SEPTEMBER-OCTOBER 2021

BCN Provider News

BCN Provider News User Guide

Home health care agencies can administer the COVID-19 vaccine in the home for eligible patients

The COVID-19 vaccine reimbursement has expanded to home health care agencies, allowing eligible patients to receive the vaccine at home. Home health care agencies have already begun administering vaccines to homebound patients.

Blue Cross Blue Shield of Michigan and Blue Care Network are following the Centers for Medicare & Medicaid Services' guidelines for determining which patients qualify for in-home COVID-19 vaccination. Patients qualify if they meet one of these requirements:

- The patient has difficulty leaving the home to get the vaccine, which includes:
  - Having a condition, due to an illness or injury, that restricts their ability to leave home without a supportive device or help from a paid or unpaid caregiver
  - Having a condition that makes them more susceptible to contracting a pandemic disease such as COVID-19
  - Being generally unable to leave the home, or doing so requires a considerable and taxing effort

What you need to know

- Home health care agencies receive reimbursement to administer COVID-19 vaccine to eligible patients within their home
- Provider guidelines for eligible Blue Cross Blue Shield of Michigan or Blue Care Network members with commercial coverage
- CMS guidelines for Medicare Plus Blue and BCN Advantage℠ members

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Home Health care, *continued from Page 1*

- The patient is hard to reach due to a disability or faces clinical, socioeconomic or geographic barriers to getting a COVID-19 vaccine in settings other than their home. This includes patients with transportation, communication or caregiving challenges.

The provider must document the patient's clinical status or barriers that justified the in-home vaccination in the patient's medical record. The additional payment described below and in the CMS links below applies if the only service provided during the home visit is administration of the COVID-19 vaccine.

This temporary expansion of COVID-19 vaccine coverage in the home for eligible patients is effective:

- June 8, 2021, for patients with Medicare coverage
- July 1, 2021, for patients with Blue Cross and Blue Care Network commercial coverage

This expansion is in place until further notice.

Here's what you need to know.

For eligible patients with commercial coverage:

Follow these guidelines for patients with Blue Cross or Blue Care Network commercial coverage.

- **Contact us to enroll** — Home health care agencies interested in administering the COVID-19 vaccine to eligible commercial members in their homes need to contact Provider Enrollment and Data Management at 1-800-822-2761 to enroll for this expanded service. You'll receive notification when you can begin providing this service.

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Network Operations

Home Health care, *continued from Page 2*

- **Submit professional claims using standard vaccine administration codes plus M0201** — Once you're approved to provide this service, home health care agencies need to submit professional claims using standard COVID-19 vaccine administration codes for dates of service July 1, 2021, and after. In addition, home health care agencies approved for this service should include HCPCS Level II code M0201 to receive additional payment in recognition of the cost agencies will incur for traveling to the patient's home.
- For M0201 to be payable, these requirements must be met:
  - The service is provided to a patient that meets the above requirements.
  - The provider documents justification for the service in the patient's record.
  - The only service provided was COVID-19 vaccine administration.
  - The service is administered in a home location (see **Medicare Payment for COVID-19 Vaccination Administration in the Home** for more information.)
  - The code is reported only once per individual home per date of service.

The COVID-19 vaccine administration codes are available on our COVID-19 webpages within our provider portal or on our public website at **bcbsm.com/coronavirus**. Refer to **COVID-19 vaccine information for providers** and **COVID-19 vaccine billing information at a glance**.

For eligible patients with Medicare primary or Medicare Advantage coverage:

Follow CMS guidelines for patients with Medicare Advantage coverage (Medicare Plus Blue℠ and BCN Advantage℠) and coverage with Medicare primary. More information is available at these links:

- **MLN Connects® special edition: Biden Administration Continues Efforts to Increase Vaccinations by Bolstering Payments for At-Home COVID-19 Vaccinations for Medicare Beneficiaries**
- **Medicare COVID-19 Vaccine Shot Payment webpage**
- **Medicare Billing for COVID-19 Vaccine Shot Administration**

Network Operations

BCN names new chief medical officer

Scott Betzelos, M.D., has been named the new chief medical officer for Blue Care Network succeeding Marc Keshishian, M.D., who retired in January from Blue Cross Blue Shield of Michigan after many years of service.

Scott has more than 20 years of experience as a practicing emergency physician in Chicago while serving as chairman of Saints Mary and Elizabeth emergency department and president of the physician management group supporting four Chicago emergency departments and two hospitalist groups through 2010.

He also served as chairman of the board of EMPAC RRG, a medical malpractice insurance company for emergency medicine provider organizations. Most recently Scott served as chief quality officer at Presence Healthcare in Chicago, Ill., and chief clinical officer at ThedaCare in northern Wisconsin. While at Inova Health System in suburban Washington, D.C, he served as chief medical officer at Inova Fairfax, system chief patient safety officer and chief executive officer of Inova Medical Group.

"My vision as CMO for BCN will continue to build on the success of the past and focus on multiple areas within BCN while advancing convenience and affordability to our members and the population we serve," said Dr. Betzelos.

"My unique experience will afford me the opportunity to enhance and optimize the network through innovative ideas, and to advance the already strong relationships with our providers and members."

Dr. Betzelos says one of his goals is to create new experiences and relationships with our providers and to collaborate to develop mutually beneficial arrangements that will positively impact members, providers and the population we serve.

"I believe that value is achieved through optimizing quality, safety and ensuring members and providers are engaged, while reducing cost through payer-physician collaboration and focus groups. My aim is to achieve and outperform the industry in member experience, provider experience, innovative risk programs and digital engagement," he said.

No-cost COVID-19 treatment to end Sept. 30, 2021

As COVID-19 cases remain low throughout Michigan, we're ending our $0 cost share for COVID-19 treatment. The last date of service for the temporary waiver of member cost share for COVID-19 treatment is Sept. 30. We'll still pay for medically necessary treatment, but it will now be subject to member cost sharing. This change applies to Blue Cross, BCN, Medicare Plus Blue℠, BCN Advantage℠ and Medigap plans.

We initially published the extension of no-cost COVID-19 treatment through Sept. 30, 2021, in the **March-April BCN Provider News**. Effective Oct. 1, member cost share will apply for COVID-19 treatment.*

Throughout the pandemic, Blue Cross Blue Shield of Michigan and Blue Care Network have implemented many short-term changes to help our providers and our members during this difficult time. This included waiving authorization requirements and member cost sharing for COVID-19 testing and treatment. Many of our policies had ending dates that were revised throughout the health emergency. We are continuing to revise the end dates for temporary changes to our policies. For more information, refer to our **Temporary changes due to the COVID-19 pandemic document**.

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

***Note:** Some commercial self-funded groups may conclude the temporary waiver of member cost share on a different date. For example, the Michigan Education Special Services Association, known as MESSA, is extending the waiver of member cost share through the end of 2021. Providers are encouraged to submit claims to Blue Cross and BCN and wait for the voucher before charging member cost share, if applicable.

Network Operations

New rider for large groups in the Upper Peninsula will limit coverage outside Michigan

Effective Oct. 1, Blue Care Network large group plans will require a mandatory rider for group customers with locations in the Upper Peninsula. The rider will be added to all existing large groups upon renewal Oct. 1, 2021 and after and to new large group business upon their effective date.

The rider will limit coverage outside Michigan to urgent, emergency or accidental services. Non-urgent and non-emergency BlueCard® travel coverage outside of Michigan won't be covered.

We'll issue new member ID cards. The suitcase icon on the front of the card (which indicates coverage by BlueCard while traveling outside of Michigan) will be removed. Language on the back of the card will read, "Members do not have coverage outside the state of Michigan except for emergency, urgent or accidental services."

When you look up these members' benefits in web-DENIS and click on *Medical Benefits* to view the Benefits Description page, then Certificate/Rider, you will see one of the following riders listed:

- BCADD2 — for fully insured large groups
- BCNUSF — for self-funded large groups

Members will be able to see these updated riders by logging in to their member accounts at **bcbsm.com**.

What you need to know

Some information in the following article has been updated since we ran it in the July-August issue. Use this one as your reference.

Refer our members only to 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:

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

Identifying a Blue Cross / BCN network DME supplier

For all members, you can find a Blue Cross or BCN network DME supplier by using the **Find a Doctor** tool on **bcbsm.com**.

Identifying a Northwood network DME supplier

For some members, you must use a supplier that's part of the Northwood, Inc., network, which is a subset of our general DME supplier network. This applies to:

- Fully insured Blue Cross commercial members
- Medicare Plus Blue℠ members
- BCN commercial members
- BCN Advantage℠ members

You can find a Northwood DME supplier by using the **Find a Doctor** tool on **bcbsm.com** and filtering by "Northwood Provider."

For additional help identifying a supplier in the Northwood network, call Northwood at 1-800-393-6432.

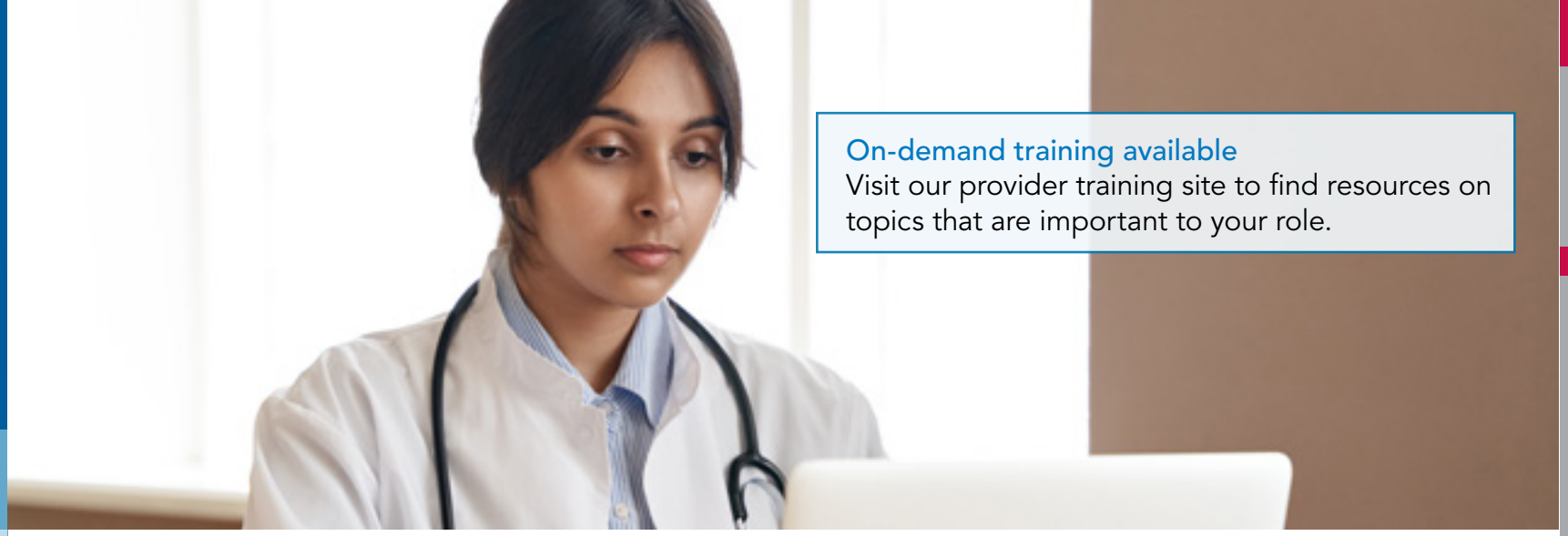
What happens when you use an out-of-network DME supplier

When you use out-of-network DME suppliers, members may be responsible for additional out-of-pocket costs. 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

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

Network Operations



On-demand training available
Visit our provider training site to find resources on topics that are important to your role.

We're offering training resources for health care providers and staff.

We've posted recordings of webinars previously delivered this year. Video and eLearning modules are also available on specific topics. The on-demand courses are designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

Here are the newest resources that are available:

- *Evaluation and management guidelines for 2020 and beyond:* This eLearning video reviews general coding and documentation requirements, evaluation and management guideline requirements and coding scenario examples.
- *HCPCS and revenue code combinations for facility claims:* This eLearning course teaches how to use the look-up tools that help providers match HCPCS/CPT codes with the correct revenue codes for facility claims.
- *Home Health Care Services Overview webinar:* This webinar recording reviews the CareCentrix® home health care authorization program and provider portal.
- *RBCE/MCG Self-Service user videos:* This series of videos demonstrate the steps for using the RCBE/MCG self-service tool to enroll new practitioners, modify status within your entity and make updates to practitioner affiliation.

Last month, we announced our new provider training site to enhance the training experience for health care providers and staff.

Active training courses and materials from 2019 to 2021 have moved from *BCBSM Provider Training* and *BCN Learning Opportunities* in Provider Secured Services 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 assistance creating your login ID or navigating the site, contact **ProviderTraining@bcbsm.com**.

Network Operations

Contact Provider Inquiry for claims issues

If you're experiencing claims or complex claims issues, contact Provider Inquiry. If you call your provider consultant, you'll first need a reference number from Provider Inquiry.

- Medical providers call 1-800-344-8525
- Facility provider call 1-800-249-5103
- Dental, hearing and vision providers call 1-800-482-4047
- Medicare Advantage providers call 1-866-309-1719

If your issue isn't satisfactorily resolved, ask the representative to escalate your inquiry to their leadership.

For enrollment questions, contact Provider Enrollment and Data Management at 1-800-822-2761 from 8 a.m. to 4 p.m. Monday through Friday.

Online tutorials about our e-referral system are available on the **Training Tools** page at **ereferrals.bcbsm.com**.

You'll also find job aids, FAQs, brochures, flyers and user guides on the *BCBSM Newsletters and Resources* and *BCN Provider Publications and Resources* pages on Provider Secured Services.

Build COVID-19 vaccine confidence with online resources from the Centers for Disease Control and Health and Human Services

We're getting closer to the State of Michigan's goal to vaccinate 70% or more of Michigan's population, but COVID-19 vaccine hesitancy remains one of the major roadblocks. Despite the massive amount of information provided by national public health messengers, some subgroups of our population are still on the fence about getting vaccinated or are refusing it altogether.

Reasons for the hesitancy could be lack of trust in the public figures or perceiving the information relayed by them as conflicting. The most trusted messengers of COVID-19 vaccine information are individual health care providers, according to the Kaiser Family Foundation's **COVID-19 Vaccine Monitor**, an ongoing research project launched in December 2020.

Please see Build Vaccine Confidence continued on Page 9

Build Vaccine Confidence, *continued from Page 8*

Online toolkits and resources

To help providers increase acceptance of the vaccine, the Centers for Disease Control and Prevention and the U.S. Department of Health and Human Services provide helpful **online toolkits** for providers to address vaccine hesitancy not only among patients, but also among their health care provider staff.

Some of the resources in the CDC toolkits include:

- Strategies for building confidence in medical center and clinic immunization coordinators
- Materials for communicating with health care providers
- Digital and print communication resources
- Printable stickers
- Samples of social media messages and graphics

The **HHS COVID-19 Public Education Campaign** website includes resources and toolkits, a vaccine hesitancy map, campaign ads and information about joining the COVID-19 Community Corps, which emails weekly tips, news and resources to share with your community. One unique attribute of the HHS website allows you to target vaccine information using the filters below:

- Audience — by race or ethnicity, older adults, health care professionals, rural communities
- Format — social media, posters and flyers, video, informational content
- Language — Chinese, English, Filipino, Japanese, Korean, Spanish and Vietnamese
- Topic — building vaccine confidence, getting vaccinated, preventive measures, vaccine safety and efficacy

Please remind your patients that they will have zero out-of-pocket costs or network requirements to receive any of the COVID-19 vaccines. Blue Cross Blue Shield of Michigan and Blue Care Network thank you for your continued participation with our plans. We support and appreciate your ongoing efforts in caring for our members and improving the health of the citizens in our community.

Evaluation and management guidelines are available through on demand eLearning videos on new Provider Training website

The evaluation and management guidelines and scenarios for 2020 and beyond is an eLearning lesson that helps you follow the new evaluation and management guidelines as you prepare claims for submission.

The course includes a video summary of the important points with links to supporting documents from Blue Cross Blue Shield of Michigan.

The lesson is available on our new provider training website. Access to the site will differ slightly for new and existing users.

- New users must **click here to register**.
- Existing users can follow this **link to log in**.

Once logged in, users can access the module two ways:

- Enter 'Evaluation' in the search box at the top of the screen.
- Look in the course catalog under Medical record documentation and coding.

If you need assistance creating your login ID or navigating the site, email **ProviderTraining@bcbsm.com**.

CareCentrix to manage network for independent home infusion therapy and ambulatory infusion suite providers, starting Jan. 1

Effective Jan. 1, 2022, Blue Cross Blue Shield of Michigan and Blue Care Network will delegate management of the in-state independent home infusion therapy and ambulatory infusion suite provider network to CareCentrix® for commercial members. (AISs are a subset of ambulatory infusion centers.)

This change won't affect hospital-owned HIT or AIS providers or members with Medicare Plus Blue℠ or BCN Advantage℠ plans.

See the article on **Page 35** for information about contracting and billing.

Encourage eligible Medicare Advantage patients to get screened for colorectal cancer

Colorectal cancer is the third leading cause of cancer death for both men and women in the United States, according to the American Cancer Society. Screening, early detection and treatments are effective at reducing deaths from this cancer.

The Colorectal Cancer Screening, or COL, HEDIS® star measure assesses patients ages 50 to 75 who had appropriate screenings for colorectal cancer.

Colonoscopy is the gold standard for colorectal cancer screening. There are alternative options for patients who are hesitant to have one.

Read the *Colorectal Cancer Screening* tip sheet to learn about this measure, including what information to include in medical records, codes for patient claims and tips for talking with patients.

Healthcare Effectiveness Data Information Set; HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Colorectal Cancer Screening tip sheet PDF

Help improve health of patients with diabetes while reducing medical record review requests

The Comprehensive Diabetes Care, or CDC, HEDIS® star measure is a composite measure that supports the consistent medical care and monitoring needed by patients with diabetes to reduce the risk of severe complications and improve outcomes.

Interventions to improve diabetes outcomes go beyond glycemic control. The CDC measure includes HbA1c control and blood pressure control, as well as screening for diabetic retinopathy and nephropathy.

View the Comprehensive Diabetes Care tip sheet to learn more about what is included in the measure, exclusions that include advanced illness and frailty, and ways you can close gaps in care for patients with diabetes.

The tip sheet also covers medical record documentation and claims coding that can reduce the need for medical record reviews.

Healthcare Effectiveness Data Information Set; HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Comprehensive Diabetes Care tip sheet PDF

Be sure to check out the tip sheets for the *Health Outcomes Survey* and the *Consumer Assessment of Healthcare Providers and Systems Survey* to learn how you can use the survey data to address care opportunities with patients.

Learn more about the HOS and CAHPS surveys

What are the Health Outcomes Survey and the CAHPS® survey?

The Health Outcomes Survey asks patients to report on their health outcomes, while the Consumer Assessment of Healthcare Providers and Systems Survey asks patients to report on their experiences with a wide range of health care services.

Why are these surveys important?

The goal of the Health Outcomes Survey is to gather clinically meaningful health status data from Medicare Advantage patients about health outcomes. The data gleaned from the survey is used to support quality improvement activities, monitor health plan performance and improve the health of this patient population.

The Consumer Assessment of Healthcare Providers and Systems Survey gathers data from members about a wide range of health care services. According to the **Agency for Healthcare Quality and Research**, a positive health care experience for patients is associated with positive clinical outcomes and better business outcomes, including improving patient loyalty, maximizing referrals and improving patient compliance.

To support discussions with your patients about their experiences, we began sending postcards to members in late July. The postcards remind patients to discuss their health care experiences and health-related concerns with their health care provider or office staff member at their next visit.

How can patients' experiences with health care services affect their health?

The health care team at a doctor's office not only includes physicians and medical assistants, but often includes nurses, customer service representatives, care managers and others. The entire team can affect the health of patients and how they assess their health care experience.

We encourage you to improve the experiences of your patients by addressing the following topics:

- Explain the benefits of getting COVID-19 and flu vaccinations.
- Discuss the importance of checking blood pressure regularly for patients with hypertension.
- Explain the importance of checking Hgb A1c for patients with diabetes.
- Tell patients how to find their results after testing. Let patients know the time frame in which they will receive their test results and when to call if they haven't received their results.
- Let them know to get a needed office appointment in a timely manner. Remind them that some appointments are routine or not urgent, so it's OK to have them scheduled at some point in the future. Help them understand what "urgent" means.
- Perform an assessment of your patient's physical activity and make recommendations on how to improve.
- For Medicare Advantage patients, perform an assessment of your patient's fall risk, and discuss measures to prevent falls.
- For your Medicare Advantage patients, ask if they have urinary incontinence or urine leakage, and review options for treatment.
- Perform an assessment of a patient's medication compliance and ability to pay for medications. Change prescriptions as appropriate. Let them know about avenues to explore if they need financial help.

We appreciate all you do to help keep your patients healthy and safe.

PDF *CAHPS survey*

PDF *star-tips-medicare-health-outcomes-survey*

BCN Advantage

New eLearning training videos focus on Medicare star ratings

The Quality and Provider Education team continues to offer important training resources to health care providers and staff. New eLearning training videos, designed for physician office staff responsible for closing gaps related to Medicare star measures, are now available. The video series will discuss closing gaps and emphasize the importance of creating positive patient experiences.

Topics include:

- Clarifications on quality measure requirements
- Assistance with coding and documentation
- Tips for closing gaps
- Current information about HEDIS® quality measures (Note: Many HEDIS measures are also Medicare star ratings measures.)
- The Consumer Assessment of Healthcare Providers and Systems and Health Outcomes Survey

The video series will be available on our new provider training site. Access to the site will differ slightly for new and existing users:

- New users must register **here**.
- Existing users can log in **here**.

Log in to access the module in the course catalog under Quality management or by entering "Star" in the search box at the top of the screen.

Watch this **video** to learn more about the provider training site. If you need assistance creating your login ID or navigating the site, email **ProviderTraining@bcbsm.com**.

Aduhelm, Empaveli and Arcalyst require prior authorization for Medicare Advantage members

The following medications require prior authorization through the NovoLogix® online tool:

- Aduhelm™, (aducanumab), HCPCS code J3590 — for dates of service on or after June 8, 2021
- Empaveli™, (pegcetacoplan), HCPCS codes J3490, J3590 — for dates of service on or after June 14, 2021
- Arcalyst® (rilonacept), HCPCS code J2793 — for dates of service on or after Sept. 13, 2021

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

When prior authorization is required

For Medicare Advantage members, we require prior 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 (place of service codes 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 prior 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 NovoLogix.

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

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

BCN Advantage

What you need to know

- We clarify when you can substitute services provided by clinicians with lower-level credentials.
- We explain when you need to submit authorization request for additional disciplines that haven't been authorized by CareCentrix®.

Home health care: Helpful tips for adding disciplines and substituting services provided by clinicians with lower-level credentials

CareCentrix has managed authorizations for home health care services for Medicare Plus Blue℠ and BCN Advantage℠ members since June 1, 2021.

Here are some clarifications on this new program:

- For Medicare Plus Blue members who receive services in Michigan, you don't need to submit requests to add disciplines to existing 30-day episodic authorizations that have already been approved by CareCentrix.

Notes:

- For Medicare Plus Blue members receiving services outside of Michigan, follow the reimbursement guidelines for your local Blue Cross plan.
- For BCN Advantage members, home health care services use a fee-for-service payment methodology, so you need to submit authorization requests for additional disciplines that haven't been authorized by CareCentrix; see below for additional details.
- For BCN Advantage members, you don't need to update approved authorizations when services are provided by a clinician with a lower-level credential than the clinician who was authorized by CareCentrix. This substitution is allowed as long as the clinician with the lower-level credential is within the same discipline that CareCentrix authorized. For example:
  - A licensed practical nurse can provide services when CareCentrix authorized services to be provided by a registered nurse.
  - A physical therapy assistant can provide services when CareCentrix authorized services to be provided by a physical therapist.

Note: You also don't need to update authorizations for Medicare Plus Blue members when services are provided by clinicians with lower-level credentials.

See the following table to determine which HCPCS codes are associated to revenue codes by discipline:

Please see Home health care continued on Page 16

Home health care, *continued from Page 15*

Service	HCPCS code	Associated revenue codes
Home health aide	• G0156: Home health aide	0570, 0571, 0572, 0579
Medical social services	• G0155: Medical social worker	0560, 0561, 0562
Occupational therapy	• G0152: Occupational therapist • G0158: Occupational therapist assistant • G0160: Occupational therapist, establish or deliver occupational therapy maintenance program	0430, 0431, 0432, 0434
Physical therapy	• G0151: Physical therapist • G0157: Physical therapist assistant • G0159: Physical therapist, establish or delivery physical therapy maintenance program	0420, 0421, 0422, 0424, 0429
Skilled nursing	• G0299: RN visit • G0300: Licensed vocational nurse/LPN visit • G0162: RN, for management and evaluation of the care plan • G0493: RN clinical assessment, initial • G0494: LPN, for the observation and assessment of patient condition • G0495: RN, training / education of a patient or family member • G0496: Practice nurse, training/ education of a patient or family member	0550, 0551, 0552
Speech therapy	• G0153: Speech therapist • G0161: Speech language pathologist, establish or deliver speech language pathology maintenance program	0440, 0441, 0442, 0444

We've updated the **Home health care: Frequently asked questions** for providers document to reflect these clarifications.

As a reminder, CareCentrix manages prior authorizations for home health care services for Medicare Plus Blue and BCN Advantage members as follows:

- For episodes of care that start on or after June 1, 2021
- For episodes of care that started prior to June 1, 2021, when one of the following occurs on or after June 1: recertification is needed, resumption of care is needed or there's a significant change in condition.

Inflammation side effect of COVID-19 vaccine can cause inaccurate mammogram results

Before scheduling patients' screening mammograms, ask if they've received a COVID-19 vaccine in the last four to six weeks. The Centers for Disease Control and Prevention suggests scheduling any screening mammograms before getting a COVID-19 vaccination. Patients who already received the vaccine should schedule their screening mammogram four to six weeks **after** getting their complete vaccination dose, per the CDC's recommendation.

The COVID-19 vaccine, like some other vaccines including influenza and pneumococcus, can cause temporary swelling of lymph nodes in the underarm area, or axilla, near where a patient received the shot. The swelling may produce a false positive result on a mammogram performed too soon after the vaccine. These false positive results may lead to repeat studies and member anxiety.

Waiting will reduce unnecessary call-backs for more diagnostic screenings and radiation exposure.

If patients ask questions about the vaccination, reassure them that:

- The COVID-19 vaccine is not associated with breast cancer.
- The lymph node inflammation is normal and means the immune system is working.

Patients can find more information on the CDC's website here: **COVID-19 Vaccination and Other Medical Procedures**.

Another good source of information on this topic is from Johns Hopkins' website, hopkinsmedicine.org: **COVID-19 Vaccine: Can It Affect Your Mammogram Results?**

We've updated our *choices for care* and Blue Cross Online Visits toolkits

We've refreshed our *choices for care* and Blue Cross Online Visits℠ employer toolkits to continue supporting member education about the care that's always there with their Blue Cross Blue Shield of Michigan and Blue Care Network health plans.

These employer toolkits, which contain print, digital and video resources, are part of our continuing efforts to make sure members know they have 24-hour access to care that's always there. You are welcome to use these materials in your office.

Choices for care

In the *choices for care* campaign, we remind members to check with their primary care providers first when they need care and that many primary care providers have the following options available:

- In-person care
- Virtual care
- Phone consultations
- Extended hours, including weekends

We also stress that members follow up with their primary care provider when they receive care elsewhere.

The other choices for care available to members when their primary care provider isn't available are:

- The 24-Hour Nurse Line
- Blue Cross Online Visits
- Walk-in clinics

Download materials from the ***choices for care* toolkit**.

Blue Cross Online Visits

We know that many primary care providers offer virtual care. If your office doesn't offer virtual care or your Blue Cross and BCN patients need virtual care after hours, you can let them know about Blue Cross Online Visits. Download materials from the **Blue Cross Online Visits toolkit**.

Culturally competent health care can improve health outcomes and patient satisfaction

This is part of a series of articles we're running on health and 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 improve them.

The increasing diversity of the country has underscored the importance for health care providers, health care systems and policy makers to create and deliver culturally competent services.

According to the National Institutes of Health, **4 out of 10 Americans** will belong to a racial or ethnic minority group by 2030. This is especially important to keep in mind since racial and ethnic minorities have higher rates of morbidity and mortality from chronic diseases.

Yet, despite the increase in diversity in this country overall, the medical field has been predominantly white. A recent survey by the Association of American Medical Colleges found 56.2% of active physicians identified as white, 17.1% identified as Asian, 5.8% identified as Hispanic and 5% identified as Black or African American.

This relative lack of diversity representation in the medical field can play a key role in contributing to health care disparities. Sometimes the assumptions and stereotypes on which we unconsciously rely — what we call unconscious bias — not only can influence the decisions and actions of health care providers but can affect the quality of care delivered.

Cultural competency defined

Cultural competency is the ability of providers and organizations to effectively deliver health care services that meet the social, cultural and linguistic needs of patients.

A culturally competent health care system can help improve health outcomes and quality of care, and contribute to the elimination of racial and ethnic health and health care disparities, according to **an article** published by Georgetown University's McCourt School of Public Policy.

The article stated that If providers, organizations and systems aren't working together to provide culturally competent care, patients are at higher risk of having negative health consequences, receiving poor quality care or being dissatisfied with their care. For example:

- African Americans and other ethnic communities report less partnership with physicians, less participation in medical decisions and lower levels of satisfaction with care.
- The quality of patient-physician interactions is lower among non-white patients, particularly Latinos and Asian Americans.
- Lower quality patient-physician interactions are associated with lower overall satisfaction with health care.

Additionally, **one in five Americans** say communication with physicians is a problem in receiving health care — a figure that increases to 27% among Asian Americans and 33% among Latinos. Research has shown that when there are language barriers between providers and patients, providers often compensate by ordering additional diagnostic tests. This can result in higher costs for the patient and health care system.

Please see Cultural Competency continued on Page 19

Cultural Competency, *continued from Page 18*

A lack of cultural competency can also have the following effects on patients:

- Lower patient satisfaction with care
- Poor comprehension and adherence to treatment plans
- Lower quality of care
- More interactions with the health care system
- Negative health consequences
- Less partnership with physicians in medical decisions

How to improve cultural competency

Acknowledging the need to address cultural competency among health care providers is a good first step, according to a **blog** on MI Blues Perspectives. Here are some other strategies to consider:

- Consult with traditional, culturally appropriate leaders as needed.
- Coordinate your efforts with community health workers.
- Ensure that services and materials — including medical billing, appointment bookings, flyers and registration forms — are available in more than one language.
- Offer interpreter services.
- Expand hours of operation.
- Include family and community members in health care decision-making.
- Offer clinic locations in areas accessible for the population you're trying to reach.
- Provide staff training to increase cultural awareness, knowledge and skills. (See article in the **July-August issue** of *BCN Provider News* for information on available training modules.)
- Seek out a diverse staff that's representative of different cultures, communities and backgrounds.

The bottom line

A health care system that is culturally competent can help eliminate racial and ethnic health disparities and help improve health outcomes and quality of care for all.

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

- Breast reduction for breast-related symptoms (title changed from Reduction mammaplasty for breast-related symptoms)
- Genetic testing for FMR1 and FMR2 variants (Including Fragile X and Fragile XE syndromes)
- Genetic testing — Preimplantation
- Analysis of human DNA in stool samples as a technique for colorectal cancer screening
- BMT— hematopoietic cell transplantation (HCT) for CNS tumors, embryonal tumors and ependymoma
- Laboratory tests for post-transplant (kidney and heart) and for heart failure
- Noninvasive techniques for the evaluation and monitoring of patients with chronic liver disease
- Orthognathic surgery
- Light and laser therapy for vitiligo and atopic dermatitis
- Myolysis of uterine fibroids using laparoscopic percutaneous or transcervical techniques
- Responsive neurostimulation for the treatment of refractory partial epilepsy
- Circulating tumor DNA for management of non-small-cell lung cancer (liquid biopsy)

Noncovered service

- Noncontact ultrasound treatment for wounds

Medical Policy Updates

MIU Men's Health Foundation hosts annual event in Detroit to promote preventive screenings

On average, men die five years earlier than women in America, and about seven years earlier worldwide. Preventive health screenings can catch early signs of cancer, heart disease and other serious health conditions. The MIU Men's Health Foundation is hosting its 11th annual Men's Health Event which offers no-hassle preventive screening.

Roughly 535,000 Michigan residents did not have health insurance in 2018 which help cover preventive and medical expenses. In addition, more than 111,000 residents in Wayne County, Michigan under the age of 65 did not have health insurance in 2018. MIU Men's Health foundation wants to ensure **men of any age over 18 will be seen regardless of insurance status** at their event.

The Men's Health Event is Oct. 9, 2021 at Ford Field, in Detroit, from 9 a.m. to 3 p.m.

The event offers vital screenings, in-depth bloodwork, flu vaccinations, HIV testing, skin cancer screening and more. By taking advantage of preventive screenings and other medical care, conditions such as cardiovascular disease can lower risk by up to 50%. Preventive health screenings and other medical services can help men sustain healthier and longer lives.

For event information, please visit the **Men's Health Foundation website**. For more information about the importance of preventive screening, please see ***Preventive care saves lives***.

Requirement for CADC credential for facilities that treat substance abuse orders, effective July 1

For members with a diagnosis involving a substance use disorder, group counseling and didactic group sessions must be provided by a certified CADC professional, a registered nurse or someone with a higher credential. This was effective starting July 1, 2021.

This requirement applies to facilities that treat members who have coverage through these plans:

- Blue Cross Blue Shield of Michigan commercial
- Medicare Plus Blue℠
- Blue Care Network commercial
- BCN Advantage℠

This requirement applies to facilities that provide and bill for one or more of the following types of treatment for substance use disorders:

- Subacute detoxification
- Residential treatment
- Partial hospital program
- Intensive outpatient program
- Individual treatment

When employees don't have the CADC credential

Fully licensed mental health practitioners who are employed by these facilities but who do not have the CADC credential can provide group counseling and didactic group sessions, but they must do the following:

- Within 30 days of hire, document the submission of an application to obtain the CADC credential. The application must be submitted to the **Michigan Certification Board for Addiction Professionals**.

  Note: MCBAP allows the submission of an application within 30 days of hire as part of the normal process of obtaining the CADC credential.

  - Within the first 40 months of employment, obtain the CADC credential through MCBAP.

    Note: MCBAP indicates on its website that three years is generally provided or needed to obtain the credential, but we're allowing an additional four months to accommodate any interruption of the process for sickness or for other issues that may temporarily interfere with completion of the educational program within the intended time frame.

  Note: Group psychotherapy must be provided by a fully licensed mental health practitioner, for example, a licensed master's social worker, or LMSW.

From the medical director: Consider these guidelines for documenting psychotherapy in 2021 and beyond

By William Beecroft, M.D.

We've all had training on the important role that documentation plays in everything we do. As changes occur within the health care industry, the documentation needs to evolve accordingly.

Over the past few years, there have been additional interventions behavioral health practitioners can provide to better address the needs of our patients — and these interventions need to be coded appropriately. Here are a few examples of some recent developments:

- During the COVID-19 pandemic, we witnessed a significant increase in the use of telemedicine services for patients.
- The use of extended service codes has expanded in concert with the expansion of such treatments as:
  - Evidence-based interventions, such as exposure response prevention therapy for obsessive compulsive disorder, anxiety and phobias.
  - Eye movement desensitization, or EMDR, for trauma and post-traumatic stress disorder.
  - Use of esketamine for the treatment of severe depression and suicidal thoughts. (This medication isn't part of psychotherapy. It's a new treatment that will require observation over time.)
- Crisis codes that have always been available are now easier to use — and documenting the interventions you perform becomes even more important.
- Telephone check-in visits and health assessments, including behavioral health assessments, have proliferated to provide more comprehensive care for patients.

As you know, the traditional 30- ,45- and 60-minute psychotherapy sessions have been a mainstay of the treatment process. Like any provider of a service to another individual, documenting the items that were addressed during the time you're billing for is essential. It's not only important for reimbursement purposes, but to retain as background in case a patient asks what you've done for them. In addition, regulatory agencies may ask to see your records to assess your treatment practices or courts may request documentation related to the consequences of an injury.

Please see From the medical director, continued on Page 23

William Beecroft, M.D. is medical director of Behavioral Health for Blue Cross Blue Shield of Michigan and Blue Care Network.

Behavioral Health

From the medical director, *continued from Page 22*

The main tenet to keep in mind is this: If it's not written, you didn't do it.

Clinically, there's evidence that "treating to target" is the gold standard of care. For example, treating diabetes to a A1c less than 7 or treating depression to a PHQ-9 less than 5 is necessary to show the progress and eventual success of your intervention. Using this model proves your dedication to quality and adherence to scientific methods, along with the art of behavioral health interventions.

Blue Cross Blue Shield of Michigan and Blue Care Network want you to get reimbursed for the work you do but, at the same time, we want you to bill us appropriately for that work. Documenting what has transpired in the practice setting will support that.

Much like the architect designing a building will document the time and tasks represented in his or her bill, we expect you to document the components of the work you're doing and objectively justify that the interventions are for the member's best interest.

For many years, we've required the elements below in your documentation to support medical necessity:

- Date of the visit and the start and stop times
- Names of those present during the session. (If separate individuals are interviewed, include the duration each is present. Identify the service provided.)
- Updated medical history and current medications (changes) along with the name of the prescribing medical provider and evidence that coordination of care has occurred at least quarterly
- Clinical findings on reexamination
- Brief indication of the patient's reaction to therapeutic intervention (for example, "The patient is open to treatment suggestions" or "The patient is reluctant to make recommended changes.")
- Objectively stated treatment plan and rationale, if changed from the last visit
- Results of objective screening or monitoring tools to gauge improvement
- Instructions, recommendations and precautions given to the patient or other significant parties
- Signature and credentials of the treating provider and by the supervisor, as applicable

In my opinion, this would be a minimum needed for documentation that truly reflects your work. See the full **documentation requirements** for more details.

The American Psychological Association also has **guidelines** you may want to check out.

At Blue Cross, we appreciate all you do to take care of our members. We recognize this is a big responsibility and we value your partnership. We hope the information in this column will help you stay current on documentation and practice trends that are changing rapidly as the clinical science evolves.

Behavioral Health

New method of obtaining emergency crisis assessment for psychiatric issues, treatment coming soon

Starting Oct. 1, 2021, Blue Cross Blue Shield of Michigan and Blue Care Network will begin covering mobile crisis and crisis stabilization services. Both urgent care and crisis residential services are already covered.

Note: Medicare Plus Blue℠ members won't be included in this new program at this time.

Mobile crisis services include:

- Professional mental health teams in the community who can evaluate the members wherever they are located
- Face-to-face or telephone evaluations to determine appropriate placement for the member
- The mobile crisis team may stay involved for two to four weeks after the initial encounter to ensure members are connected to the right level of care for mental health or substance use disorder treatment and to provide treatment, as necessary.

Crisis stabilization services (formerly psychiatric observation) include:

- Behavioral health evaluation to initiate appropriate treatment (similar to medical observation services)
- Physical site-based services that are necessary to support the mobile crisis team
  - Services include intake assessment, psychiatric evaluation, crisis intervention, psychotherapy, medication administration, therapeutic injection, observation and peer support
- Initiate linkages and "warm handoffs" to the appropriate level of care and community resources

Please see Emergency Crisis continued on Page 25

Emergency Crisis, *continued from Page 24*

"The goal of such services is to make sure our members get treated at the right place at the right time," said Dr. William Beecroft, medical director of behavioral health.

Facilities to be used for physical site-based services would be open 24/7 and use the services of a multidisciplinary staff, including physicians, registered nurses, LMSWs, psychologists, clinical supervisors and additional support staff. Members may be referred to a facility from a mobile crisis team, law enforcement or other community-based services, or they may walk in on their own.

Blue Care Network recently conducted a pilot program with two providers in Southeast Michigan — **COPE Intervention Center** ** and **Common Ground Resource and Crisis Center**. As the State of Michigan further develops the certification process for crisis stabilization units in freestanding and hospital-affiliated locations across the state, Blue Cross and BCN will expand their efforts to include additional providers within the state.

Here's some additional information about the Common Ground and COPE centers:

Common Ground Resource and Crisis Center

Hours: Open 24 hours
Phone: 248-451-2600
Services: Mobile, walk-in, crisis stabilization (observation), residential

COPE Intervention Center

Hours: Open 24 hours
Phone: 734-721-0200
Services: Mobile, walk-in, crisis stabilization (observation), residential

BCN has had two years of experience working with these two centers, with positive results. Some of the benefits for members receiving treatment at one of these two locations include:

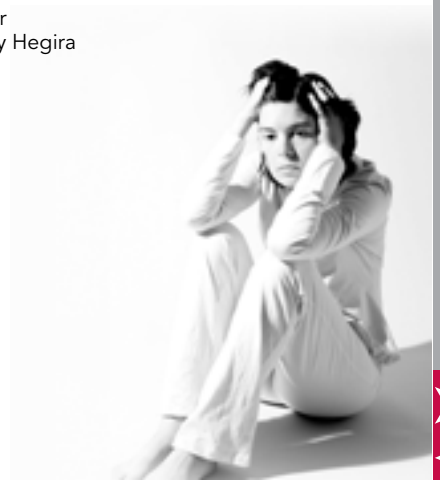
- A speedy assessment of their immediate needs. Members can be seen by a behavioral health specialist promptly.
- A multidisciplinary evaluation, which leads to a plan of care and placement in the appropriate level of care.
- A positive, less stigmatizing experience than with some other systems of care.
- Rapid access to behavioral interventions, including medication, nursing care, psychotherapy and psychoeducation.
- Alleviation of a sense of crisis, encouraging feelings of hope.

As part of the evaluation and treatment process at these centers, some members may still need psychiatric hospitalization.

Dr. Beecroft pointed out that the Substance Abuse and Mental Health Services Administration, or SAMHSA, published a paper suggesting that a significant number of individuals presenting for crisis services don't require hospital admission and can be treated in another, more appropriate care setting. "Centers that offer mobile crisis and crisis stabilization services make it more likely that people will get treated quickly and at the right level of care," he said.

We'll be publishing additional details about our coverage of crisis services as they become available, and let you know of additional providers that join us in this transformative program of care. We'll also be including program criteria in our provider manuals. Watch for further updates in web-DENIS, *The Record* and *BCN Provider News* for information on how you can become involved.

**COPE, which stands for Community Outreach for Psychiatric Emergencies, is a program created by Hegira



We're transitioning to a new pharmacy benefit manager

Blue Cross Blue Shield of Michigan and Blue Care Network's transition to a new pharmacy benefit manager, which we reported in a March-April *BCN Provider News* **article**, will result in certain changes we want to alert you to.

As you may have read, we're moving from Express Scripts, Inc. to OptumRx on Jan. 1, 2022, for commercial and individual group members, and Jan. 1, 2023, for Medicare Advantage individual and group members. The change is expected to improve the pharmacy experience for members and customers, better manage drug costs and drive better health outcomes.

While we anticipate that the bulk of the transition will be seamless for our members and health care providers, members who use home delivery pharmacy services may be affected. Most of these members' current prescriptions with Express Scripts will automatically transfer to OptumRx if they have refills remaining, but prescriptions for controlled substances won't transfer automatically.

Members with a prescription for a controlled substance will need to see their doctor to request a new prescription for our new home delivery pharmacy. Examples include medications for ADHD and seizures, as well as opioid pain medications like oxycodone, methadone and other drugs that put a person at high risk for developing substance use disorder.

We're sending letters to members in mid-September to explain what they need to do. A second letter from OptumRx will follow in November.

After receiving these letters, some members may schedule appointments with their health care providers, including primary care doctors and specialists, to request new prescriptions for medications they want delivered to their homes.

New ID cards

Due to the transition to OptumRx, we'll mail about 1.8 million new ID cards to members this fall, beginning Oct. 3. Members must show their new cards at the pharmacy starting Jan. 1 in order for their prescriptions to be covered correctly under their benefits.

Electronic tools for providers

We'll provide more information later this year about electronic tools for prior authorization requests and member benefits information related to this transition.

What you need to know

- We're moving from Express Scripts, Inc. to Optum Rx as our pharmacy benefit manager and home delivery pharmacy.
- Some patients may make appointments with you this fall to get new prescriptions for medication they're filling through our home delivery pharmacy if the medications are controlled substances or if they're out of refills.
- Our members will receive new ID cards.

Pharmacy News

Quarterly update:

Requirements changed for some commercial medical benefit drugs

During April, May and June 2021, Blue Cross Blue Shield of Michigan and Blue Care Network made changes to prior authorization requirements, site-of-care requirements, or both for the following medical benefit drugs:

HCPCS code	Brand name	Generic name
J9999*	Abecma®	idecabtagene vicleucel
J3590*	Empaveli®	pegcetacoplan
Q5112	Ontruzant®	trastuzumab-dttb
Q5114	Ogivri®	trastuzumab-dkst
Q5113	Herzuma®	trastuzumab-pkrb
J9355	Herceptin®	trastuzumab
Q5108	Fulphila®	pegfilgrastim-jmdb
Q5111	Udenyca®	pegfilgrastim-cbqv
Q5120	Ziextenzo®	pegfilgrastim-bmez
J9312	Rituxan®	rituximab
Q5115	Truxima®	rituximab-abbs
J9035	Avastin®	bevacizumab
J3590*	Evkeeza™	evinacumab-dgnb
J3590*	Nulibry™	fosdenopterin

*Will become a unique code

For a detailed list of requirements, see the **Blue Cross and BCN utilization management medical drug list**. This list is available on the following pages of the **ereferrals.bcbsm.com** website:

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

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

Opioid medications will be limited to a 30-day supply, starting Sept. 1

Blue Cross Blue Shield of Michigan and Blue Care Network are changing the way we cover opioid medications in support of the Food and Drug Administration's efforts to educate patients and providers about balancing the serious risk of opioids with the drugs' pain management benefits.

Starting Sept. 1, 2021, we'll limit all supplies of opioids to a 30-day fill. This includes new prescriptions and any refills members have left on a current prescription.

We're making exceptions for members who have prescription opioids. Prescription opioids are powerful pain-reducing medications that include prescription oxycodone, Vicodin and Tylenol No. 3, among others. Members will still have access to their medication, but depending on the type of opioid prescription, they may need a new prescription.

We've sent letters to members about this change. We're also recommending they talk to their doctors about their treatment options or any concerns they may have.

We're changing how we pay for some prostate cancer drugs that must be administered by a health care provider

Starting Oct. 1, 2021, Blue Cross Blue Shield of Michigan and Blue Care Network will no longer pay for the drugs in the chart below with the patients' drug benefits.

These drugs should only be administered by a health care provider; therefore, we'll pay for them when billed under the patients' medical benefits. Our drug plans only pay for drugs that can be self-administered by the patient, per FDA-approved prescription labeling.

If a member fills a prescription for one of these drugs at a pharmacy on or after Oct. 1, 2021, he or she will be responsible for the full cost.

Drugs that will be paid for only by medical benefits starting October 1, 2021	HCPCS Code	Common use
Eligard®	J9217	Prostate cancer
Lupron Depot® 7.5mg, 22.5mg, 30mg, and 45mg	J9217	
Trelstar®	J3315	
Zoladex®	J9202	Prostate cancer, endometriosis, endometrial thinning, breast cancer

We're notifying affected members of these changes and advising them to talk with their providers about continuing to receive treatment. Providers should bill these drugs under the patient's medical benefits.

We're covering additional vaccines, effective June 14

Blue Cross Blue Shield of Michigan and Blue Care Network have added the following vaccines to our list of vaccines covered under the pharmacy benefit.

Our goal is to increase access to vaccines and decrease the risk of vaccine-preventable disease outbreaks.

Vaccine	Common name	Age requirement	Date added
MenQuadfi™	Meningococcal A, C, W and Y	None	June 14
Daptacel®	Tdap (Tetanus, diphtheria and whooping cough, also known as pertussis)	None	June 14
Infanrix®	Tdap (Tetanus, diphtheria and whooping cough, also known as pertussis)	None	June 14

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

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
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 and B	None
Gardasil®9	HPV (Human papillomavirus)	None
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
MenQuadfi™	Meningococcal A, C, W and Y	None
Ipol®	Polio	None
Pneumovax 23	Pneumonia	None

Please see Additional Vaccines, continued on Page 30

Additional Vaccines, *continued from Page 29*

Vaccine	Common name	Age requirement
Prevnar 13®	Pneumonia	None
Rotarix®	Rotavirus	None
RotaTeq®	Rotavirus	None
Shingrix®	Shingle (Zoster)	None
Boostrix®	Tdap (Tetanus, diphtheria and whooping cough, also known as pertussis)	None
Daptacel®	Tdap (Tetanus, diphtheria and whooping cough, also known as pertussis)	None
Infanrix®	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
Diphtheria 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 for a vaccine, we 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.

Rybrevant requires prior authorization for dates of service on or after Sept. 27 for most members

For dates of service on or after Sept. 27, 2021, Rybrevant™ (amivantamab-vmjw), HCPCS codes J9999, J3490, J3590 and C9399, will require prior authorization through AIM Specialty Health®. This drug is covered under the medical benefit.

Prior authorization requirements apply when this drug is administered in outpatient settings for:

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

Exceptions: This requirement doesn't apply to Michigan Education Special Services Association members or members who have coverage through the Michigan Blue Cross and Blue Shield Federal Employee Program®. This requirement also doesn't apply to UAW Retiree Medical Benefits Trust PPO non-Medicare members and other members with coverage through self-funded groups.

- 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**
- **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.

Aduhelm, Empaveli and Arcalyst require prior authorization for Medicare Advantage members

The following medications require prior authorization through the NovoLogix® online tool:

- Aduhelm™, (aducanumab), HCPCS code J3590 — for dates of service on or after June 8, 2021
- Empaveli™, (pegcetacoplan), HCPCS codes J3490, J3590 — for dates of service on or after June 14, 2021
- Arcalyst® (rilonacept), HCPCS code J2793 — for dates of service on or after Sept. 13, 2021

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

See full article on **Page 14** for details.

We're updating our policy for non-chemotherapy drug administration coding

Beginning later this year, Blue Care Network will update our policy for non-chemotherapy drug administration. We're adopting the Centers for Medicare & Medicaid Services LCD A58544 for our commercial and Medicare Advantage lines of business. Non-chemotherapy drugs should be reported with the administration CPT code *96372, not chemotherapy administration CPT code *96401.

- *96401: Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
- *96372: Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

If the following drugs are billed with a chemotherapy administration code, the administration code will be denied.

Generic name	Trade name	HCPCS code
benralizumab	Fasenra™	J0517
canakinumab	Ilaris®	J0638
certolizumab pegol	Cimzia®	J0717
denosumab	Prolia/Xygeva®	J0897
filgrastim (g-csf) excludes biosimilars	Neupogen®	J1442
tbo-filgrastim	Granix®	J1447
filgrastim-sndz biosimilar	Zarxio®	Q5101
filgrastim-aafi	Nivestym®	Q5110
luspatercept-aamt	Reblozyl®	J0896
mepolizumab	Nucala®	J2182
octreotide acetate depot	Sandotstatin LAR depot	J2353
omalizumab	Xolair®	J2357
pegfilgrastim	Neulasta®	J2505
pegfilgfrastim-jmdb, biosimilar	Fulphila®	Q5108
pegfilgrastim-cbqv	Udenyca®	Q5111
pegfilgrastim-bmez	Ziextenzo®	Q5120
pegfilgrastim-apgf, biosimilar	Nyvepri™	Q5122
rilonacept	Arcalyst®	J2793
tildrakizumab-asmn	Ilumya™	J3245

To check that you are using the correct administration code when billing non-chemotherapy drugs, see examples of correct coding provided in this CMS LCD A58544 (Complex Drug Administration Coding) billing and coding **article**:

We'll provide updates on this policy in future communications.

Sign up for webinars on risk adjustment and coding

Action item
Sign up now for live, monthly, lunchtime webinars.

We're continuing to offer lunchtime webinars that provide updated information on risk adjustment documentation and coding of common challenging diagnoses.

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
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**

You can watch previously hosted sessions on our new provider training site.

Past topics include:

- Acute conditions reported in the outpatient setting
- Morbid (severe) obesity
- Major depression
- Diabetes with complication

Access to the site will differ slightly for new and existing users.

- New users must click **here to register**.
- Existing users can follow this **link to log in**.

Once logged in, users can access the module two ways:

- Look in the course catalog under *Quality management*
- Enter 'Lunch and Learn' in the search box at the top of the screen

If you need assistance creating your login ID or navigating the site, email **ProviderTraining@bcbsm.com**.

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

Reminder: Use the correct diagnosis codes for COVID-19 testing

Here's a reminder and clarification on which diagnosis codes to use for COVID-19 testing for commercial members:

Blue Cross Blue Shield of Michigan and Blue Care Network continue to cover COVID-19 testing that is considered medically necessary by an attending health care provider.

For commercial members, when an attending health care provider administers or refers a patient for COVID-19 testing, Blue Cross and BCN assume the health care provider has determined the test to be medically necessary, unless it's coded with a noncovered diagnosis code (see below). Medical necessity is possible regardless of whether the patient is experiencing symptoms or has been exposed to COVID-19.

- For medically necessary testing (includes symptomatic testing and testing due to contact with and [suspected] exposure to COVID-19): Use Z20.822 as the primary diagnosis for dates of service on or after Jan. 1, 2021. (Use Z20.828 for dates of service on or before Dec. 31, 2020.)
- For pre-operative COVID-19 testing: Use Z01.810, Z01.811, Z01.812 or Z01.818

Blue Cross and BCN don't cover COVID-19 administrative tests that aren't medically necessary. Examples include tests that are required by an employer, school or sports team or that occur as part of a research study. Use Z11.52 or Z11.59 for coding these tests.

These diagnosis codes aren't payable for commercial members. For our Medicare Advantage plans (Medicare Plus Blue℠ and BCN Advantage℠), continue to follow Centers for Medicare & Medicaid Services guidelines.

For more information, see the **COVID-19 patient testing recommendations for physicians document** on our public website at **bcbsm.com/coronavirus** or within Provider Secured Services by clicking on *Coronavirus (COVID-19)*.

eviCore to use its clinical editing software with BCN radiation oncology claims starting fourth quarter 2021

What you need to know

- BCN commercial and BCN Advantage radiation oncology claims will be subject to clinical editing through eviCore's Claims Studio program. Currently, they're subject to clinical editing carried out by Blue Care Network.
- To increase the chances that your radiation oncology claims will be payable after the Claims Studio clinical editing, we encourage you to review the eviCore documents linked in the article.

Starting sometime in the fourth quarter of 2021, eviCore healthcare® will use its Claims Studio℠ clinical editing software for radiation oncology claims for BCN commercial and BCN Advantage℠ members.

Claims Studio is eviCore's proprietary claims editing program. The claims are reviewed before payment and correct-coding edits are applied using guidelines from the American Society for Radiation Oncology, or ASTRO, and the Centers for Medicare & Medicaid Services.

You may already be familiar with eviCore's clinical editing program. It's been used with radiation oncology claims for Blue Cross Blue Shield of Michigan commercial fully insured members and Medicare Plus Blue℠ members for the last few years.

What will change

Here's what will change starting later this year:

- BCN commercial and BCN Advantage radiation oncology claims will be subject to clinical editing through eviCore's Claims Studio program. Currently, they're subject to clinical editing carried out by Blue Care Network.
- We'll update the *BCN Provider Manual* to reflect this change.
- We'll update the list of radiation oncology procedure codes for which eviCore manages authorizations. You can access that list on BCN's **eviCore-Managed Procedures** page on our **ereferrals.bcbsm.com** website. Scroll down and click ***Procedures that require authorization by eviCore healthcare***.

What won't change

You'll still submit your radiation oncology claims to BCN.

Review eviCore documents

To increase the chances that your radiation oncology claims will be payable after the Claims Studio clinical editing, we encourage you to review these eviCore documents:

- **Coding guidelines for radiation oncology**
- **Clinical guidelines for radiation oncology**

For more information about the radiation oncology and other services managed by eviCore for BCN, refer to BCN's **eviCore-Managed Procedures** page on our **ereferrals.bcbsm.com** website.

On that page, you'll find a link to the document ***Requesting authorizations from eviCore: Frequently asked questions for providers***.

CareCentrix to manage network for independent home infusion therapy and ambulatory infusion suite providers, starting Jan. 1

Effective Jan. 1, 2022, Blue Cross Blue Shield of Michigan and Blue Care Network will delegate management of the in-state independent home infusion therapy and ambulatory infusion suite provider network to CareCentrix® for commercial members. (AISs are a subset of ambulatory infusion centers.)

This change won't affect hospital-owned HIT or AIS providers or members with Medicare Plus Blue℠ or BCN Advantage℠ plans.

CareCentrix is a leader in managing infusion therapy services through a national network of more than 800 HIT and AIS providers. We expect the transition to CareCentrix to improve member care through better management of HIT and AIS services.

Here's what you need to do

1. **If you aren't already contracted with CareCentrix, contract with them as soon as possible and prior to Jan. 1, 2022.** This will allow you to continue to provide in-network services to Blue Cross commercial and BCN commercial members. You'll receive a letter from CareCentrix that outlines the steps you'll need to take.

   If you're already contracted with CareCentrix, you don't need to do anything. Your CareCentrix contract manager will reach out to you to discuss this change.

2. **For services provided in Michigan to Blue Cross commercial and BCN commercial members on or after Jan. 1, 2022, independent HIT and AIS providers who are contracted with CareCentrix must bill CareCentrix.** Don't bill Blue Cross or BCN for HIT or AIS services; Blue Cross and BCN will reject these claims with a message to bill CareCentrix.

What you need to know

- You need to contract with CareCentrix before Jan. 1, 2022, to continue providing HIT or AIS services to commercial Blue Cross and BCN members.
- To learn more, see the document titled *Home infusion therapy and ambulatory infusion suite provider network management: Frequently asked questions*. There's a link to this document at the bottom of this article

Note: Independent HIT and AIS providers can continue to bill Blue Cross and BCN for services provided to Medicare Advantage members and for other services, such as providing durable medical equipment and supplies. These services aren't affected by this change.

We'll end-date all Blue Cross and BCN independent HIT and AIS contracts for commercial coverage, effective Dec. 31, 2021.

Who is affected by this change

This change applies to independent HIT and AIS providers who:

- Participate with Blue Cross and BCN
- Aren't owned by a hospital system
- Provide home infusion services to Blue Cross and BCN commercial members in Michigan

This change doesn't apply to hospital-owned HIT and AIS providers.

We'll notify all non-hospital-owned HIT and AIS providers of this change by mail. We'll also send letters to members who may be affected by this change, and we'll work with CareCentrix to ensure that there are no gaps in care.

Questions?

To learn more, see the document titled ***Home infusion therapy and ambulatory infusion suite provider network management: Frequently asked questions***.

If you have questions about provider contracting, email CareCentrix at **homeinfusion@carecentrix.com**.

Billing Bulletin

Providers may only bill members for applicable deductibles and copayments

We want to reminder providers that you must bill Blue Cross Blue Shield of Michigan and Blue Care Network for all covered services and may only bill members for applicable deductibles and copayments. In keeping with provider contracts, you may not collect deposits or bill members upfront for unpaid balances of covered services.

The following guidance comes from the Member Eligibility chapter of the *BCN Provider Manual*,

- *For office and outpatient or ancillary services:* When the member's benefit includes a copayment, providers should collect the copayment from the member at the time of service.
- *For all services:* When the member's benefit includes a deductible, coinsurance or out-of-pocket maximum dollar limit, providers may collect amounts that members owe at the time medical care is provided.

Providers also have the option to wait until they receive the Remittance Advice before they collect from the member. The Remittance Advice shows the provider what the member owes; it also shows whether the member has satisfied the out-of-pocket maximum for that plan year and is not currently responsible for a deductible, copayment or coinsurance. Waiting for the Remittance Advice can help avoid situations in which providers are later required to reimburse members.

We encourage you to use web-DENIS to check the member's remaining deductible, coinsurance maximum or out-of-pocket maximum amounts. The amounts on web-DENIS may vary from the amount shown on the Remittance Advice if additional claims are processed before the provider's claim shown on the Remittance Advice.

As a reminder, contracted providers may not bill members for unpaid balances of a covered service beyond the member's deductible, copayment or coinsurance.

Billing Bulletin

Facility charges for daily respiratory therapy services will be prorated

Blue Cross Blue Shield of Michigan and Blue Care Network are prorating daily respiratory therapy services by hours used, not to exceed 24 hours in a single day. We communicated this in a January 2021 ***Record* article** titled, "Facilities required to prorate respiratory therapy services."

Providers have told us that they're unable to bill respiratory therapy on an hourly basis. Therefore, we will manually prorate the service and won't reimburse the full charge.

This reimbursement policy is effective Jan. 1, 2021, for Blue Cross commercial, Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ members. It applies to an inpatient setting only.

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

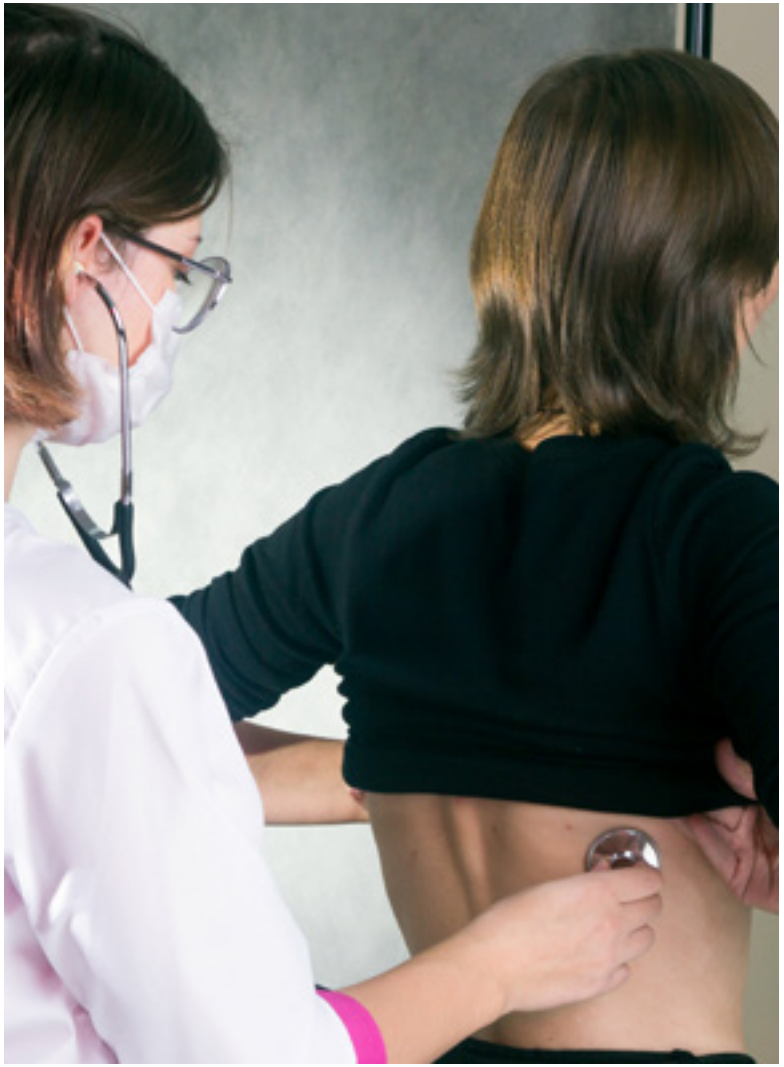
- All types of ventilators
- Continuous Positive Airway Pressure, or CPAP
- Bilevel Positive Airway Pressure, or BIPAP
- All types of oxygen

Billing guidance

If, 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 of the day, Blue Cross and BCN will only provide reimbursement for those hours used for each modality. Currently, services are billed at a daily rate, regardless of hours used.

Background

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



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:

- Clinical editing resources

Clinical editing billing tips

We've updated questionnaires in the e-referral system

On June 27, 2021, we updated the following questionnaires in the e-referral system:

- *Artificial heart, total questionnaire* — For adult and pediatric Blue Care Network commercial members. This questionnaire will no longer open for procedure code *33929. It now opens for procedure code *33995 and continues to open for other codes listed in the **Artificial heart**, total preview questionnaire.
- *Hammertoe correction surgery* — For adult Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ members. This questionnaire will no longer open for procedure code *28160. It will continue to open for the other procedure codes listed in the **Hammertoe correction surgery** preview questionnaire.
- *Pediatric feeding* — For BCN commercial members ages 18 and younger.

We also updated the corresponding preview questionnaires and authorization criteria on the **ereferrals.bcbsm.com** website.

As a reminder, 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.

Preview questionnaires

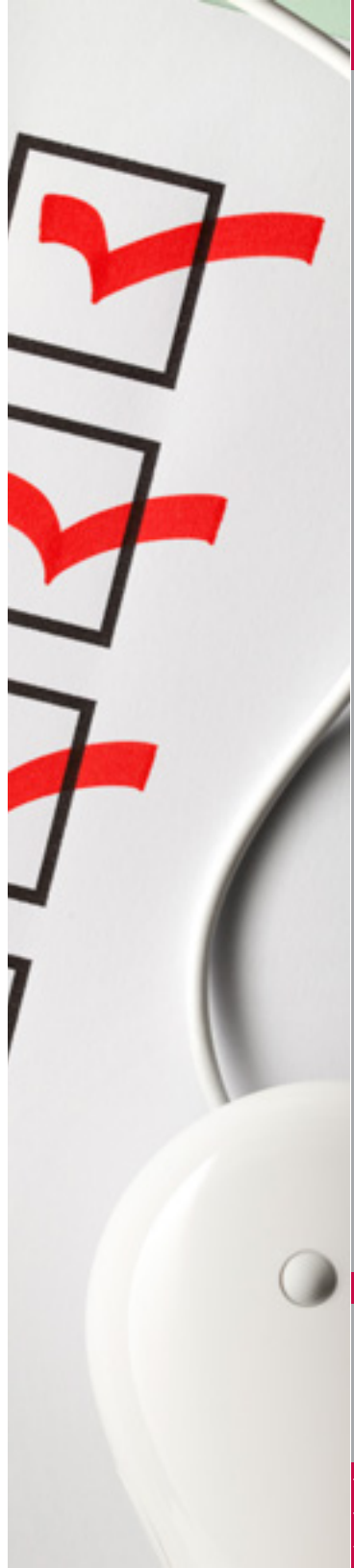
You can access preview questionnaires at **ereferrals.bcbsm.com**. They show the questions you'll need to answer to help you prepare your answers ahead of time.

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 members" section, look under the "Authorization criteria and preview questionnaires — Medicare Plus Blue" heading.

Authorization criteria and medical policies

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



We've updated pain management questionnaires and *Postservice change request form* for TurningPoint

Blue Cross Blue Shield of Michigan, Blue Care Network and TurningPoint Health Care Solutions LLC continue to identify ways to enhance your experience with the TurningPoint surgical quality and safety management program.

We've added the following enhancements in July:

- **For pain management procedures:** We've updated the questionnaires you complete when you request authorizations.
- **For all orthopedic, pain management and spinal procedures:** We've updated the *Postservice change request form*.

The updated forms are available on the **ereferrals.bcbsm.com** website.

Pain management questionnaires

To simplify the process for submitting prior authorization requests, we've updated most questions on the following questionnaires to require a "yes" or "no" response:

- Epidural steroid injections
- Facet joint injections
- Neuroablation procedures
- Sacroiliac joint injections

These questions appear on the questionnaires in the TurningPoint provider portal and in the fax forms for submitting prior authorization requests.

Postservice change request form

We've updated the *Postservice change request* fax form as follows:

- Added information about procedure code substitutions to help you identify situations where you can substitute a different procedure code for the procedure code TurningPoint authorized
- Added the following questions:
  - "Have you submitted a claim to Blue Cross or BCN?"
  - "Have you submitted an appeal to Blue Cross or BCN?"

Your answers to these questions will streamline the steps required to process postservice change requests.

Where to find fax forms for the TurningPoint program

You can find all fax forms for the TurningPoint program on the following pages of the **ereferrals.bcbsm.com** website, along with other resources:

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

Please see Pain Management Questionaires continued on Page 41

Pain Management Questionaires, *continued from Page 40*

Information about previous enhancements to this program

To view other enhancements to the TurningPoint program, see:

- The article titled **We're enhancing TurningPoint surgical quality and safety management program to improve your experience** in the July-Aug 2021 issue of *BCN Provider News*.

We also published this information in the July 2021 issue of *The Record*.

- The Provider Alert titled **Additional enhancements to the TurningPoint musculoskeletal surgical quality and safety management program**

Additional information

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**.

Changes to TurningPoint medical policies for some pain management procedures

As of May 25, 2021, TurningPoint updated pain management medical policies to align more closely with Centers for Medicare & Medicaid Services guidelines. Pain management medical policies have been updated as follows.

Note: TurningPoint applies CMS local and national coverage determination guidelines for Medicare Plus Blue℠ and BCN Advantage℠ members. For more information about the criteria TurningPoint uses to make determinations on authorization requests for pain management procedures for all members, see this news item on the ereferrals. bcbsm.com website.

Frequency of sessions allowed for Zepidural steroid injections

Previous policy	Updated policy
Allowed a total of 3 ESI injection sessions in a 6-month period **regardless of region** (cervical / thoracic or lumbar)	Allows 3 injection sessions in a 6-month period **per episode of pain per region** (cervical / thoracic or lumbar)

Number of levels allowed per session for epidural steroid injections

Previous policy	Updated policy
Allowed one ESI level regardless of type	Number of levels allowed depends on type: • One level is allowed for caudal, interlaminar or bilateral transforaminal • Two levels are allowed for unilateral transforaminal

Time frame requirements for conservative treatments

Previous policy	Updated policy
Required 6 weeks of conservative treatment for epidural steroid injections, facet joint injections and sacroiliac joint injections	Requires only 4 weeks of conservative treatment for epidural steroid injections, facet joint injections and sacroiliac joint injections

We're removing prior authorization requirements for select procedures

For dates of service on or after July 1, 2021, we won't require prior authorization for the following procedure codes for refilling and recharging pain pumps: *62367, *62368, *62369 and *62370.

Home health care: Helpful tips for adding disciplines and substituting services provided by clinicians with lower-level credentials

CareCentrix has managed authorizations for home health care services for Medicare Plus Blue℠ and BCN Advantage℠ members since June 1, 2021.

See the full article on **Page 15** to learn when you can substitute services provided by clinicians with lower-level credentials and when you need authorization request for additional disciplines that haven't been authorized by CareCentrix®

Clarification: We started pending some authorization requests, starting July 25

We ran an article in the May-June 2021 issue of *BCN Provider News*, titled *"Starting in June, we'll use clinical information to validate providers' answers to some questionnaires in the e-referral system."*

The effective date has changed to July 25. On that date, we started pending some authorization requests that would usually be auto-approved based on your answers to the questionnaires in the e-referral system. This allows us to validate the answers you provided on the questionnaire

Review the original **article** for details.

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Starting sometime in the fourth quarter of 2021, eviCore healthcare® will use its Claims Studio℠ clinical editing software for radiation oncology claims for BCN commercial and BCN Advantage℠ members.

Claims Studio is eviCore's proprietary claims editing program. The claims are reviewed before payment and correct-coding edits are applied using guidelines from the American Society for Radiation Oncology, or ASTRO, and the Centers for Medicare & Medicaid Services.

For details, see the full article on **Page 35**.

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