facilities should use when billing respiratory therapy services. The new policy went into effect Jan. 1, 2021, as we reported in a recent ***BCN Provider News*** article.

We subsequently received some questions from providers about this change. Following is a list of answers to some frequently asked questions, which we hope will make the transition as smooth as possible for health care providers.

Q: Does the new policy pertain to both inpatient and outpatient?

A: The new policy pertains to inpatient only.

Q: Does there need to be a change in coding?

A: No. There will be no changes to revenue codes or units. The only change being made will be in the amount being charged.

Q: Can you give an example of how providers should be billing now for claims with admission dates of Jan. 1, 2021, and later, versus how they billed previously?

A: Yes. Let's say on a single day of service, a patient is on the ventilator for five hours and then weaned to CPAP for the remaining 19 hours. Previously, services were billed at a daily rate, regardless of hours used. With the new policy, providers should be adjusting the charges billed to reflect only the hours used (for example, dividing the daily charge by 24 hours to determine an hourly charge and multiplying by actual hours used).

Q: Can these claims be audited?

A: Yes. Every claim is subject to audit.

Q: Why is Blue Cross making these changes when other payers have not?

A: Blue Cross has the obligation to make sure we pay claims correctly. The new policy supports this effort. We understand this may not have been how things were handled in the past, but industry norms have been shifting. Payers and customers are highly concerned that overpayment of claims is being overlooked and not identified up front. Implementing new, innovative ways to address and prevent overpayments early will reduce the necessity for a back-end review and recovery effort for both facilities and Blue Cross.

Lunch and learn webinars for physicians and coders focus on risk adjustment, coding

Sign up now for live, monthly, lunchtime webinars focusing on risk adjustment and coding. These educational sessions will update you on documentation and coding of common challenging diagnoses. You'll also have an opportunity to ask questions.

Webinars run through September and are led by physicians. The last three sessions of the year focus on coding guideline updates and are led by coders.

While the session topics could change, our current schedule and tentative topics follow. All sessions start at 12:15 p.m. Eastern time and generally run for 15 to 30 minutes. Click on a "Register here" link below to sign up for a session.

Session date	Topic	Sign up link
Wednesday, May 19	Morbid (severe) obesity	Register here
Thursday, June 17	Major depression	Register here
Tuesday, July 20	Diabetes with complications	Register here
Wednesday, Aug. 18	Renal disease	Register here
Thursday, Sept. 23	Malignant neoplasm	Register here
Tuesday, Oct. 12	Updates for ICD-10-CM	Register here
Wednesday, Nov. 17	Coding scenarios for primary care and specialty	Register here
Thursday, Dec. 9	E/M coding tips	Register here

Don't use F codes when requesting authorization for inpatient medical admissions

When requesting authorization for acute care inpatient medical (non behavioral health) admissions, select a medical ICD-10 diagnosis code in the e-referral system — one that doesn't begin with F.

If you select an ICD-10 diagnosis code that begins with F, the processing of your request will be delayed because:

- You'll trigger a behavioral health questionnaire that you must complete.
- Your request will be routed to the incorrect department for review.

Background

We've noticed that for members admitted to a medical unit for acute detoxification (such as withdrawal from alcohol or other drugs), some providers are submitting authorization requests with diagnosis codes that begin with F.

However, these are considered medical — not behavioral — health admissions, even though the member's condition involves the use of alcohol or other substances.

This applies to:

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

This applies to authorization requests submitted for BCN commercial, Medicare Plus Blue℠ and BCN Advantage℠ members.

When we pend a request, you'll get this message in the e-referral system: "Case requires validation. Medical records required. Please attach clinical information from the patient's medical record applicable to this request in the Case Communication field."

For instructions on how to attach clinical information to the authorization request in the e-referral system, refer to the **e-referral User Guide**. Look in the section titled "Create New (communication)."

When we receive the clinical information, we'll review it to confirm that it supports the information you provided in the questionnaire and then we'll make a determination.

If we don't receive the clinical information or if the clinical information you send doesn't support your answers in the questionnaire, we won't be able to approve the request.

You can access the preview questionnaires at ereferrals.bcbsm.com:

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

What you need to know

- We'll start pending some authorization requests to validate answers you provided on questionnaires.
- You'll get a message to submit clinical information from the patient's medical record.

Starting in June, we'll use clinical information to validate providers' answers to some questionnaires in the e-referral system

Beginning in June 2021, we'll pend some authorization requests that would usually be auto-approved based on your answers to the questionnaires in the e-referral system. This will allow us to validate the answers you provided on the questionnaire.

Referral Roundup

Some prior authorization requests for hyperbaric oxygen therapy will pend for clinical review, starting this summer

Starting sometime this summer, prior authorization requests for hyperbaric oxygen therapy for wounds and osteomyelitis will pend for clinical review. Currently, some of these requests are auto-approved.

This change will apply to requests submitted for BCN commercial and BCN Advantage℠ members.

You'll need to do the following when you submit these requests in the e referral system:

1. Complete the questionnaire, as usual.
2. Attach clinical information pertinent to the request. Some examples of information to include with the request are:
   - Serial wound measurements
   - The medical and surgical treatments that were attempted, but failed to improve the member's condition

These prior authorization requests can't be approved in the absence of clinical information supporting the request.

How to attach clinical information to the request

To learn how to attach clinical information to the request in the e-referral system, refer to the **e referral User Guide**. Go to the section titled "Submit Outpatient Authorization" and look for "Create new (communication)."

Additional information about the questionnaires

You can access preview questionnaires related to hyperbaric oxygen therapy to guide you in preparing answers before you submit the request.

To find the preview questionnaires, visit BCN's **Authorization Requirements & Criteria page** on the **ereferrals.bcbsm.com** website. Scroll down and click to open:

- **BCN commercial preview questionnaire**
- **BCN Advantage preview questionnaire**

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 the authorization of home health care for Medicare Advantage members.

For episodes of care starting on or after June 1, 2021, providers will need to request prior authorization from CareCentrix for Medicare Plus Blue℠ and BCN Advantage℠ members.

See the full article on **Page 17** for more information and webinar registration.

Tips for submitting commercial SNF requests using the e-referral system

Starting Dec. 1, 2020, skilled nursing facilities have been required to submit authorization requests for Blue Cross commercial and BCN commercial members through the e-referral system and not by fax.

You should fax the form only when the e-referral system is not available.

Here are important tips to follow when submitting your requests through the e-referral system:

- On requests for initial admissions:
  - o Submit only one request for each member admitted. Don't submit a duplicate request while waiting to get the response.
  - o Include the admitting or attending physician in addition to the name of the facility.
- On requests for additional days:
  - o Add an extension line so we know you're requesting the days. Follow the instructions in the **e-referral User Guide** for "Extending an Inpatient Authorization."
  - o *Don't* add more than one extension line.
- On all requests:
  - o Complete the **Skilled Nursing Facility Assessment Form** and attach it to the request in the e-referral system instead of faxing it.

Note: Include on the form the name and phone number of the person submitting the authorization request.

- o Complete each field. Don't indicate "see attached" in lieu of completing the fields.
- o *Don't* request more than seven days.

Training resources for SNFs

Use the available training resources to familiarize yourself with the e-referral system, especially:

- Checking member eligibility and benefits
- Submitting an inpatient authorization request (requests for admissions and requests for additional SNF days)
- Attaching a document to the authorization request

You can access a recorded webinar for SNFs and the webinar slides at **ereferrals.bcbsm.com**. Click **Training Tools** and scroll down to find the "e-referral Overview for Skilled Nursing Facilities presentation" — specifically:

- **Recorded webinar**
- **Presentation slides (PDF)**

Important next steps

If you haven't done so already:

1. **Register now for access to the e-referral system.** We encourage you to register now for access to the e-referral system. It takes some time to process registration requests.

   To register, follow the instructions on the **Sign Up or Change a User** webpage on our **ereferrals.bcbsm.com** website.

2. **Use the online tools to learn the e-referral system.** Visit the **Training Tools** page of our **ereferrals.bcbsm.com** website for:
   - **e-referral User Guide**
   - **Online self-paced learning modules**

We've made questionnaire changes 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 February and March, we added, updated and removed questionnaires in the e-referral system. Those changes are reflected in the corresponding preview questionnaires on the **ereferrals.bcbsm.com** website.

New questionnaires

On Feb. 28, we added the following questionnaires:

- *Out-of-network providers* — This questionnaire for BCN commercial and BCN Advantage℠ members opens when you submit a prior authorization request for a procedure to be performed by a provider who isn't contracted with BCN.

  If you're requesting authorization for a procedure that requires you to complete a questionnaire, you'll have to complete the questionnaire for the service itself in addition to the *Out-of-network provider* questionnaire.

- *Pediatric feeding* — This questionnaire for BCN commercial members 18 years of age or younger opens for procedure code S0317.

On March 28, we added the following questionnaires:

- *Gastric pacing / stimulation* — This questionnaire now opens for BCN commercial members for procedure codes *43647, *43648, *43881, *43882, *64590 and *64595.

  Note: This questionnaire already opened for BCN Advantage and Medicare Plus Blue members.

- We replaced the *Chemical peels* questionnaire with the following two questionnaires for pediatric and adult BCN commercial and BCN Advantage members:

  - *Dermal chemical peel* — This questionnaire opens for procedure codes *15789 and *15793.
  - *Epidermal chemical peel* — This questionnaire opens for procedure codes *15788, *15792 and *17360.

What you need to know

- We've made changes to some questionnaires in the e-referral system.
- Refer to the link in the article to see preview questionnaires.

Updated questionnaires

- On Feb. 7, we updated the *Cardiac rehabilitation 1* questionnaire for BCN commercial members.
- On March 28, we updated the following questionnaires for BCN commercial and BCN Advantage members:
  - *Bone-anchored hearing aid*
  - *Sleep studies*

Removed questionnaire

On Feb. 7, we removed the *Cardiac rehabilitation 2* questionnaire for BCN Advantage. The e-referral system now automatically approves requests for procedure codes *93797 and *93798 for BCN Advantage members.

Preview questionnaires

You can access preview questionnaires at **ereferrals.bcbsm.com**. This can help you prepare your answers ahead of time.

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 pages.

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Save time: Don't fax unnecessary information about inpatient stays

We're receiving faxes related to inpatient stays from hospital utilization review departments. Most of these faxes aren't required.

The table below shows how to save time and get the information to the right place.

Type of information	How to send it
Lists of members admitted to the hospital	• Use the e-referral system to submit an authorization request for each admission.
Lists of members discharged from the hospital	• If the case is still open in the e-referral system, you can enter the discharge date. • If the case has closed because the authorized days have elapsed, you don't need to do anything.
Clinical information	• If the authorization request was approved in the e-referral system, we don't need additional clinical information. • If the member needs additional days, use the e-referral system to request those days and attach the clinical information to the request there.
Information on sick newborns (authorization requests separate from the delivery)	Make sure you're faxing to the correct fax number: • For Blue Cross commercial: 1-800-482-1713. • For BCN commercial: 1-866-313-8433. Note: You **do** need to fax information about sick newborns because those members can't be found in the e referral system.
Retroactive authorization requests for inpatient admissions that started as outpatient services	Use the e-referral system to submit a retroactive authorization request for each inpatient admission.
Adjustments in dates of service for procedures managed by vendors such as TurningPoint Healthcare Solutions LLC	Submit this information to the vendor that manages the procedure. For information about submitting requests to vendors, visit **ereferrals.bcbsm.com**.

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