JULY-AUGUST 2021

BCN Provider News

BCN Provider News User Guide

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Virtual Option for BCN plans reduces member cost for telehealth

Effective July 1, 2021, large employer groups can choose to purchase a rider for their Blue Care Network health plan that lowers out-of-pocket costs when a BCN member accesses care virtually.

Members with either a BCN Virtual Option℠ HMO or a BCN Blue Elect Plus Virtual Option℠ POS rider pay less for a virtual visit than an in-person visit.

- Members with a BCN health savings account-qualified high-deductible health plan will pay $0 for coinsurance after deductible for a virtual visit. (The deductible applies only to non-preventive services.)
- Members with other BCN plans, including Blue Elect Plus℠ POS, will have a $10 copay for a virtual visit.

What is a virtual visit?

A virtual visit includes online and certain telemedicine visits from the member's primary care physician or a BCN-contracted medical or behavioral health specialist. Members with Blue Cross Online Visits℠ coverage (provided by Amwell) will also pay the lower cost share when they have a Virtual Option rider.

Which telemedicine visits qualify for the lower member cost share?

In general, the most commonly used telemedicine visits qualify for the lower cost share. These include:

- Office visits with new and existing patients
- Hospital discharge follow-up visits
- Medical evaluation and management
- Diagnostic psychiatric and psychological evaluation
- Behavioral health visits, including crisis response and family therapy

Please see BCN Virtual Option continued on Page 2

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Network Operations

BCN Virtual Option, *continued from Page 1*

A list of procedure codes included in the reduced member cost share is available at **bcbsm.com/bcnvirtualoption**. Telehealth visits beyond those listed will apply the member's standard in-person out-of-pocket cost share (deductible, copay or coinsurance). Also, any visit (virtual or in-person) with a non-contracted provider will apply the standard out-of-network cost share for products that allow out-of-network coverage.

How do I know which patients have a Virtual Option rider?

When you look up the member's benefits in web-DENIS or listen to the benefits when calling Provider Inquiry, you'll see the following language **after** the standard office visit cost share for members with a Virtual Option rider:

Member coverage	Benefit language listed for PCP visits, specialist visits or mental health outpatient
HSA-qualified high deductible health plan	Online and select telemedicine visits when provided by a BCN participating provider or a BCN designated vendor covered in full after deductible. Refer to **bcbsm.com/bcnvirtualoption** for more information.
All other BCN coverage	$10 copay for online and select telemedicine visits when provided by a BCN participating provider or a BCN designated online vendor. Refer to **bcbsm.com/bcnvirtualoption** for more information.

When you click on *Medical Benefits* in web-DENIS to view the *Benefits Description* page, you can also look under *Certificate/Rider*. Most members with a Virtual Option rider will have one of the following:

- VIRVHD or VRVHDF — Virtual Option for BCN health savings account-qualified high-deductible health plans
- VIRV10 or VRV10F — Virtual Option for BCN plans with copays
- VR10IN or VR10IF — Virtual Option for Blue Elect Plus POS plans

Are there any other changes for members with a Virtual Option rider?

No. The only change is a lower member cost share for the online and certain telemedicine visits described above. Members should still coordinate their care through their primary care physician. Prior authorization and referral requirements continue to apply based on the member's health plan.

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Network Operations

Help Michigan reach COVID-19 vaccination benchmarks

You can help Michigan reach the benchmark of **vaccinating 70% or more of Michiganders, ages 16 and older, in the fight against COVID-19**.

How can you help?

- **Reach out to your patients and encourage them to get a COVID-19 vaccine.** You can answer questions for your patients to allay any concerns about getting the vaccine. Overcoming vaccine hesitancy can help us reach herd immunity.
- **Help patients who were vaccinated outside Michigan get their vaccines counted.** Some Michiganders may have received their vaccines outside of Michigan, either while visiting another state or purposefully going to a state bordering Michigan in early 2021, where they could more easily get them. Please ask your patients if they were vaccinated in Michigan. If not, please do one of the following:
  - If you have access to the Michigan Care Improvement Registry, ask the patient for their COVID-19 vaccination record card and upload this information in MCIR as historical information.
  - If you don't have access to MCIR, ask the patient to visit their local health department with their COVID-19 vaccination record card and their driver's license or Michigan identification card so their vaccination can be counted.

Here's how Blue Cross and BCN are helping

Blue Cross Blue Shield of Michigan and Blue Care Network have been sending communications to our members to encourage them to obtain a COVID-19 vaccine since the beginning of 2021. You can view these member communications here:

1. Log in as a provider at **bcbsm.com**.
2. Click on *Coronavirus (COVID-19)* at the top of the page.
3. Look under *Vaccines*.

To make vaccine access easier, we have waived member cost share and network requirements.

Thank you for the ongoing care you provide to your patients and our members. Together, we can defeat COVID-19.

Timely clinical information is key to receiving faster responses on authorization requests

We've received complaints from members that it sometimes takes too long for their services to be authorized by Blue Cross Blue Shield of Michigan or Blue Care Network, or by a vendor we're working with to provide utilization management decisions for certain procedures.

In addition, the National Committee for Quality Assurance and the Centers for Medicare & Medicaid Services require Blue Cross and BCN to respond to authorization requests within certain timeframes.

We're working to improve our response times and ask for your help to prevent your authorization request from being delayed or denied. It's important that providers respond quickly to requests for documentation to prevent a delay of necessary or urgent medical services for members. We require clinical information for authorization requests to ensure that we make a timely decision. Companies that we work with to manage certain procedures may also ask providers for clinical information to support your requests.

What you need to know

- Providers can help improve response time on authorization requests by submitting clinical documentation when required.
- For Blue Cross and BCN programs, submit documentation through e-referral.
- Our provider manual chapters have more information about utilization review.

It's important that you provide requested clinical information and other documentation within the designated timeframe provided in the correspondence from Blue Cross, BCN or the vendor.

Clinical information includes relevant information regarding the member's:

- Health history
- Physical assessment
- Test results
- Consultations
- Previous treatment

We recommend that you're prepared with clinical information at the time you submit your request in the event you are asked to provide it. Much of the follow-up information that we request is found on the questionnaires that open in e-referral. You can find preview questionnaires with links to related authorization criteria or medical policies on these webpages:

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

Vendors that manage certain utilization management programs usually have their own versions of these questionnaires.

The most efficient way to provide clinical information for programs managed by Blue Cross and BCN is through the e-referral system. Use the Case Communication section to document how the patient meets clinical criteria.

For more information about utilization review, refer to our provider manuals. Here's how to find them:

1. Log in as a provider at **bcbsm.com**.
2. Click on *Provider Manuals* on the lower right side of the screen
3. Select the manual you want to review.

The *Utilization Management* chapter of the *BCN Provider Manual* is also posted on **ereferrals.bcbsm.com**. You can get there without logging in. Click ***Provider Manual Chapters*** under BCN Authorizations/Referrals in the left-hand column.

Network Operations

We've transitioned to a new provider training site

Health care providers and staff can now access recorded webinars, videos, e-Learning modules and other training resources through our new provider training site, which went live June 1.

Active training courses and materials from 2019-2021 have moved from BCBSM Provider Training and BCN Learning Opportunities to the new training site. To request access:

1. Open the **registration page**.
2. Complete the registration. We recommend using the same email you use to communicate with Blue Cross for provider-related needs. This will become your login ID.
3. Follow the **link** to login.

To learn more about the provider training site, watch this **video** that guides you through the experience. If you need help creating your login ID or navigating the site, contact **ProviderTraining@bcbsm.com**.

Action item

Request access to our new provider training site to find resources on topics that are important to your role.

BCN Advantage

Medicare 2% sequestration moratorium extended to Dec. 31

President Biden signed legislation on April 14, 2021, that extends the suspension of the Medicare 2% sequestration reduction until the end of 2021. We've aligned with the Centers for Medicare & Medicaid Services and will extend the suspension of the 2% sequestration applied to Medicare Plus Blue℠ and BCN Advantage℠ claims through Dec. 31, 2021. Providers don't need to take any action.

Background information

Since 2013, 2% sequestration reimbursement reductions have been in place for our Medicare Advantage professional and facility providers. This is in accordance with the terms of our Medicare Advantage provider agreements that pay according to Original Medicare methods. The 2% reimbursement adjustment is applied after determining any applicable member deductible, copayment or other required member cost sharing.

The timeline of the suspensions is as follows:

- May 1 – Dec. 31, 2020
  Coronavirus Aid, Relief, and Economic Security, or CARES, Act suspended the 2% sequestration payment adjustment percentage applied to all Medicare fee-for-service claims to offer financial relief to providers during the COVID-19 pandemic.
- January 1 – March 31, 2021
  The Consolidated Appropriations Act, 2021, extended the suspension period to March 31, 2021.
- April 1 – December 31, 2021
  On April 14, 2021, H.R. 1868 was signed into law, which extends the suspension period to Dec. 31, 2021.

Reimbursement to providers who haven't been affected by sequestration previously, such as durable medical equipment, end-stage renal disease and lab providers, won't be affected by this change.

We expect CMS to reinstate the 2% sequestration reimbursement reduction on Jan. 1, 2022, but will alert you of any changes before that date.

We require prior authorization for Abecma for Medicare Advantage members

For dates of service on or after April 5, 2021, the CAR-T medication, Abecma™ (idecabtagene vicleucel, HCPCS code J9999), requires prior authorization through the NovoLogix® online tool.

This applies to Medicare Plus Blue℠ and BCN Advantage℠ members.

Places of service that require authorization

We require authorization for all outpatient places of service when you bill this medication as either a professional or a facility service:

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

Submit authorization requests through NovoLogix. It offers real-time status checks and immediate approvals for certain medications. If you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix.

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

List of requirements

For a list of requirements related to drugs covered under the medical benefit, please see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**.

Updates to the star measure on statin use

The Centers for Medicare & Medicaid Services has revised the star measure, Statin Use in Persons with Diabetes, or SUPD, for Medicare patients. Several ICD-10 codes have been added to the exclusion list. Historically, only patients in hospice or on dialysis could be excluded from the measure. These codes must be billed every year.

The SUPD measure is defined as the percentage of Medicare Part D patients ages 40 to 75 years old who received at least two diabetes medication fills and a statin medication fill during the calendar year.

Only statin claims billed through the patient's Part D plan count toward closing gaps in the measure. The following types of statin claims will **not** close a gap in the SUPD measure:

- Claims filled through drug discount cards or store pharmacy discount programs
- Cash claims
- Medication samples
- Fills from Veterans Affairs facilities
- Fills billed to a non-Medicare insurance plan

Patients turning 76 this year (born in 1945) must have a statin claim filled before they turn 76 to satisfy the SUPD measure requirements.

If statin therapy is not medically appropriate for your diabetic patients, make sure the proper ICD-10 code is billed to exclude them from the SUPD star measure.

New measure exclusions

Patients with the following conditions are excluded from the measure.

Medical condition	ICD-10 code
Liver disease	Various
Pregnancy and/or lactation	Various
Polycystic ovarian syndrome	E28.2
Prediabetes	R73.03 R73.09
Rhabdomyolysis/ myopathy/myositis	G72.0 G72.89 G72.9 M60.80 M60.9 M62.82 T46.6X5A

Jemperli and Zynlonta require prior authorization for most members

We're adding prior authorization requirements for the following drugs covered under the medical benefit for dates of service on or after July 26, 2021:

- Jemperli™ (dostarlimab-gxly), HCPCS codes J3490, J3590, J9999, C9399
- Zynlonta™ (loncastuximab tesirine-lpyl), HCPCS codes J3490, J3590, J9999, C9399

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

BCN Advantage

Submit prior authorization requests for CAR-T cell therapy drugs to NovoLogix for Medicare Advantage inpatient admissions

Before you begin administering CAR-T cell therapy drugs for Medicare Plus Blue℠ or BCN Advantage℠ members in an inpatient setting, you must do the following:

- Submit the request for the CAR-T cell therapy drug, **including all relevant clinical documentation**, as follows:
  - Through the NovoLogix® online tool. (See the NovoLogix section for more information.)
  - By sending a fax to the Pharmacy Part B help desk at 1-866-392-6465
- Submit a separate request for the inpatient admission and other inpatient services (not including the CAR-T cell therapy drug) through the e-referral system, as usual.

For the inpatient admission, follow the steps in the "Submit an inpatient authorization" section of the **e-referral User Guide**.

If you've been submitting the prior authorization request for CAR-T cell therapy drugs through the e-referral system, this is a change. This change is effective immediately.

If you have questions, email us at **MASRX@bcbsm.com**.

As a reminder:

- CAR-T cell therapy drugs are covered under the medical benefit. Examples of CAR-T cell therapy drugs are Yescarta®, Kymriah®, Tecartus™, Breyanzi® and Abecma®.
- Submit requests for outpatient administration of CAR-T cell drugs through NovoLogix. There's no change to how you submit outpatient requests.
- Prior authorization for CAR-T drugs is **not** managed by AIM Specialty Health®.

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.

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**.

Answers to FAQs about the Blue Cross and BCN patient experience survey now available

Blue Cross Blue Shield of Michigan and Blue Care Network launched a new Medicare Advantage member survey in June 2021 to assess patient experience. *Answers to frequently asked questions* are now available and include topics about the survey process, sampling and reporting.

The nationally recognized Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey protocol is being administered 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.

For more information about the survey, see the **article** in the May-June issue.

We'll implement 2021 InterQual criteria Aug. 2 for non-behavioral health determinations

Blue Cross Blue Shield of Michigan and Blue Care Network will implement the 2021 InterQual criteria, starting Aug. 2, 2021, for all levels of care. We'll use these criteria to make utilization management determinations for requests to authorize non-behavioral health services subject to review for the following members:

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

When BCN requests clinical information for a medical or surgical admission or other service, we require providers to submit specific components of the medical record that validate that the request meets the criteria.

Blue Cross and BCN also use local rules — modifications of InterQual criteria — in making utilization management determinations. The 2021 local rules will also be implemented starting Aug. 2, 2021.

By the end of July, you'll be able to access the updated versions of the modifications (local rules), as applicable, for:

- BCN — on the **Authorization Requirements & Criteria** page in the BCN section of our **ereferrals.bcbsm.com** website. Look under the "Referral and authorization information" heading.
- Blue Cross — on the **Authorization Requirements & Criteria** page in the Blue Cross section of our **ereferrals.bcbsm.com** website. You'll see links to the criteria in both the Blue Cross commercial and the Medicare Plus Blue sections of that page.

Refer to the table below for specific information on which criteria are used in making determinations for various types of non-behavioral health authorization requests.

Criteria/Version	Application
InterQual Acute — Adult and Pediatrics	• Inpatient admissions • Continued stay discharge readiness
InterQual Level of Care — Subacute and Skilled Nursing Facility	• Subacute and skilled nursing facility admissions • Continued stay discharge readiness
InterQual Rehabilitation — Adult and Pediatrics	• Inpatient admissions • Continued stay and discharge readiness
InterQual Level of Care — Long Term Acute Care	• Long-term acute care facility admissions • Continued stay discharge readiness
InterQual Imaging	• Imaging studies and X-rays
InterQual Procedures — Adult and Pediatrics	• Surgery and invasive procedures
Medicare Coverage Guidelines (as applicable)	• Services that require clinical review for medical necessity and benefit determinations
Blue Cross/BCN medical policies	• Services that require clinical review for medical necessity
BCN-developed Local Rules (applies to BCN commercial and BCN Advantage)	• Exceptions to the application of InterQual criteria that reflect BCN's accepted practice standards

Note: The information in the table applies to lines of business and members whose authorizations are managed by Blue Cross or BCN directly and not by a vendor.

See the article titled, "We're using updated utilization management criteria for behavioral health, starting Aug. 2," on **Page 13** for information on the updated behavioral health criteria.

Patient Care/ Quality

Medical policy updates

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

Covered services

- Gait analysis — policy title changes to comprehensive gait analysis
- Combined heart-liver transplantation
- Double balloon enteroscopy
- Artificial pancreas device systems
- Screening for lung cancer using computed tomography scanning (spiral or helical CT) or chest radiographs
- Bariatric surgery
- Sleep disorders — Diagnosis and medical management
- Transgender services

Noncovered services

- Absorbable nasal implant for treatment of nasal valve collapse
- Lumbar traction devices

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

Question:

Regarding the Infection: Covid-19 subset, acute criteria requires Covid-19 test performed: Many COVID-19 positive patients with severe symptoms present to the emergency room three to five days after learning of a positive test. Is the 24-hour rule finding still required?

Answer:

According to Change Healthcare, there is no time frame for "COVID-19 test performed." The requirement is that the test has been performed and it is documented in the patient record.

Updates to the star measure on statin use

The Centers for Medicare & Medicaid Services has revised the star measure, Statin Use in Persons with Diabetes, or SUPD, for Medicare patients. Several ICD-10 codes have been added to the exclusion list.

See the complete article on **Page 7** for details.

Addressing health care disparities among people in the LGBTQ+ community

This is the second article in a series on health care disparities in Michigan. We're looking at the various aspects of disparities and what Blue Cross Blue Shield of Michigan, Blue Care Network and its participating health care providers are doing to combat them.

What you need to know

- An estimated 4% of Michigan adults identify as LGBTQ+ and may face barriers to care.
- Providers can support LGBTQ+ patients by using terms these patients prefer and by learning about the specific health needs of this population.

Background

Across the nation, June recognized LGBTQ+ (lesbian, gay, bisexual, transgender and queer or questioning) Pride Month. The celebration commemorates the Stonewall Uprising, during which police clashed with protesters over a six-day period in Manhattan in June 1969. It's considered the tipping point for what was then called the Gay Liberation Movement.

Providers can take the opportunity any time to look more closely into care delivery — and the health care disparities that exist — for the estimated 4% of Michigan adults identified as LGBTQ+.

LGBTQ+ health and disparities

Mental health conditions, higher rates of alcohol, tobacco and other substance use, as well as higher odds of obesity and eating disorders, are common conditions within the community. In 2016, the LGBTQ+ community was identified as a "health disparity population" by the **National Institute on Minority Health and Health Disparities**. This is the result of such issues as access to health care and low utilization of health services due to the population not feeling comfortable or safe sharing gender or sexual identity with health care providers.

Barriers to care

Members of the LGBTQ+ community face several barriers to care, including exclusion from a partner's health insurance, provider-related discrimination, psychosocial barriers (for example, fear of disclosing sexual orientation and gender identity or illegal behaviors) and poor matches between the needs of LGBTQ+ people and the kinds of services that are available.

A 2017 Center for American Progress survey showed that once people experience discrimination in some form, they're more likely to avoid doctor's offices. Among LGBTQ+ people who had experienced discrimination in the year before the survey, more than 18% reported avoiding doctors' offices out of fear of discrimination.

Such statistics highlight the importance of ensuring that LGBTQ+ patients have the same opportunities to obtain the best possible clinical outcomes.

Please see LGBTQ+ community continued on Page 12

LGBTQ+ community, *continued from Page 11*

What health care providers can do to support LGBTQ+ patients

Structural inequities and bias drive disparities. To address these issues, providers and their office staffs are encouraged to take LGBTQ+ training.

It's important for health care providers to learn about such things as:

- Specific health care needs of the LGBTQ+ population
- Terminology that LGBTQ+ patients prefer
- Community resources that can help patients with their concerns

Following are links to two training modules you may want to consider:

- **Creating an LGBT-Friendly Practice**
- **Quality Health Care for Lesbian, Gay, Bisexual and Transgender People**

Note: These are not Blue Cross-sponsored training sessions.

Blue Cross' Value Partnerships program recently added a "capability" to the Patient-Centered Medical Home program that includes training on LGBTQ+ health care issues and how to create more inclusive processes. This capability, available for PGIP-participating providers through their physician organization, gives physicians resources to help them provide more compassionate, effective care for members of the LBGTQ+ community.

Blue Cross and its physician organizations are committed to promoting more inclusive practice units, where staff receives training on the specific needs of LGBTQ+ patients. Here are some examples of how you can build a more inclusive practice:

- Review policies, procedures, documents and forms to ensure they are inclusive.
- Allow patients the opportunity to indicate the pronouns and names they wish to use.
- When you call patients from the waiting room, address them in a way that's not specific to a particular gender.
- Understand the distinction between biological sex and gender identity.
- Share community resources that can help patients with their concerns.
- Ensure that forms and policies don't assume a patient's gender or their marital or partner status.
- Make sure the equal opportunity statement on forms addresses gender identity and sexual orientation.

For more information

If you'd like to learn more, check out the following resources, which were used as source material for this article:

- **The State of Health Disparities in the United States**
- **The Impact of Stigma and Discrimination Against LGBT People in Michigan**
- **LGBT Identification Rises to 5.6%**
- **Outness, Stigma, and Primary Health Care Utilization among Rural LGBT Populations**

We're using updated utilization management criteria for behavioral health, starting Aug. 2

On Aug. 2, 2021, we'll begin using the 2021 InterQual® criteria to make utilization management determinations for behavioral health services.

This applies to determinations on behavioral health services for Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ members.

In addition, certain types of determinations will be based on modifications to InterQual criteria or on local rules or medical policies as shown in the table below:

Product	Modified 2021 InterQual criteria for:	Local rules or medical policies for:
BCN commercial and BCN Advantage	• Substance use disorders: partial hospital program and intensive outpatient program • Mental health disorders: partial hospital program and intensive outpatient program • Residential mental health treatment (adult, geriatric, child and adolescent members) Note: Neither BCN commercial members with BCN1, BCN5 and BCN10 plans nor BCN Advantage members have residential mental health treatment benefits.	• Applied behavior analysis for autism spectrum disorder — for BCN commercial members only • Neurofeedback for attention deficit disorder and attention deficit hyperactivity disorder • Transcranial magnetic stimulation, or TMS • Telemedicine (telepsychiatry and teletherapy)
Medicare Plus Blue	• Substance use disorders: partial hospital program and intensive outpatient program • Mental health disorders: partial hospital program and intensive outpatient program Note: Only State of Michigan Medicare Plus Blue members have intensive outpatient program benefits.	• Telemedicine (telepsychiatry and teletherapy) Note: Medicare Plus Blue members don't have neurofeedback or TMS benefits.

To find additional information on telemedicine, refer to the document **Blue Cross and BCN: Telehealth for behavioral health providers**.

Note: Determinations on Blue Cross PPO (commercial) behavioral health services are handled by New Directions, an independent company that provides behavioral health services for some Blue Cross members.

In early July, we'll have links to the updated versions of the modified criteria, local rules and medical policies on these pages on our **ereferrals.bcbsm.com** website:

- **Blue Cross Behavioral Health page**
- **BCN Behavioral Health page**
- **BCN Autism page**

Also, see the article titled "2021 InterQual criteria implemented Aug. 2, 2021, for non-behavioral health determinations" on **Page 9** for information on the updated non-behavioral health criteria we'll use starting Aug. 2, 2021.

From the medical director: Diagnosing and treating ADHD

By Kristyn Gregory, D.O.

Attention deficit hyperactivity disorder is a common health condition in children, as well as adults. As a chronic condition, ADHD should be managed in line with the principles guiding the chronic care model.

Diagnosis

Children ages 4 to 18 with behavioral or academic concerns who have symptoms of hyperactivity or inattention should be considered for assessment for **ADHD**, according to Michigan Quality Improvement Consortium guidelines.

Children under 4 should be considered for referral to a specialist and coordination of care. There are two groupings, or **constellations of symptoms**, according to the Centers for Disease Control and Prevention: the inattention constellation characteristics of ADHD and the hyperactive form of ADHD constellation of symptoms. DSM5 has clarified that when six or more of these symptoms are present most of the time for a six month period in a patient 4 to 18 years old — in either or both of these constellations of symptoms — they likely have a diagnosis of ADHD of the inattentive, hyperactive, or mixed type.

Comorbidities and current recommendations

Approximately, 75% of patients diagnosed with ADHD have comorbidities. Common comorbidities include bipolar disorder, oppositional defiant disorder, substance use disorder and depression.

Comorbid conditions should be diagnosed and treated accordingly. Indication for mental health referral may include evaluation of coexisting conditions and mental health disorders.

In addition to a clinical interview, assessment should include use of standardized diagnostic rating scales that detect symptoms of ADHD. Further information and symptoms can be obtained from parents, teacher, family members and, when appropriate, the child.

Certain diagnostic tests, including neuroimaging, electroencephalogram and continuous performance testing, should **not** be ordered routinely to evaluate children with suspected ADHD.

Psychological and neuropsychological testing may be useful in complicated clinical presentations; however, such tests are not indicated for routine diagnosis of ADHD and are not a substitute for the clinical interview.

Please see From the medical director, continued on Page 15

Dr. Gregory is Medical Director of Behavioral Health at Blue Cross Blue Shield of Michigan and Blue Care Network

Behavioral Health

From the medical director, *continued from Page 14*

Treatment

The mainstays of treatment are pharmacologic and non-pharmacologic, including behavior therapy and education. For those patients older than 5 years of age, first line treatments include ADHD medication approved by the Food and Drug Administration, and either parent- or teacher-administered behavior therapy, preferably both medication and behavior therapy. Providers should educate patients and parents about the proper supervision and use of medication as well as risks of misuse, diversion and abuse.

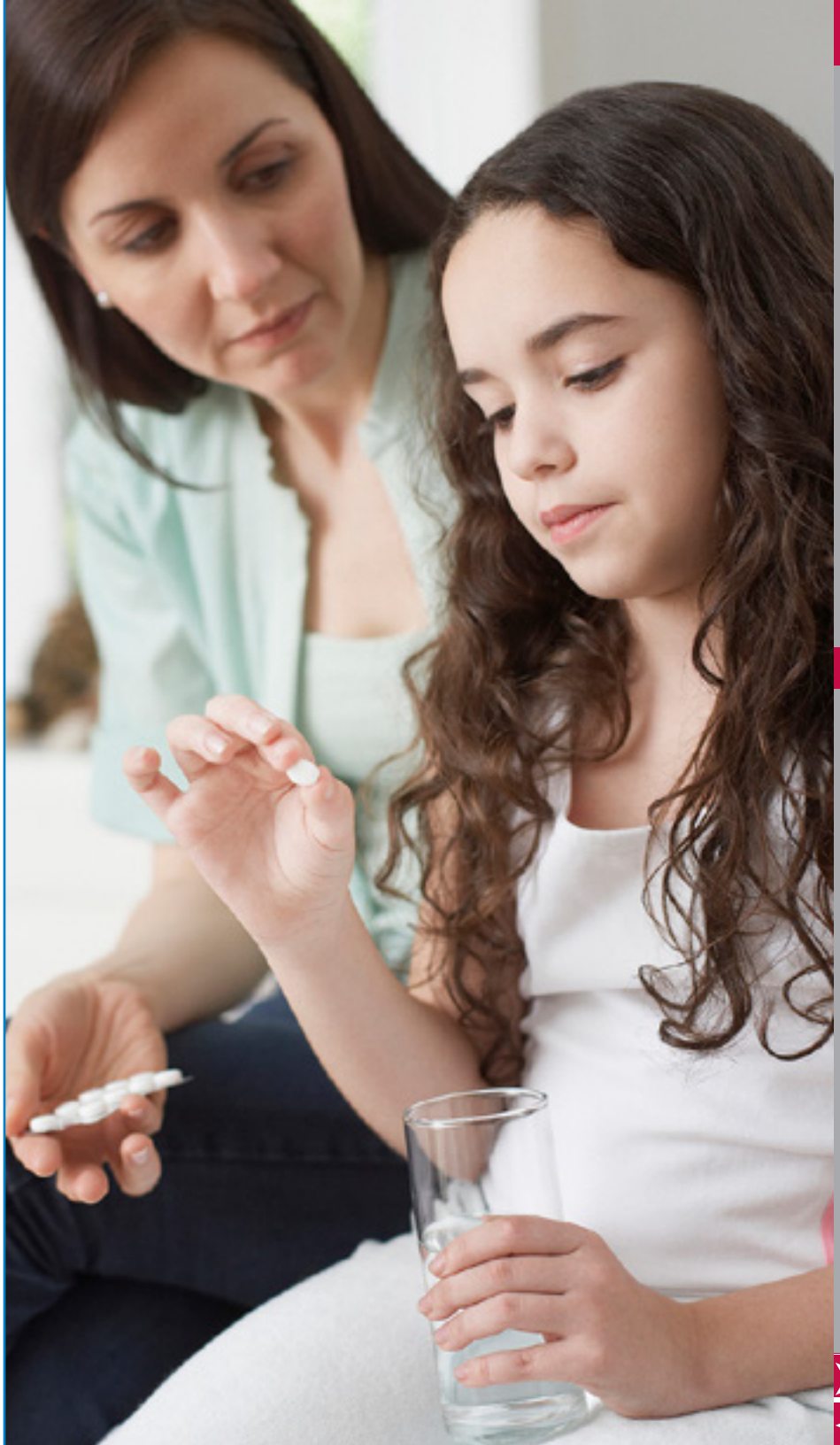
For patients in whom pharmacotherapy is indicated, consider trial of psychostimulants starting with a low dose of a preparation with a short half-life and increase weekly or biweekly to clinical improvement or stabilization at the lowest dose necessary. After the effective dose is known, transition to a longer-acting agent if desired.

Follow-up is critical

Follow-up with the prescriber within 30 days after starting a psychostimulant and at least two more times within the first nine months of treatment to monitor symptom improvement and monitor for side effects such as weight loss, growth deceleration, adverse cardiovascular effects, insomnia, depression, psychosis or tics.

Monitor weight, vital signs and behavior at each visit. Screen for both medication benefit and side effects routinely. Reassess when issues arise.

For patients who don't have desired response after adequate trial or have significant side effects, evaluate adherence, consider second-line non-stimulant medications, reconsider diagnosis and comorbid conditions or refer to a specialist and coordination of care.



Cosela and Pepaxto require prior authorization for most members

For dates of service on or after May 24, 2021, we've added prior authorization requirements for the following drugs covered under the medical benefit:

- Cosela™ (trilaciclib), HCPCS codes J3490, J3590, J9999, C9399
- Pepaxto® (melphalan flufenamide), HCPCS codes J3490, J3590, J9999, C9399

The prior authorization requirements apply when these drugs are administered in outpatient settings for:

- Members covered through Blue Cross commercial fully insured groups, except Michigan Education Special Services Association members
- Blue Cross commercial members with individual coverage
- Medicare Plus Blue℠ members
- BCN commercial members
- BCN Advantage℠ members

These requirements don't apply to Blue Cross commercial self-funded groups, including:

- Blue Cross and Blue Shield Federal Employee Program® members
- UAW Retiree Medical Benefits Trust non-Medicare members
- All other Blue Cross commercial self-funded groups

How to submit authorization requests

Submit authorization requests to AIM using one of the following methods:

- Use the **AIM *ProviderPortal***
- Call the AIM Contact Center at 1-844-377-1278

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

For additional information on requirements related to drugs covered under the medical benefit, see the following documents:

- For 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**.

Jemperli and Zynlonta require prior authorization for most members

We're adding prior authorization requirements for the following drugs covered under the medical benefit for dates of service on or after July 26, 2021:

- Jemperli™ (dostarlimab-gxly), HCPCS codes J3490, J3590, J9999, C9399
- Zynlonta™ (loncastuximab tesirine-lpyl), HCPCS codes J3490, J3590, J9999, C9399

Submit prior authorization requests through AIM Specialty Health®.

Prior authorization requirements apply when these drugs are administered in outpatient settings for:

- Blue Cross and Blue Shield of Michigan commercial — Members who have coverage through fully insured groups and members with individual coverage

  Exceptions: The Blue Cross commercial requirements don't apply to members who have coverage through Michigan Education Special Services Association or the Blue Cross and Blue Shield Federal Employee Program®, or to UAW Retiree Medical Benefits Trust non-Medicare members.
- Medicare Plus Blue℠ members
- Blue Care Network commercial members
- BCN Advantage℠ members

How to submit authorization requests

Submit authorization requests to AIM using one of the following methods:

- Through the **AIM *ProviderPortal***
- By calling the AIM Contact Center at 1-844-377-1278

More about the authorization requirements

Authorization isn't a guarantee of payment. As always, health care practitioners need to verify eligibility and benefits for members.

For additional information on requirements related to drugs covered under the medical benefit, see:

- **Blue Cross commercial and BCN commercial:**
  - **Medical oncology prior authorization list for Blue Cross commercial fully insured and BCN commercial members**
  - **Blue Cross and BCN utilization management medical drug list**
- **Medicare Advantage: Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**

We'll update the appropriate drug lists to reflect the information in this message prior to the effective date.

Correction: We're extending quantity limits on medical benefits drugs, starting Oct. 1

We published an article in the **May-June** issue titled, "We're extending quantity limits on medical benefit drugs to BCN commercial members." The implementation date for that program has been moved to Oct. 1, 2021.

Starting Oct. 1, 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.

Starting August 1, Michigan outpatient facilities must bill NDCs with NOCs or commercial claims will reject

Drugs billed for a commercial member on an outpatient claim with a HCPCS code that has a narrative description indicating miscellaneous — not otherwise classified, unlisted, or non-specified — must also include the National Drug Code, or NDC. Not otherwise classified, or NOC, drug HCPCS codes billed without this information will be rejected and you'll need to resubmit the claim with the missing information.

Submitting National Drug Codes on claims

We're publishing the following guidelines for outpatient facility claims to help you properly submit valid NDCs:

- The NDC must be submitted along with the applicable drug NOC HCPCS codes.
- Many National Drug Codes are displayed on drug packaging in a 10-digit format. Proper billing of an NDC requires an 11-digit number in a 5-4-2 format (11 numeric digits with no spaces or special characters). If the NDC on the package label has fewer than 11 digits, you must add a strategically placed zero. The following table shows common 10-digit NDC formats indicated on packaging and the appropriate conversion to an 11-digit format. The correctly formatted additional "0" is in bold and underlined in the following examples.
- Hyphens below are used only to illustrate the various formatting examples for NDCs. **Do not use hyphens when entering the NDC in your claim.**

The NDC must be active on the date of service.	Example: 10-digit format on package	11-digit format on package	Example: 11-digit format on package
To submit electronic claims (ANSI 837I), report the following information:	0002-7597-01	5-4-2	**0**0002-7597-01
5-3-2	50242-040-62	5-4-2	50242-**0**040-62
5-4-1	60575-4112-1	5-4-2	60575-4112-**0**1

The NDC must be active on the date of service.

To submit electronic claims (ANSI 837I), report the following information:

Field name	Field description	ANSI (Loop 2410) reference description
Product ID Qualifier	Enter N4 in this field.	LIN02
National Drug Code	Enter the 11-digit NDC assigned to the drug supplied	LIN03
National Drug Unit Count	Enter the quantity (number of units)	CTP04
Code Qualifier	Enter the dispensing unit of measure	CTP05-1

Quarterly update:

Requirements changed for some commercial medical benefit drugs

During January, February and March 2021, we made changes to prior authorization requirements, site-of-care requirements or both for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members for the following medical benefit drugs:

- Amondys 45® (casimersen), HCPCS code J3490
- Oxlumo™ (lumasiran), HCPCS code J3490
- Breyanzi® (lisocabtagene-maraleucel), HCPCS code J9999

Note: The HCPCS codes shown above will become unique codes.

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

List of requirements

For a detailed list of requirements, see the **Blue Cross and BCN utilization management medical drug list**. Links to this list are also available on the **Blue Cross Medical Benefits Drugs** and **BCN Medical Benefit Drugs** pages of the **ereferrals.bcbsm.com** website.

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

We maintain a comprehensive list of requirements for both Blue Cross commercial and BCN commercial members as part of our effort to encourage proper utilization of high-cost medications covered under the medical benefit.

Starting July 1, we'll change how we cover some drugs on the Preferred Drug List

We're making some changes to how we cover some drugs on Preferred Drug List for BCN commercial members, starting July 1, 2021.

We'll no longer cover the following brand name and generic drugs. If a member fills a prescription for one of these drugs on or after July 1, they'll be responsible for the full cost. The drugs that won't be covered are listed along with the preferred alternatives that have similar effectiveness, quality and safety.

Unless noted, both the brand name and available generic equivalents won't be covered. The example brand names of preferred alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs that won't be covered	Common use/drug class	Preferred alternatives
Afrezza®	Diabetes	Fiasp® (all forms), Novolin® (NDCs ending in 00, 01, 11, or 15), Novolog® (all forms)
Annovera® Balcoltra® Lo Loestrin Fe® Natazia®	Contraceptives	Generic oral and ring contraceptives, Xulane® patches
Apokyn®	Parkinson's disease	Kynmobi®
Besivance®	Ophthalmic anti-infective	Ciloxan® drops, Garamycin®, Ocuflox®, Quixin®, Vigamox®, Zymaxid®
Betimol® Rhopressa® Rocklatan®	Glaucoma	Alphagan®, Azopt®, Betagan®, Betopic®, Combigan®, Cosopt®/PF, Istalol®, Lumigan®, Ocupress®, Optipranolol®, Timoptic®, Travatan Z®, Trusopt®, Xalatan®, Zioptan®
Bijuva® Premphase® Prempro®	Estrogen/progestin combinations (oral)	Activella®, FemHRT®
Bystolic® Corlanor®	Cardiovascular conditions	Cardioselective beta-blockers (such as Lopressor, Tenormin, Toprol XL, etc.)
Clenpiq® Golytely® packets Plenvu® Suprep®	Bowel preparation	Colyte®, Golytely®, Glycolax® OTC, Nulytely®, Peg-Prep®

Please see Preferred Drug List, continued on Page 21

Changes coming to preferred products, *continued from Page 20*

Daliresp®	Chronic obstructive pulmonary disease (COPD)	Combination products: Advair® HFA, Anoro® Ellipta®, Bevespi® Aerosphere®, Breo® Ellipta®, Breztri® Aerosphere®, Dulera®, fluticasone/salmeterol (by Prasco, Proficient Rx), Stiolto® Respimat®, Symbicort®, Trelegy® Ellipta®, Yupelri® Single ingredient products: Arnuity® Ellipta®, Asmanex®/HFA, Flovent® HFA/Diskus, Incruse® Ellipta®, Perforomist®, Qvar® Redihaler®, Serevent® Diskus®, Spiriva®/ Respimat®
Divigel® Evamist® Estring® Imvexxy® Menest® Osphena® Premarin® tablets	Menopause symptoms	Climara®, Estrace®, Minivelle®, Premarin® cream, Vivelle-Dot®, Vagifem®v
Drysol®	Hyperhidrosis	Over-the-counter antiperspirants
Edarbi®	Hypertension	Atacand®, Avapro®, Benicar®, Cozaar®, Diovan®, Micardis®
Edarbyclor®	Hypertension	Atacand® HCT, Avalide®, Benicar® HCT, Diovan® HCT, Hyzaar®, Micardis® HCT
Envarsus XR®	Organ rejection prophylaxis	Prograf®
Flarex®	Ophthalmic steroid	Decadron® ophthalmic, FML®, Inflamase®/Forte, Inveltys®, Pred Forte®, Lotemax®
Pexeva® Viibryd®	Depression	Celexa®, Cymbalta®, Effexor®/XR, Elavil®, Lexapro®, Luvox®/CR, Paxil®/ CR, Pristiq®, Prozac®, Wellbutrin®/SR/XL, Zoloft®
Pulmicort® Flexhaler®	Inhaled steroids	Arnuity® Ellipta®, Asmanex®/HFA, Flovent® HFA/Diskus, Qvar® Redihaler®
Qnasl®	Nasal steroids	Flonase®, Nasalide®, Nasonex®
Slynd®	Contraceptives	Ortho Micronor®, Nor-QD®
Tirosint® Tirosint-SOL®	Thyroid replacement therapy	Synthroid®
Tobradex ST® Zylet®	Ophthalmic anti-infective and steroid	Tobradex® suspension, Tobradex® ointment

Pharmacy News

Use the correct HCPCS code for Spravato

Use the correct HCPCS code when requesting prior authorization or billing for Spravato® (esketamine).

- Use S0013 for dates of service on or after Jan. 1, 2021.
- Use J3490 or J3590 for dates of service prior to Jan. 1, 2021.

We first communicated about this in the article titled **HCPCS replacement codes established**, in the March 2021 issue of *The Record*.

The Centers for Medicare & Medicaid Services established the permanent HCPCS code of S0013 for this medical benefit drug to be used for dates of service on or after Jan. 1, 2021. However, many providers are using the older codes for these newer dates of service. This has resulted in problems with reimbursing claims.

Prior authorization information

Providers must request prior authorization for Spravato when it is administered in outpatient settings for:

- Members covered through Blue Cross commercial fully insured groups except for groups that have opted out of the prior authorization program

  Note: For groups that have opted out of the prior authorization program, Spravato is covered for the FDA approved indications.
- Blue Cross commercial members with individual coverage
- Medicare Plus Blue℠ members
- BCN commercial members
- BCN Advantage℠ members

Additional information

For more information on requirements related to drugs covered under the medical benefit, see the following documents:

- For commercial members, see the **Blue Cross and BCN utilization management medical drug list for Blue Cross PPO (commercial) and BCN HMO (commercial) members** document.
- For Medicare Advantage members, see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members** document.

We require prior authorization for Abecma for Medicare Advantage members

For dates of service on or after April 5, 2021, the CAR-T medication, Abecma™ (idecabtagene vicleucel, HCPCS code J9999), requires prior authorization through the NovoLogix® online tool.

This applies to Medicare Plus Blue℠ and BCN Advantage℠ members.

See the full article on **Page 6**.

Submit prior authorization requests for CAR-T cell therapy drugs to NovoLogix for Medicare Advantage inpatient admissions

Before you begin administering CAR-T cell therapy drugs for Medicare Plus Blue℠ or BCN Advantage℠ members in an inpatient setting, you must submit the request for the CAR-T cell therapy drug, **including all relevant clinical documentation**, as follows:

- Through the NovoLogix® online tool.
- By sending a fax to the Pharmacy Part B help desk at 1-866-392-6465.

See the article on ***Page 8*** for more information.

Billing Bulletin

BCN Provider *News*

Feedback

Clinical editing billing tips

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

This issue's tip includes:

- Coding epidurography
- Vitamin D lab test editing
- Modifier 59 usage document
- Billing for chemo administration or infusion vs. therapeutic, prophylactic, or diagnostic administration
- Billing for cataract post-op care

Clinical editing billing tips

Use the correct HCPCS code for Spravato

Use the correct HCPCS code when requesting prior authorization or billing for Spravato® (esketamine).

- Use S0013 for dates of service on or after Jan. 1, 2021.
- Use J3490 or J3590 for dates of service prior to Jan. 1, 2021.

See the article on **Page 22** for details.

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

Action item

Sign up now for live, monthly, lunchtime webinars.

Starting in April, we began offering webinars that provide updated information on risk adjustment documentation and coding of common challenging diagnoses.

All sessions start at 12:15 p.m. Eastern time and run for 15 to 30 minutes. They also provide physicians and coders with an opportunity to ask questions.

Click on a link below to sign up for a webinar.

Session date	Topic	Led by	Sign-up link
Tuesday, July 20	Diabetes with complications	Physician	**Register here**
Wednesday, Aug. 18	Renal disease	Physician	**Register here**
Thursday, Sept. 23	Malignant neoplasm	Physician	**Register here**
Tuesday, Oct. 12	Updates for ICD-10-CM	Coder	**Register here**
Wednesday, Nov. 17	Coding scenarios for primary care and specialty	Coder	**Register here**
Thursday, Dec. 9	E/M coding tips	Coder	**Register here**

If you have any questions about the sessions, contact April Boyce at aboyce@bcbsm.com. If you have questions regarding registration, email Patricia Scarlett at pscarlett@bcbsm.com.

Use our ereferrals.bcbsm.com website to find information about referrals and authorizations

This article is part of a series we're publishing over the next few issues to refamiliarize you with the resources available on the ereferrals.bcbsm.com website.

Do you need the latest news we posted about referrals and authorizations?

Are you looking for authorization requirements and criteria?

Or are you new in your provider office role and need training in how to use the e-referral system?

All the information you need is one place. Our **ereferrals.bcbsm.com** website has a wealth of information you can use, including news, training and authorization and criteria information. The **ereferrals.bcbsm.com** website is separate from the e-referral system, where you log in to make a referral or request prior authorization.

Whether you're new or just haven't visited the site in a while, we want to remind you of what's available.

On the home page, the news items we post give you the latest information about referral and authorization requirements. You'll also find information on new requirements and utilization management programs.

You can view news articles by the month published and search the News Archive page for older news postings. Simply go to the search box at the top of the page and type what you're looking for into the box. Filters allow you to search the full site, or just BCN or Blue Cross. You can use the search feature to look for something specific anywhere on the site, not just in the news postings.

But there's much more to the website than the news postings. Here are some benefits of exploring the site.

- The site is public; you don't need to log in. Just go to **ereferrals.bcbsm.com**.
- The website has a filter so you can search for information specific to BCN or Blue Cross.
- It only contains information about referrals and authorizations, so if you're a referral coordinator, this may be the first place you check for information.
- The site includes information pertinent to all our members, including our commercial members (Blue Cross and BCN) and our Medicare Advantage members (Medicare Plus Blue and BCN Advantage).
- The site has a Blue Cross section (with Blue Cross commercial and Medicare Plus Blue information) and a BCN section (with BCN commercial and BCN Advantage information).
- You can find links to the *BCN Provider Manual* chapters that cover referral and authorization information. (BCN only)
  - Utilization Management chapter
  - BCN Advantage chapter
  - Behavioral Health chapter

  Note: There's no link to the Blue Cross PPO (commercial) Provider Manual from the **ereferrals.bcbsm.com** site, but you can find the manual here:
  - Visit **bcbsm.com/providers**.
  - Log in to Provider Secured Services
  - Click *Provider Manuals*.
  - Click *Blue Cross PPO Provider Manual*.

If you look at the left-hand navigation in either the Blue Cross or BCN section of the site, you'll see links to pages for specific types of services, including behavioral health, musculoskeletal and pharmacy services. In upcoming articles, we'll explore in more detail what those pages offer.

Tip

Need to process a referral or submit a prior authorization request?

Click *Login* at the top of the page to get to the e-referral system.

We've added and updated questionnaires in the e-referral system

We added and updated questionnaires in the e-referral system on May 9. We've also updated the corresponding preview questionnaires on the **ereferrals.bcbsm.com** website.

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.

New questionnaires

We added the following questionnaires:

- *Experimental and investigational services* — This questionnaire opens for adult BCN commercial and BCN Advantage℠ members for all procedure codes that are configured as experimental in our systems.
- *Medical formula for inborn errors of metabolism* — This questionnaire opens for adult and pediatric BCN commercial and BCN Advantage members for procedure codes B4157 and B4162 for certain diagnosis codes.
- *Not otherwise classified codes* — This questionnaire opens for adult and pediatric BCN commercial and BCN Advantage members for all procedure codes that are configured as not otherwise classified in our systems.

Updated questionnaires

We updated the following questionnaires:

- *Bariatric surgery 2* — For adult BCN Advantage members
- *Endoscopy, upper gastrointestinal, for GERD* — For adult BCN commercial and BCN Advantage members. This questionnaire no longer opens for procedure code *43201. It continues to open for all other procedure codes and all diagnoses listed in the **Endoscopy, upper gastrointestinal, for GERD** preview questionnaire.
- *Excess skin removal* — For adult BCN commercial and BCN Advantage members
- *Prostatic urethral lift* — For adult BCN commercial and BCN Advantage members. This questionnaire now opens for procedure code C9769. It continues to open for procedure codes *52441 and *52442.
- *Sacral nerve neuromodulation/stimulation* — For adult Medicare Plus Blue℠, BCN commercial and BCN Advantage members

Preview questionnaires

You can access preview questionnaires at **ereferrals.bcbsm.com**. They show the questions to help you prepare your answers ahead of time.

To find the preview questionnaires:

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

Authorization criteria and medical policies

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

Enhancing your experience with the TurningPoint surgical quality and safety management program

The Blue Cross Blue Shield of Michigan and Blue Care Network Utilization Management department is committed to enhancing your experience with the TurningPoint Healthcare Solutions LLC surgical quality and safety management program. Since we implemented the program, we've made the following enhancements based on provider feedback.

- Published the code substitutions that are available for musculoskeletal procedures
- Detailed the steps required to determine whether prior authorization is required for Blue Cross commercial members
- Simplified the process for requesting peer-to-peer conversations
- Clarified clinical documentation requirements
- Updated and added informational resources for the TurningPoint program

Code substitutions for musculoskeletal procedures

In some situations, you may not know which orthopedic or spinal procedure will be required in advance of a surgery, or the surgical plan may change intraoperatively. As a result, the procedure code TurningPoint authorized may not represent the procedure that was performed.

Prior to submitting claims for these procedures, you'll need to determine whether you can substitute the code for the procedure that was performed for the code TurningPoint authorized. If you can substitute the code, you won't need to contact TurningPoint to update the procedure coding.

To determine if the approved code allows substitutions and to view all codes that allow substitutions, see the **Musculoskeletal procedure code substitutions for orthopedic and spinal surgeries** document.

What you need to know

- To improve your experience with the TurningPoint program, we've published code substitutions that are available for musculoskeletal procedures.
- We've also simplified the process for requesting peer-to-peer conversations.

This document is available on the Musculoskeletal Services pages of our **ereferrals.bcbsm.com** website.

Process for requesting peer-to-peer conversations

The steps that lead to peer-to-peer conversations with TurningPoint vary depending on whether the member has coverage through a commercial or a Medicare Advantage product.

Commercial members

If TurningPoint denies an authorization request for a Blue Cross or BCN commercial member, you have two options for requesting reconsideration:

- You can ask TurningPoint to review additional clinical documentation, provide clarifying details that are pertinent to the request or both. Submit the documentation, details or both using one of the following:
  - TurningPoint Provider Portal
  - Fax (Include a cover sheet that identifies patient):
    - **313-879-5509** for joint and spine procedures
    - **313-483-7323** for pain management procedures
- You can call **1-833-217-9670** to request a peer-to-peer conversation to review the case with a physician. You'll need to provide three dates when you're available to meet. TurningPoint will schedule the conversation based on the dates you request.

Please see TurningPoint, continued on Page 27

TurningPoint, *continued from Page 26*

You can request a reconsideration or a peer-to-peer conversation any time before providing services or filing an appeal with the health plan.

If you completed a reconsideration or peer-to-peer conversation and are dissatisfied with the decision, you may appeal.

Medicare Advantage members

Before denying an authorization request for a Medicare Plus Blue℠ or BCN Advantage℠ member, TurningPoint will make three attempts to notify you of their intent to deny any request that doesn't meet medical necessity criteria. As part of this notification, TurningPoint will offer to schedule a peer-to-peer conversation. You'll need to give TurningPoint three dates when you're available to meet. TurningPoint will schedule the conversation based on the dates you requested.

If TurningPoint is unable to contact you, they'll proceed with the authorization decision based on the information you provided with the authorization request.

Alternately, you can request a peer-to-peer conversation any time before providing services or filing an appeal.

For TurningPoint to consider information obtained during a peer-to-peer conversation when making an authorization determination, the peer-to-peer conversation must take place before the denial of an authorization request.

Note: If the peer-to-peer conversation takes place after TurningPoint denies the authorization request, TurningPoint can't reverse the denial. In such cases, the peer-to-peer conversation is for informational purposes only.

Clinical documentation requirements

We recently published updated information about the clinical documentation you must include when submitting prior authorization requests to TurningPoint Healthcare Solutions LLC.

We updated or added information related to the specific clinical documentation requirements for:

- Conservative therapies
- Body mass index
- Smoking status
- Surgical plan

To view the updated requirements, see the **Clinical documentation requirements for musculoskeletal procedures** document. This document is available on the Musculoskeletal Services pages of our **ereferrals.bcbsm.com** website.

Resources for the TurningPoint program

Resources are available to help you navigate the TurningPoint musculoskeletal surgical quality and safety management program.

We update these resources on a regular basis to provide you with the most current information.

To learn more, see the *Resources for the TurningPoint musculoskeletal surgical quality and safety management program* article, **Page 28**.

Resources for the TurningPoint musculoskeletal surgical quality and safety management program

We have resources to help you navigate the TurningPoint musculoskeletal surgical quality and safety management program.

You can find them on the following pages of the **ereferrals.bcbsm.com website**:

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

The most comprehensive resource is the **frequently asked questions** document. Here are a few of the things you'll find in the FAQ:

- How to submit authorization requests to TurningPoint through their portal, and by fax or phone
- How the peer-to-peer conversation process works
- Information related to submitting claims

Some resources you'll find on these pages:

- The list of orthopedic, pain management and spinal procedure codes that require prior authorization by TurningPoint
- The list of orthopedic and spinal procedure codes for which we allow code substitutions
- A document that walks through the steps to determine whether prior authorization is required for Blue Cross commercial members (This document is accessible only from the Blue Cross Musculoskeletal Services page.)
- Clinical documentation requirements for musculoskeletal procedures
- The *TurningPoint Provider Training Manual*
- Fax forms for requesting authorization for musculoskeletal procedures
- Recordings and presentations from the TurningPoint provider training sessions

We encourage you to take advantage of these resources.

As a reminder, TurningPoint manages authorizations for orthopedic, pain management and spinal procedures for the following:

- Blue Cross commercial* — All fully insured groups, select self-funded groups and all members with individual coverage
- Medicare Plus Blue℠ members
- BCN commercial members
- BCN Advantage℠ members

*To determine whether you need to submit prior authorization requests for Blue Cross commercial members, see the document titled **Determining whether Blue Cross commercial members require prior authorization for musculoskeletal surgeries and related procedures**.

Refer our members only to in-network DME suppliers

When obtaining durable medical equipment, or DME, for our members, you must use suppliers who are part of the Blue Cross Blue Shield of Michigan or Blue Care Network supplier network. Your contract with us obligates you to do this. The only exceptions are for emergencies or for other situations described in the policies we publish.

Here are two guidelines to keep in mind:

- You must not refer to DME suppliers who are outside of our network.
- You must determine whether a particular DME supplier participates with the member's plan before referring the member.

How to identify an in-network DME supplier

Here's how to identify a DME supplier who is part of our network.

- **For certain Blue Cross commercial members**, find a supplier using the **Find a Doctor** tool on **bcbsm.com**. This applies only to Blue Cross commercial members who either:
  - Have coverage through the Michigan Public School Employees' Retirement System
  - Are Ford or General Motors salaried employees
- **For all other members**, use a supplier that's part of the Northwood, Inc., network. This applies to these members:
  - Blue Cross commercial members who do not have coverage through one of the groups referred to above.
  - Medicare Plus Blue℠ members
  - BCN commercial members
  - BCN Advantage℠ members

To identify a supplier in the Northwood network, call Northwood at 1-800-393-6432.

What happens when you use an out-of-network DME supplier

When you use out-of-network DME suppliers, members may be responsible for additional out-of-network cost sharing. They may also be subject to balance billing by the suppliers because the suppliers aren't in the Blue Cross or BCN network or aren't following medical necessity requirements for replenishing supplies.

Our goal is to partner with you to ensure that our members have convenient access to appropriate high-quality, cost-effective DME supplies that meet their clinical needs and that are covered by their plan.

Choose the correct servicing provider in e-referral to avoid denied claims

To avoid issues or denied claims when you are submitting authorizations and referrals in e-referral, make sure you've selected the correct servicing provider. The provider you're looking for may be listed multiple times.

We've clarified the steps you should take:

1. When your servicing provider results are returned, select the listing based on where the member is going to see the provider.
2. If the provider has several listings with the same address, select the listing that also shows a group affiliation. If there are multiple group affiliations listed, make sure to choose the correct one.
3. Not all provider addresses are considered in network. If you select a listing that shows the provider is out of network ("Out" in the Network column), you will have to go through an out-of-network review.

This information can be found in the following sections of the e-referral user guides:

- ***e-referral User Guide***
  - Submit a global referral
  - Submit a referral
  - Submit an inpatient authorization
  - Submit an outpatient authorization
- ***Behavioral Health e-referral User Guide***
  - Submitting Higher Levels of Care Inpatient authorizations
  - Submitting Higher Levels of Care Outpatient authorizations
  - Submitting an Electroconvulsive Therapy Authorization
  - Submitting a Transcranial Magnetic Stimulation Authorization
  - Submitting a Neurofeedback Authorization
- ***Blue Cross® Physician Choice PPO e-referral User Guide***
  - Submit a Referral
  - Submit an Inpatient Authorization

You can also look in the ***e-referral Quick Guide*** under the Select provider/patient section.

What you need to know

- We've clarified the steps you should take to find the correct servicing provider in e-referral.
- Not all provider addresses are considered in network.
- Refer to our user guides for additional information.

Alacura's telephone number has changed for non-emergency air transport of commercial members

The telephone number for Alacura Medical Transport Management has changed to 1-844-425-2287.

We've updated the **Air ambulance flight information (non-emergency) form** to reflect the change. The fax number for Alacura is on the form as well; that number hasn't changed.

As a reminder, prior authorization by Alacura is required for non-emergency air transport of Blue Cross Blue Shield of Michigan commercial members and Blue Care Network commercial members. You'll find more details about the authorization requirements on the form (linked above).

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