NOVEMBER-DECEMBER 2021

BCN Provider News

BCN Provider News User Guide

We're moving to Availity in 2022

We're excited to share the timeline for our transition to the Availity® provider portal. Here are the main dates:

★ PROVIDER PILOTS → ★ CURRENT AVAILITY USERS → ★ OPEN TO NEW AVAILITY USERS → ★ WEB-DENIS ACCESS ENDS

December 2021
We'll test our Availity applications with a group of preselected providers who are familiar with Availity and have agreed to help us make sure everything is functioning as expected.

March 2022
Blue Cross Blue Shield of Michigan and Blue Care Network information will be available for use by providers who are already registered with Availity.

April 2022
Providers who currently use our Provider Secured Services (web-DENIS) system and are not registered with Availity will be asked to register for access and begin using Availity.

June 2022
Access to the Blue Cross Blue Shield of Michigan and Blue Care Network Provider Secured Services (web-DENIS) website will end.

Don't worry. We'll share more information with you along the way, and there will be plenty of opportunities for training when it's your turn to make the move to Availity. In the meantime, we're working to ensure that the move to Availity provides you with the features you want and the accuracy and dependability you're used to.

Questions?

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

Feedback | Subscribe

Inside this issue…

Get ready for Availity — Browser needs

Take a look at the internet browser you're using in preparation for moving to the Availity® provider portal in the coming months. Since we shared technical requirements with you in the January-February 2021 issue of ***BCN Provider News***, there has been a change. Availity no longer supports Internet Explorer 11. If you're using Internet Explorer now, you need to switch to a new browser. If you don't, your experience on Availity will be affected.

The preferred browser for Availity is Google Chrome, but Microsoft Edge (version 79 or higher) and Firefox® are also acceptable. You can download **Google Chrome** for free.

For more information on Availity technical requirements, go to the **Availity website**. Scroll down and click on the *Requirements* tab.

Previous articles about Availity

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

- New, secure provider website coming in 2021 (September-October 2020 **issue**)
- Availity multi-payer provider portal brings advantages to providers (November-December 2020 **issue**)
- After moving to Availity in 2021, many of our current online tools will still be available (November-December 2020 **issue**)
- Get ready for Availity — How to select an administrator (January-February 2021 **issue**)
- Get ready for Availity — Technical requirements (January-February 2021 **issue**)
- Availity will bring new online search and favoriting capabilities (March-April 2021 **issue**)
- The move to Availity expected in late 2021 or early 2022 (May-June 2021 **issue**)

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Network Operations

We're introducing Blue Elect Plus HSA plan in January

Providers may see patients in our new Blue Elect Plus HSA℠ POS plan starting January 2022.

The plan has the same features as BCN's Blue Elect Plus℠ POS, except that it's an HSA-qualified high deductible health plan.

Blue Elect Plus HSA is a point-of-service plan and doesn't require referrals to see a specialist, either in or out of network. The ID card prefix is the same prefix that's on the ID card for HMO coverage. But the plastic ID card specifically indicates "POS" as the plan type. In addition, language on the back of the member ID card notes that referrals aren't required for Blue Elect Plus.

For both Blue Elect Plus plans, some services, including most preventive care, are only covered when received from an in-network provider. Providers should also be aware that some services require prior approval. See the Blue Elect Plus page of **ereferrals.bcbsm.com** for more information or watch our Blue Elect Plus **video**.

Changes to the provider search tool will allow Blue Elect Plus POS and Blue Elect Plus HSA POS members to find out-of-state providers, since both plans can be sold to Michigan employers with out-of-state employees.

As always, we encourage you to use web-DENIS to check the member's cost share along with 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.

Direct reimbursement available to genetic counselors, effective Jan. 1, 2022

Genetic counselors have the opportunity to participate in Blue Cross Blue Shield of Michigan's Traditional and TRUST PPO networks, and BCN commercial, effective Jan. 1, 2022.

Participating genetic counselors can bill their professional services using codes *96040 and S0265. They can receive direct reimbursement for covered services within the scope of their licensure at 85% of the applicable fee schedule, minus any member deductibles and copayments.

This change, effective for outpatient services provided on or after Jan. 1, applies to Blue Cross and BCN benefit plans that cover services that these providers are licensed to provide. To find out if a member has coverage, check web-DENIS for member benefits and eligibility or call Provider Inquiry at 1-800-344-8525.

Requirements

Prior authorization is not required for genetic counseling services for any member. For BCN commercial members who have a primary care physician that is part of a medical care group based in the East or Southeast region, their primary care provider must submit a referral for a specialist office visit. Referrals are not required for other members.

Enrollment forms

Genetic counselors can find enrollment forms and practitioner agreements on **bcbsm.com/providers**. To find enrollment information, click on *Enroll to become a provider*. Specific qualification requirements are identified within each agreement.

All applicants must pass a credentialing review before participation. We'll notify applicants in writing of their approval status.

What genetic counselors do

Genetic counselors obtain and evaluate individual, family and medical histories to determine the risk for genetic or medical conditions or diseases in a member, the member's descendants or other family members. Genetic counselors explain to the member the clinical implications of genetic laboratory tests and other diagnostic studies and their results.

Medical policy

Refer to the Blue Cross/BCN medical policy titled **Genetic Testing and Counseling** for additional information.

Online Training

ACTION ITEM

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

New on-demand training available

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

Our newest resources include:

- ***AIM Preauthorization Program Overview*** — This updated video gives an overview of the Blue Cross Blue Shield of Michigan and Blue Care Network preauthorization program managed by AIM Specialty Health®.
- ***Blue Care Network PCP Orientation*** — This recorded webinar provides fundamental knowledge for new BCN primary care providers and staff. Topics include roles and responsibilities, referrals and online tools.
- ***Medicare Advantage risk adjustment program*** — These training modules focus on topics that include clinical criteria, medical documentation and coding guidelines. The first three modules are *Commercial CDI alert, Major depressive disorder* and *Telehealth and telemedicine visits*.
- ***CMS Star Measures Overview*** — This video course discusses closing gaps and the importance of creating positive patient experiences. This activity has been approved for AMA PRA Category 1 Credit™. Licensed doctors and nurses interested in earning credit must complete all 13 lesson modules **and** submit a course evaluation.
- ***2021 lunch and learn webinar recordings*** — *Chronic kidney disease* is the newest topic added to the series that focuses on risk adjustment documentation and coding of common challenging diagnoses.

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

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, please contact ProviderTraining@bcbsm.com.

Our care management program now called Blue Cross Coordinated Care Core

Our care management program, previously called Blue Cross Coordinated Care, is now called Blue Cross Coordinated Care Core℠. It's part of a broader portfolio of health care solutions. To read more about it and to find out how it can offer support to patients and health care providers, see the **September *Record* article**.

Audit vendor, HMS, launches new provider portal called HMS Portal

Our audit vendor, Health Management Systems, or HMS, launched an updated provider portal in August called HMS Portal. It replaced the portal providers had been using for their audit activity. HMS is an independent company working for Blue Cross Blue Shield of Michigan and Blue Care Network.

Providers don't need to register for the new portal

Providers, hospitals and facilities with provider portal accounts won't have to register for the new portal. Their access has been migrated to HMS Portal automatically. They can use the same user ID and password to access the new portal.

Not registered for the provider portal?

Providers, hospitals and facilities involved in HMS audits who don't have provider portal accounts can register for an HMS Portal account now. Here's how:

- Go to **https://hmsportal.hms.com/registration**
- Click "Register" in the Provider box

All communication with HMS regarding audits will go through the new portal, but providers will still receive audit information through the mail as a secondary form of reporting notification.

Some features of HMS Portal:

- Reduces administrative efforts
- Displays real-time audit status and reporting
- Manages multiple addresses
- Provides a self-disclosure application
- Allows users to:
  - Update contact information
  - Upload documents for review

Training

Providers can access and download documents needed for training staff on using the new portal at **hms-portal-user-guide-provider-portal**.

Questions?

HMS is available for you during any step of the process. Feel free to call your HMS Provider Relations team at **1-866-875-1749**.

We've made improvements to the *BCN Provider Manual*

If you've noticed some differences in the *BCN Provider Manual* chapters over the last few weeks, you weren't imagining things! We redesigned the chapters so they'd be easier for you to use.

The features that are new

The chapters have some new features, including:

- A more comprehensive table of contents, including titles for both sections and subsections. This should make it easier for you to find the topic you're looking for. You can still click each entry to go right to the information you need.
- An indication of which products are covered in the manual: BCN commercial and BCN Advantage. Look for this at the top of the first page of each chapter and in the footer at the bottom of each page.

The features we kept

We kept some things that have proven useful over the years, including:

- Section headings and subsection titles, to help organize the information
- Links to other documents that provide more detail
- Updates marked with blue dots and explanations of what changed
- The date each chapter was last revised, in the lower right corner of each page

Other provider manuals

The *BCN Provider Manual* is the first one to be redesigned, but the other Blue Cross manuals will follow. These include the *Blue Cross PPO (commercial) Provider Manual* and the *Medicare Plus Blue PPO Manual*.

When they're done, all the manuals will have a similar look, but each will have a different color theme and a distinguishing image on the opening page of each chapter.

What the manual is for

The *BCN Provider Manual* is intended to make it easier for you to do business with us. The manual describes BCN's products, both BCN commercial and BCN Advantage. It also offers information about BCN's operating structure, policies and procedures. The manual provides guidelines to help you serve BCN members.

Where to access the manual

To access the entire manual, log in to Provider Secured Services as a provider, click *Provider Manuals* (on the right) and then click *BCN Provider Manual*. You'll find a link to each manual chapter.

You can also click *BCN Provider Manual – Entire Manual for Searching* to open all the chapters in one document. This is especially useful when you're for searching for a particular topic and aren't sure which chapter it's in or want to make sure you find all references to that topic. Remember, you can use Ctrl+F to search.

EquiClaim will conduct commercial DRG audits for Blue Cross and BCN

EquiClaim, a company that provides audit recovery services, will provide auditing support for Blue Cross Blue Shield of Michigan and Blue Care Network, beginning in November.

The audits will:

- Focus on DRG coding validation
- Review data going back one year
- Base the look-back date on the date the claim was paid
- Require providers to submit medical charts

The company will review medical records to ensure that claims were paid accurately and to detect and correct fraud, waste or abuse.

You'll need to provide medical charts for review at the time of an audit. After an audit, EquiClaim will send you a letter with the findings and information on how to request an appeal.

Contact EquiClaim Customer Service at 1-866-481-1479 if you have any questions or need to request an extension.

Network Operations

Confirm your provider directory information in CAQH

Have you attested in CAQH within the past 90 days? Did you know that if you don't re-attest with CAQH every 90 days, you won't be included in our provider directories, including our *Find a Doctor* search tool? That's one of the main reasons it's so important to take the time to perform this task.

Here are some other reasons to re-attest with CAQH, a nonprofit alliance of health plans and trade associations focused on simplifying health care administration:

- To ensure that your affiliations with Blue Cross Blue Shield of Michigan and Blue Care Network aren't interrupted
- To update your CAQH information if you change your practice location
- To ensure that claims payment isn't interrupted

Regardless of whether you're practicing at an office location or exclusively in an inpatient hospital setting, practitioners need to perform this attestation every 90 days. If you're practicing exclusively in an inpatient hospital setting, be sure you have indicated this on your CAQH application; this information is used to determine whether full credentialing is required.

Blue Cross and BCN use CAQH to gather and coordinate our practitioner credentialing information. All health care practitioners, including hospital-based health care providers and nurse practitioners, need to be registered with CAQH.

If you have any questions about CAQH, call the CAQH help desk at 1-888-599-1771 or go to **CAQH.org**.

Share your opinions with Blue Cross and BCN

Blue Cross Blue Shield of Michigan and Blue Care Network would like to hear from physicians and office staff about experiences and interactions with us. We strive to make doing business with us easy and we're asking providers for feedback on our efforts.

Randomly selected physicians and office staff will be invited to take the survey in October and November 2021. We'll use the results to identify areas for improvement. An independent research firm is conducting the research on our behalf and individual responses will be confidential.

Stay up to date on all opportunities to give feedback at the new "Share your opinion with Blue Cross and BCN" webpage. On that page, you'll find current opportunities to share your opinions with us on various topics. To find the webpage:

- Log in to Provider Secured Services.
- Go to either *BCN Provider Publications and Resources* or *BCBSM Provider Publications and Resources* and click on *BCBSM Newsletters & Resources*.

BCN Advantage

What are Medicare star ratings and why do they matter?

You may have read about Medicare star ratings in our provider-facing newsletters, and perhaps you've wondered: What exactly are star ratings and why do they matter to Blue Cross Blue Shield of Michigan and health care providers?

Let's take a look at how star ratings affect three stakeholders: patients, providers and health plans.

Medicare star ratings is a rating system developed by the Centers for Medicare & Medicaid Services to help consumers find the best Medicare Advantage plan for them. Blue Cross Blue Shield of Michigan has two MA plans – Medicare Plus Blue℠ for its PPO members and BCN Advantage℠, for its HMO members.

We want consumers who are shopping for an MA plan to choose one of ours. What's more, higher star ratings lead to increased reimbursement from CMS that go directly into providing more affordable Medicare Advantage plans.

CMS determines its performance ratings by looking at multiple measures that include clinical quality and operational measures, as well as patient experience, as determined by patient survey results. They convert the performance into 1 to 5 stars, with 5 stars indicating the highest possible performance.

Achieving a 5-star rating is clearly a challenge for everyone to work more closely together, including doctors, hospitals and Blue Cross.

CMS assesses a member's health plan experience through the Consumer Assessment of Healthcare Providers and Systems, or CAHPS, member survey. The survey asks patients to report on their experiences with a wide range of health care services. A large portion of the CAHPS survey is driven by the member's experience with his or her physician's team, including such things as follow-up on labs and imaging, and getting timely doctor appointments.

Patient experience: A key driver of star ratings

CMS recently increased the weight allotted to patient experience when determining star ratings, making CAHPS performance the key driver of overall ratings. Similar to how providers and hospitals (through Hospital CAHPS) are being asked by CMS to provide an improved patient experience, health plans, such as Blue Cross Blue Shield of Michigan, are being asked the same.

We believe that a person who has a good experience with their health care provider and their health plan is more likely to follow up with their doctor to further improve their health and take their medications as prescribed. This allows for greater ease in closing multiple clinical gaps in care.

From a provider perspective, research supports this belief. 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, improving patient compliance and reducing staff turnover.

And, most importantly for patients, a positive patient experience results in better adherence to protocol, better relationships with health care providers and a feeling of mutual respect between them and their medical team.

Improving the patient experience: A team effort

Blue Cross continues to center its efforts on improving consumer experiences, specifically related to the questions about health plan interactions on the survey. And with CAHPS measuring the patient experience across the continuum of care, the survey provides insight into how our provider partners can affect the health of patients and how they assess their overall health care experience.

Please see Medicare star ratings continued on Page 9

BCN Advantage

Medicare star ratings, *continued from Page 8*

The entire team at a doctor's office can affect the health of patients and how they assess their health care experience.

(See the **article** in the September-October *BCN Provider News* for tips on improving the patient experience.)

What we're doing to help

To assist you in improving our Medicare star ratings, we've implemented a series of initiatives:

- We provide skilled Patient Experience coaches (at no cost to you) to help offices improve their patient experience and train staff on providing excellent service to patients.
  - For example, we provide office staff training sessions on the attributes of good service, facilitate patient experience working sessions and provide tips and materials for implementing best practice ideas. For more details, see this **article** that ran in the *Value Partnerships Update* earlier this year.
- We also provide training to offices on improving the patient experience and how to close gaps related to Medicare star ratings.
  - For example, we recently launched an eLearning video series on Medicare star ratings that you may have read about in a September-October *BCN Provider News* **article**.
- We've put together a series of more than a dozen tip sheets called Star Measure Tips. They highlight what you can do to meet the various clinical quality measures, ranging from breast cancer screening to transitions of care. You can access them through Provider Secured Services by following these steps:
  - Log in to Provider Secured Services.
  - Go to *BCBSM Provider Publications and Resources*, then on *Newsletters and Resources*.
  - Click on *Clinical Quality Corner* and scroll down to see the Star Measure Tip Sheets.

By focusing on CMS' clinical quality measures and the patient experience, you can help make sure that people get the quality care they need when and how they need it.

We're offering the same BCN Advantage plans in 2022 with minor enhancements

BCN Advantage℠ is offering the same plans in 2022 that we offered last year with some improvements to provide value to members.

- All BCN Advantage plans will include caregiver support and we're extending that benefit to members with Alzheimer's disease and dementia. Caregiver support includes digital-based support for caregivers. Members are required to be enrolled in a care management program. The program aims to reduce emergency room visits and decrease hospitalization.
- We've reauthorized our vendor to provide over-the-counter advantage dollars and food benefits. Every BCN Advantage individual plan offers a quarterly allowance for members to purchase certain over-the-counter and grocery items. Amounts may differ based on plan and region.
- For BCN Advantage℠ HMO-POS Prime Value and BCN Advantage℠ HMO-POS Community Value, we're continuing to have a vendor administer the in-home support benefit. Eligible members will continue to receive either four or eight hours per month in-home or virtual services, including companionship, house help, meal preparation and transportation.

Remember to check eligibility and benefits when you see patients, starting in January. Some patients may have changed their coverage during open enrollment.

BCN Advantage℠ HMO-POS Elements
BCN Advantage℠ HMO-POS Classic
BCN Advantage℠ HMO-POS Prestige
BCN Advantage℠ HMO ConnectedCare
BCN Advantage℠ HMO-POS Prime Value
BCN Advantage℠ HMO-POS Community Value

Nonclinical, transitional care program to reduce readmissions for Medicare Advantage members

Blue Cross Blue Shield of Michigan and Blue Care Network are contracting with naviHealth to reduce avoidable inpatient readmissions through a nonclinical, transitional care program.

This program will be available to Medicare Plus Blue℠ and BCN Advantage℠ members who are discharged from inpatient facilities in Michigan and will be implemented in two phases:

- On Nov. 1, 2021, the program starts for Medicare Advantage members who are discharged to certain post-acute care facilities in Southeast Michigan. (We piloted this program starting in April 2021, as communicated in the May– June 2021 issue of *BCN Provider News.*

  Note: To learn which post-acute care facilities are included in this program, email Lana Davis at ldavis8@bcbsm.com.
- On Feb. 1, 2022, the program starts for Medicare Advantage members who are discharged directly to their homes.

naviHealth staff will support these members as they transition out of inpatient facilities. These efforts will extend for up to 30 days after members are discharged. With each interaction, naviHealth staff members will introduce themselves to the member, using their name and licensure (if applicable) and the naviHealth name.

What happens before discharge from an inpatient facility

naviHealth navigation specialists will work with members before discharge from an inpatient facility to:

- Discuss the member's current health and whether the member feels they're ready to be discharged
- Identify social determinants of health through naviHealth's proprietary technology
- Address barriers to continuity of care

The navigation specialists will share this information with the naviHealth patient navigator assigned to the member for post-discharge care.

After members leave inpatient facilities

naviHealth patient navigators will work with members after discharge from inpatient facilities to:

- Review members' discharge needs
- Educate members to achieve better outcomes based on the discharge plan
- Create a plan to address any health barriers members may be facing
- Help members overcome barriers that were identified before discharge (may include scheduling appointments, coordinating care or connecting members to community resources to address social determinants of health)
- Assist members with medication adherence

If the patient navigator has concerns about a member, he or she may reach out to the member's provider.

Note: Patient navigators are commonly known as community health workers. These naviHealth staff members are trusted, knowledgeable frontline personnel who typically reside in or near the communities they serve.

Additional information

For more information about this program, see the **Readmissions Reduction page** on naviHealth's website.

CareCentrix home health care program: Updated training resources, new and updated documents available

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

Where to find CareCentrix home health care resources:

You can find the training resources and links to the documents related to this program on the following pages of the **ereferrals.bcbsm.com** website:

- **Blue Cross Home Health Care**
- **BCN Home Health Care**

More about the updated training resources

Based on provider feedback, we updated the webinar recording and the PDF of the webinar presentation. These updated resources are available on our dedicated provider training site.

For information about accessing this site, see the webpages that are linked above.

More about the new and updated documents

We added these documents:

- *Home health care: Clinical documentation requirements*
- *Home health care: Submitting authorization requests to CareCentrix*
- *Home health care: Linking your agency's NPI(s) and TIN(s)*

We clarified and added information in these documents:

- *Home health care: Frequently asked questions for providers*
- *Home health care: Quick reference guide*

BCN Advantage

Remind your eligible patients to get regular mammograms

One in eight women in the United States will be diagnosed with invasive breast cancer in her lifetime, according to the American Cancer Society. You play an integral role in early detection by recommending regular screenings to your patients. Early detection through regular screening is key to a better outcome for your patients.

The Breast Cancer Screening, or BCS, HEDIS® measure (also a Medicare star ratings measure) assesses female patients ages 52 to 74 who had a mammogram to screen for breast cancer within the past two years. Specifically, we look at those who had a mammogram two years prior to a date that falls within the measurement year of Oct. 1 through Dec. 31.

The National Committee for Quality Assurance now allows patients to be excluded from the measure due to advanced illness and frailty. They acknowledge that measured services most likely would not benefit patients who are in declining health.

Read the *Breast cancer screening tip sheet* to learn more about this measure, including information to include in medical records, codes to include on patient claims to exclude for mastectomy and tips for talking with patients.

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

Breast cancer screening tip sheet

Manage osteoporosis to limit disability

Musculoskeletal conditions are the second largest contributor to disability, according to the World Health Organization.

The Osteoporosis Management in Women who had a Fracture, or OMW, HEDIS® star measure assesses women 67 to 85 years of age who suffered a fracture and had either a bone mineral density test or received a prescription to treat osteoporosis within six months of the fracture.

Read the *Osteoporosis Management in Women who had a Fracture tip sheet* to learn more about this measure, information to include in medical records and ICD-10 codes to include on patient claims.

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

Osteoporosis Management in Women who had a Fracture tip sheet

Saphnelo and Nexviazyme require prior authorization for Medicare Advantage members

The following drugs require prior authorization through the NovoLogix® online tool for dates of service on or after Sept. 1, 2021:

- Saphnelo™ (anifrolumab-fnia), HCPCS code J3590
- Nexviazyme™ (avalglucosidase alfa-ngpt), HCPCS code J3590

This requirement 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 drugs.

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.

List of requirements

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

We're waiving cost share for certain drugs for BCN Advantage Prestige members

We're continuing a program in 2022 to waive cost sharing for certain drugs for eligible members in the BCN Advantage℠ HMO-POS Prestige plan who have been diagnosed with coronary artery disease or congestive heart failure.

The initiative is part of a five-year Value-Based Insurance Design program pilot through the Centers for Medicare & Medicaid Services. For coronary artery disease, we're waiving the cost share for four drug classes: antiplatelet drugs, statins, ACE/ARBs and beta-blockers for members diagnosed under one of 59 ICD-10 codes.

For congestive heart failure, we're waiving the cost share for these drug classes: ACE/ARBs, beta-blockers, diuretics, vasodilators and some other drugs for members diagnosed under one of 24 ICD-10 codes.

We'll identify members for the program based on diagnosis and mail a letter informing members that we've enrolled them in VBID and a care management program. Members can opt out of care management, but they'll still receive their eligible prescriptions with no cost share.

Advanced care planning

We'll also continue to include the Welvie℠ advanced care planning program for 2022 for all members enrolled in BCN Advantage Prestige HMO-POS. Prestige members who complete an advanced directive through the online program will receive a $25 gift card. Members can give their completed directives to their health care providers to add to their medical records.

Lessons learned from Mi-COVID19 Initiative

Our Collaborative Quality Initiative structure has helped hospitals statewide collect meaningful patient data and share information on COVID-19 treatment protocols. These protocols have helped influence care and treatment statewide. This article contains some of our most recent data and findings.

The Mi-COVID19 Initiative, a joint CQI across numerous Blue Cross quality initiatives, has played a key role in Michigan's response to the pandemic.

"This has been a journey that we have taken together over the last year," said Scott Flanders, M.D., the initiative's program director and chief clinical strategy officer at Michigan Medicine. "A large group of health professionals shared crucial information, which significantly improved the outcomes of our patients here in Michigan."

Data collection

By the end of January 2021, data on more than 3,500 COVID-19-positive patients had been abstracted and analyzed. In addition to sharing best practices in more than 30 webinars, four peer-reviewed papers have been published, with another seven currently under review.

Key insights

In June 2021, the Mi-COVID19 registry leaders presented a webinar to Michigan hospitals, physicians and other health care leaders on the lessons learned during the COVID-19 pandemic. They shared the following key insights:

- Early on, about one in five patients presented with nausea, vomiting and diarrhea. The collaborative was able to inform hospitals and emergency room staff statewide, so COVID-19 tests, which were limited at the time, could be appropriately administered to patients with these symptoms.
- A review of antibiotic use in hospitalized patients identified the situations in which someone should or should not be given antibiotics when hospitalized with COVID-19.
- One in 10 patients who survived an ICU stay died within 60 days of leaving the hospital. With this knowledge, providers could target the ICU patients to plan post-discharge care more carefully.
- A large portion of patients who were hospitalized with COVID-19 experienced severe physical, mental and financial challenges in the 60 days following hospital discharge. This finding helped hospitals develop important follow-up programs to connect patients to needed health, mental health and social services.
- Preventive anticoagulation therapy during hospitalization is associated with lower mortality. Mi-COVID19 participants significantly decreased the percentage of hospitalized patients who missed two or more doses of prophylactic anticoagulation.

In addition, initiative leaders have developed a **mortality risk assessment model**, which enables providers to assess a patient's risk of death at the time of admission. This allows providers to use appropriate treatment protocols more quickly.

"All of us can be proud of the important work we were able to accomplish in coordinating resources to best treat COVID-19," said Amy McKenzie, M.D., associate chief medical officer, Blue Cross Blue Shield of Michigan and one of the Mi-COVID19 CQI steering committee members. "We were able to get the CQI up and running and collecting data within a month and determine notable variations in care and arrive at best practices within a relatively short period of time. All this helped provide our hospitalized COVID patients across Michigan access to cutting-edge care."

More information on the Mi-COVID19 initiative can be found on the Michigan Hospital Medicine Safety Consortium **website**.

We're aligning local rules for acute inpatient medical admissions for BCN, Medicare Plus Blue and BCN Advantage plans

What you need to know

- We're aligning local rules across all plans for acute inpatient medical admissions.
- We're implementing a local rule for specific conditions that could be appropriately managed in an observation setting.

Blue Cross Blue Shield of Michigan and Blue Care Network are working to align local rules across all plans for acute inpatient medical admissions. We're implementing a local rule for specific conditions that could appropriately be managed in an observation setting.

You must submit an inpatient admission authorization request with clinical documentation for the following conditions after the patient has spent 48 hours in the hospital.

Allergic reaction	Dehydration	Intractable low back pain	Pneumonia
Asthma	Diabetic ketoacidosis	Meningitis	Transient ischemic attack
Anemia bleeding	Headache	Nausea/vomiting	Deep vein thrombosis
Arrhythmia	Heart failure	Nephrolithiasis	Pulmonary embolism
Chest pain	Hypertensive urgency	Skin and soft tissue infection	
COPD	Hypoglycemia	Syncope	

For patients with BCN commercial, Medicare Plus Blue℠ and BCN Advantage℠ plans, the program will begin with admissions on or after Jan. 3, 2022.

This program will decrease receipt of multiple communications and the need to submit multiple requests for clinical documentation. It will also have an impact on authorizations denied for lack of clinical information as all clinical documentation to support the admission would be received after 48 hours of hospital care.

Local Rule requirement

For patients diagnosed with conditions listed in the local rule, the facility can request an authorization for an inpatient stay after member has been in the facility for 48 hours. For admissions where a patient is receiving intensive care services requiring an ICU setting, authorizations will be accepted prior to the 48-hour period. You must provide the required clinical documentation demonstrating that InterQual critical level of care criteria have been met.

Once the 48 hours of hospitalization has occurred, or the patient is receiving intensive care services, a medical necessity review will be conducted based on the supporting clinical documentation submitted by the provider. InterQual criteria will be applied based on the patient's condition upon receipt of the clinical documentation.

- If InterQual criteria are met, the prior authorization request will be approved.
- If InterQual criteria aren't met, the prior authorization request will be sent to the plan medical director for review.
- If the patient hasn't been in the hospital for 48 hours, the inpatient authorization request will be sent to the plan medical director for review.

Applicable peer-to-peer review requests and appeals will remain available for those cases in which a facility disputes the severity of illness and intensity of services provided were higher than an observation.

Breast cancer screening rates drop in 2021

Many patients deferred breast cancer screening in 2020 due to the COVID-19 pandemic. A study recently published in the *Journal of the National Cancer Institute* showed that breast cancer screening rates aren't catching up to rates prior to the pandemic.

This is primarily due to two factors:

- Many screening sites were closed for a time during the pandemic.
- Many patients chose to defer preventive care during the pandemic.

"We continue to see breast cancer screening rates lagging this year," said Martha Walsh," medical director, Provider Engagement. "It's important that patients continue to receive this important preventive care."

What you need to know about mammograms and COVID-19 vaccine boosters

In August, the U.S. Department of Health and Human Services announced plans to begin offering COVID-19 vaccine booster shots this fall. As patients prepare to receive either a COVID-19 vaccine or the COVID-19 booster, it's important that they have their screening mammogram done prior to their vaccine or booster, or at least four weeks after.

The COVID-19 vaccine can cause a temporary enlargement of lymph nodes, making the mammogram appear abnormal and resulting in a false positive, as we wrote in a September-October *BCN Provider News* **article**.

The **Society of Breast Imaging** recommends scheduling screening mammograms either prior to the COVID-19 vaccine or four weeks after the vaccine to give the lymph nodes time to return to their normal size.

How health care providers are promoting breast cancer screening

Here are some tips from other providers who are working to boost their breast cancer screening rates:

- Send requisitions directly to patients with gaps in care to remind them to schedule their mammogram.
- Schedule the patient for their mammogram when they are in the office for another reason.
- Send a requisition for a mammogram directly to an associated radiology department and have the department call the patient to schedule.
- Call members who are past due for their breast cancer screening and connect them directly to a breast imaging center for scheduling.
- Have specialists help close breast cancer screening gaps by encouraging them to look at the "Gaps in Care" section of the patient's electronic health record.
- Reach out to patients during specific months of the year to highlight the importance of breast cancer screening. For example, in May for Mother's Day or October for Breast Cancer Screening Awareness Month.

What you need to know

This article includes some important information and tips to consider when working with patients to promote breast cancer screening this year.

- Create a contest for practices within a physician organization to close the most gaps in care, with a special lunch or some other reward provided to the practice that wins.

Breast Cancer Screening Tip Sheet

Breast cancer screening is a key HEDIS® measure** for our commercial members, as well as a star ratings measure for Medicare Advantage members. We have produced a **Breast Cancer Screening Tip Sheet** that includes information to include in medical records, codes to include on patient claims to exclude patients who had a mastectomy and tips for talking with patients about this measure.

The Breast Cancer Screening Tip Sheet is one of a series of HEDIS and Medicare Star Ratings tip sheets that have been posted in the *Clinical Quality Corner* section of web-DENIS. To access them, follow these steps:

1. Log into Provider Secured Services and click on *BCBSM Provider Publications and Resources*.
2. Click on *Newsletters & Resources*.
3. Click on *Clinical Quality Corner* under Other Resources.

We encourage you to check them out.

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

We've created a diabetes toolkit for members

In recognition of National Diabetes Month in November, we developed a diabetes flyer and other tools to help members with diabetes take control of their health. You're welcome to use the **toolkit** with your patients in your practice. These materials can be used all year and are not specific to November.

Because diabetes is the leading cause of new vision loss, according to **the National Diabetes Statistics Report 2020**, it's essential that patients with diabetes get retinal eye exams regularly from an ophthalmologist or optometrist. We encourage you to talk with your patients about the importance of this exam and how it fits into their diabetes management plan.

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

- Implantable bone-conduction and bone-anchored hearing devices
- Genetic cancer susceptibility panels using next generation sequencing
- Liver transplant
- Autism spectrum disorder services (Previously titled "Applied behavior analysis for autism spectrum disorder")
- Telemedicine services
- Percutaneous left atrial appendage closure devices for stroke prevention in atrial fibrillation
- Orthotic devices
- Prosthetic devices
- Wireless capsule endoscopy to diagnose disorders of the small bowel, esophagus and colon
- Skin and tissue substitutes
- Genetic testing for Marfan, Ehlers-Danlos, thoracic aortic aneurysms and dissections, and connective tissue-related disorders
- Transcranial magnetic stimulation as a treatment of depression and other psychiatric/neurologic disorders
- Genetic testing — carrier screening for genetic diseases

Noncovered services

- Alternative physical therapy modalities — experimental
- Dual energy X-ray absorptiometry (DXA) and bioelectrical impedance analysis (BIA) to determine body composition
- Ultrasonographic measurement of carotid intima-media thickness as an assessment of subclinical atherosclerosis
- Complementary and alternative medicine (CAM)

Medical Policy Updates

From the medical director: We need to increase our efforts to combat suicide

By Dr. William Beecroft

We've seen a steady rise in suicide rates over the past two decades, but the COVID-19 pandemic — and related social isolation and anxiety — has created additional challenges.

As my colleague Dr. Kristyn Gregory, also a medical director of behavioral health, wrote in a blog late last year, "Social isolation affects everyone in different ways, but it is also a risk factor for suicide. Measures to protect public health, such as closing schools, limited staffing, business closures and social distancing can unfortunately lead to greater isolation and loneliness."

And with the recent surge in new COVID-19 cases across the U.S., we need to remain especially vigilant as we work to reduce suicide rates. Provisional data from the Centers for Disease Control and Prevention shows there were 1,282 suicide deaths in Michigan last year, and that number is expected to rise as more reports are finalized.

Michigan Suicide Prevention Commission

I currently serve on the Michigan Suicide Prevention Commission, a group appointed by Gov. Gretchen Whitmer last year. The group released its **initial report** in April, and I encourage you to read it.

The commission is staffed with people from state departments, agencies and nonprofits who are working to adopt evidence-based practices to decrease and slow the progression of suicide in our society. Understanding the signals of people who are on a course of likely attempted suicide or who have committed suicide can help us save lives.

Suicide among young people

Especially distressing to me is rise in suicides among the young. The rate of suicide among those ages 10 to 24 increased nearly 60% from 2007 to 2018, according to the CDC. While there are many theories about why this has occurred, researchers say data is insufficient to draw firm conclusions. To my mind, one thing is clear: Young people are struggling with an increasingly complex, fast-paced world. They're in need of tools for coping with feelings of anxiety, depression and low self-esteem.

Efforts to address mental health problems, suicide

At Blue Cross Blue Shield of Michigan, we're working hard to give people of all ages the tools they need to cope with mental health struggles. As you may have read in a **column** from Dr. Amy McKenzie in the March-April issue of *Physician & Hospital Update*, we launched a new behavioral health site earlier this year to help our members who are struggling with mental or behavioral health issues. I encourage you to visit the site at **bcbsm.com/mentalhealth** and let your patients know about it. The site presents a wide array of information in an easy-to-navigate, engaging way. Most importantly, it offers resources for behavioral health support.

Dr. Beecroft is medical director of behavioral health at Blue Cross Blue Shield of Michigan and Blue Care Network.

Please see From the medical director, continued on Page 19

Behavioral Health

From the medical director, *continued from Page 18*

Blue Cross is not alone in statewide efforts to prevent suicide. I was pleased to read in the *Detroit Free Press* in February that Michigan Medicine announced that a **new digital screening tool** for use in emergency rooms could help detect and prevent youth suicides. The tool, named CASSY, short for Computerized Adaptive Screen for Suicidal Youth, is one of the latest efforts to address youth suicide, which has been of increasing concern during the pandemic.

Center for Practice-Focused Adaptive Suicide Prevention Science

More recently, Blue Cross has joined forces with the University of Michigan to support the development of a center designed to help clinicians address suicide and work to reduce this public health concern. The proposed Center for Practice-Focused Adaptive Suicide Prevention Science, or CASPS, is U-M's response to the National Institute of Mental Health's call for the creation of such practice-focused centers.

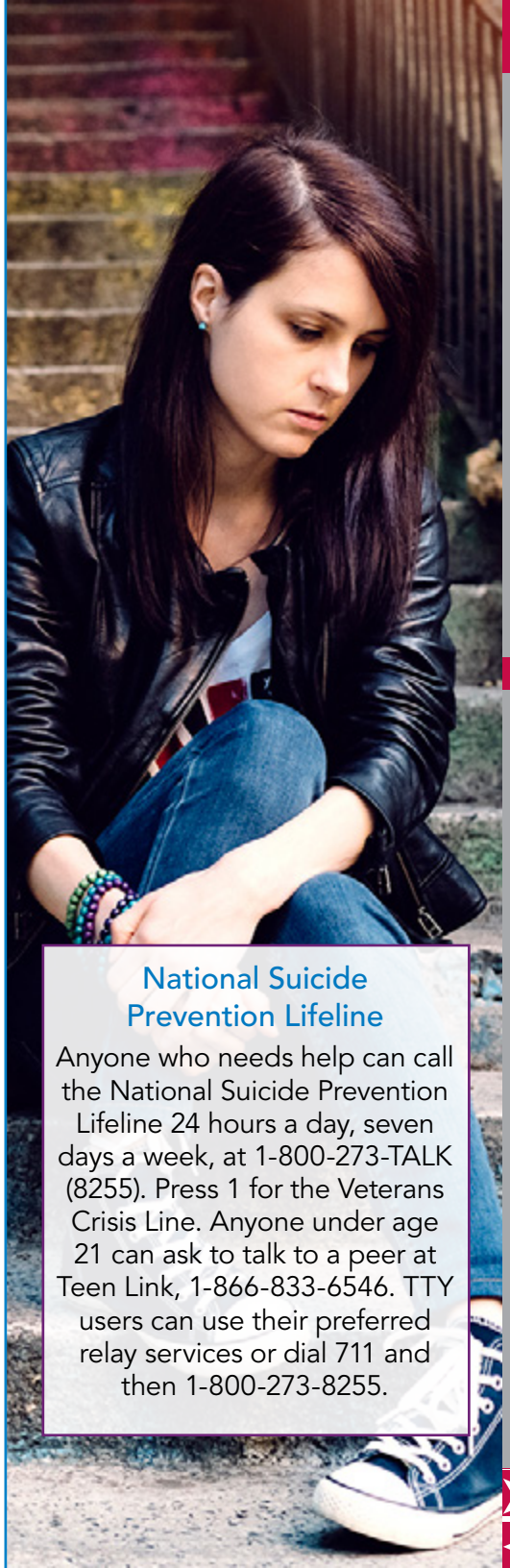
U-M invited my colleague, Dr. Duane DiFranco, senior medical director, Utilization Management, and more than a dozen other individuals, including clinicians, policymakers and service users, to serve the center as a member of its Stakeholder Advisory Group.

In a statement about this effort, he said: "CASPS — which is in its formative stages — will serve as a statewide and national resource for the development and implementation of effective, scalable interventions to reduce suicide in patients at high risk for suicide, such as those with comorbid mental health and substance use disorders. I am honored and excited to be part of U-M's response to the current national mental health crisis and their work to prevent suicide across populations."

While it's gratifying that many steps are being taken to reduce the suicide rate, we need to continue to think outside the box to find new ways to reach out to those in need and be alert to the warning signs of suicide. According to **psycom.net**, these include:

- Feeling depressed
- Lack of interest in activities they once enjoyed
- Irritability
- Anger
- Anxiety
- Shame or humiliation
- Mood swings

And, if a person indicates they're thinking of suicide, ask them if they have a plan. If they say yes, assist them in seeking immediate help. As health care professionals, we have a duty to get suicidal patients the help they need.



National Suicide Prevention Lifeline

Anyone who needs help can call the National Suicide Prevention Lifeline 24 hours a day, seven days a week, at 1-800-273-TALK (8255). Press 1 for the Veterans Crisis Line. Anyone under age 21 can ask to talk to a peer at Teen Link, 1-866-833-6546. TTY users can use their preferred relay services or dial 711 and then 1-800-273-8255.

COVID-19: Billing change for IOP services provided through telehealth for some members

For dates of service on or after Oct. 1, 2021, you should no longer include procedure code Q3014 on claims for behavioral health intensive outpatient program, or IOP, services provided through telemedicine.

Instead, you should simply bill revenue code 0905 or 0906 with modifier GT or 95.

This change affects all BCN commercial members, all BCN Advantage℠ members and select Blue Cross commercial group members.

Important!

- Facilities can provide IOP services to BCN commercial and BCN Advantage members only when their contracts specifically include IOP services.
- For Blue Cross commercial members, most plans don't cover IOP services for mental health disorders. IOP services for substance use disorders must be delivered by a substance abuse treatment facility. Be sure to check member eligibility and benefits before providing services.

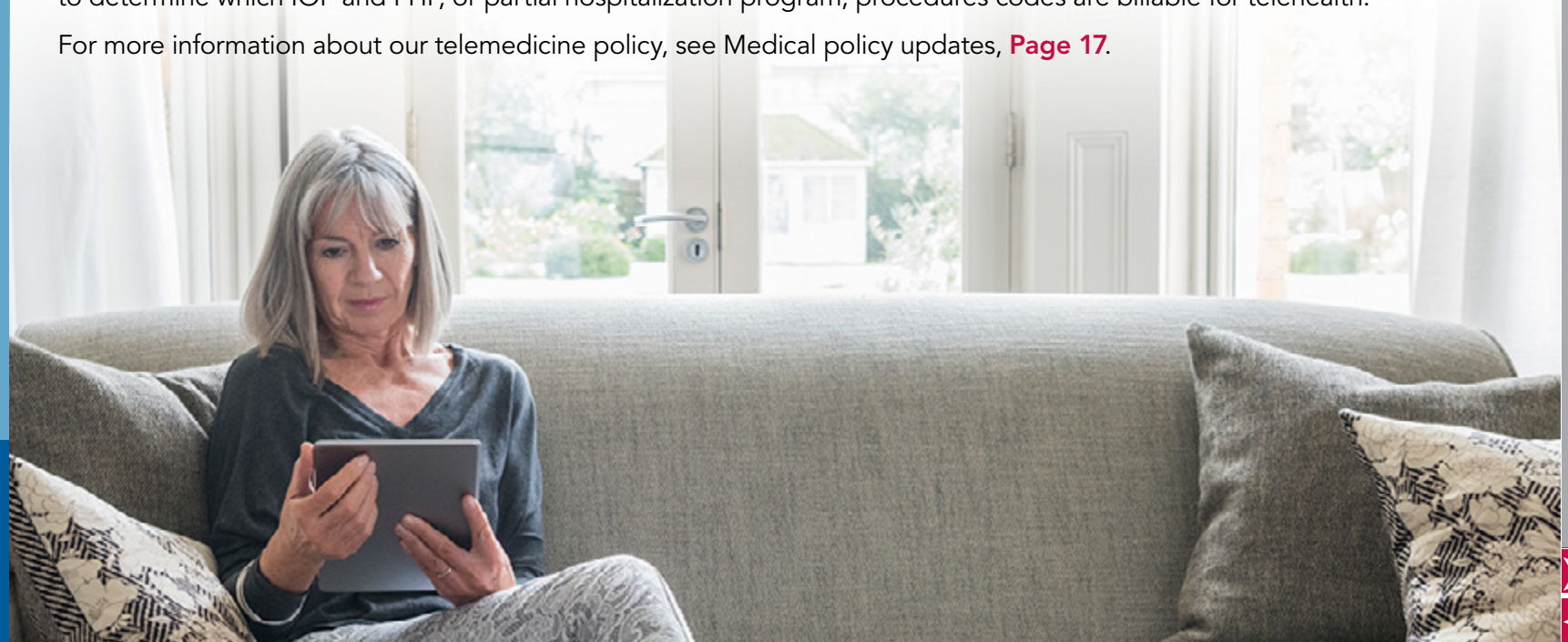
We've updated the following documents to reflect this change:

- *Telehealth for behavioral health providers*
- *Billing tips COVID-19 at a glance*

You can find these documents on our public website at **bcbsm.com/coronavirus** or within Provider Secured Services.

Note: For Medicare Plus Blue℠ members, see the **Medicare-covered telehealth services for the COVID-19 PHE** document to determine which IOP and PHP, or partial hospitalization program, procedures codes are billable for telehealth.

For more information about our telemedicine policy, see Medical policy updates, **Page 17**.



Quality corner: Metabolic monitoring for children and adolescents on antipsychotics

What is it?

The HEDIS® APM measure evaluates the rate of members ages 1 to 17 who were dispensed an antipsychotic prescription two or more times and received metabolic testing. Monitor fasting glucose and lipid panel of children and adolescents on antipsychotic medications annually.

Why it matters

Antipsychotic prescribing for children and adolescents has increased rapidly in recent decades. These medications can elevate a child's risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood. Given these risks and the potential lifelong consequences, metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.

Examples of first and second generation antipsychotic medication

First generation antipsychotic medications: chlorpromazine, fluphenazine, haloperidol, loxapine, molindone HCL, perphenazine, prochlorperazine

Second generation antipsychotic medications: aripiprazole, asenapine, brexpiprazole, cariprazine, clozapine, iloperidone, lurasidone, olanzapine, paliperidone, quetiapine, risperidone, ziprasidone

Best practices

- Reach out to caregivers who cancel appointments and assist with rescheduling as soon as possible.
- Obtain a full family history of disorders that may increase the risk of complications from antipsychotic medications (for example, diabetes, hypercholesterolemia, cardiac disease, obesity).
- Measure baseline lipid profiles, fasting blood glucose level and body mass index.
- Measure any abnormal involuntary movements before starting an antipsychotic medication, at regular intervals during treatment and while tapering medication.
- Monitor frequently for side effects.

References:

1. Patten, S.B., W. Waheed, L. Bresee. 2012. "A review of pharmacoepidemiologic studies of antipsychotic use in children and adolescents." *Canadian Journal of Psychiatry* 57:717–21.
2. Cooper, W.O., P.G. Arbogast, H. Ding, G.B. Hickson, D.C. Fuchs, and W.A. Ray. 2006. "Trends in prescribing of antipsychotic medications for US children." *Ambulatory Pediatrics* 6(2):79–83.
3. Correll, C. U., P. Manu, V. Olshanskiy, B. Napolitano, J.M. Kane, and A.K. Malhotra. 2009. "Cardiometabolic risk of second-generation antipsychotic medications during first-time use in children and adolescents." *Journal of the American Medical Association*
4. Andrade, S.E., J.C. Lo, D. Roblin, et al. December 2011. "Antipsychotic medication use among children and risk of diabetes mellitus." *Pediatrics* 128(6):1135–41.
5. Srinivasan, S.R., L. Myers, G.S. Berenson. January 2002. "Predictability of childhood adiposity and insulin for developing insulin resistance syndrome (syndrome X) in young adulthood: the Bogalusa Heart Study." *Diabetes* 51(1):204–9.

How to submit prior authorization requests for drugs that are managed by AIM when they're prescribed for non-oncology diagnoses

AIM Specialty Health® manages authorizations for medical oncology drugs for most members. They don't manage those drugs when prescribed for non-oncology diagnoses.

When prescribing these drugs **for non-oncology diagnoses**, don't submit the prior authorization to AIM. Instead:

- **For Blue Cross commercial fully insured members and UAW Retiree Medical Benefits Trust members with Blue Cross non-Medicare plans:** Fax all clinical documentation to the Blue Cross Pharmacy Help Desk at 1-866-915-9187.

  This requirement doesn't apply to the UAW Retiree Health Care Trust (group number 70605) or the UAW International Union (group number 71714).
- **For BCN commercial members:** Fax all clinical documentation to the Blue Cross Pharmacy Help Desk at 1-877-402-7695.
- **For Medicare Plus Blue℠ and BCN Advantage℠ members:** Call the Blue Cross Blue Shield of Michigan and Blue Care Network Pharmacy Clinical Help Desk at 1-800-437-3803.

To determine which drugs this applies to, see the following drug lists:

- **Medical oncology prior authorization list for Blue Cross commercial fully insured and BCN commercial members**
- **Medical oncology prior authorization list for UAW Retiree Medical Benefits Trust PPO non-Medicare members**
- **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**

We're updating these drug lists and other documents to reflect this requirement.

Saphnelo and Nexviazyme require prior authorization for Medicare Advantage members

The following drugs require prior authorization through the NovoLogix® online tool for dates of service on or after Sept. 1, 2021:

- Saphnelo™ (anifrolumab-fnia), HCPCS code J3590
- Nexviazyme™ (avalglucosidase alfa-ngpt), HCPCS code J3590

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

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

Use G codes for Spravato for Medicare Advantage claims

For dates of service on or after Aug. 23, 2021, when billing Spravato® (**esketamine**) claims for Medicare Plus Blue℠ and BCN Advantage℠ members, use one of the following HCPCS codes:

- G2082: Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified healthcare professional and provision of **up to 56 mg of esketamine** nasal self-administration, includes two hours post-administration observation
- G2083: Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of **greater than 56 mg of esketamine** nasal self-administration, includes two hours post-administration observation

This change is based on Centers for Medicare & Medicaid Services coding guidelines and applies only to Medicare Plus Blue and BCN Advantage members.

What's not changing

Don't use these G codes when billing Spravato claims for Blue Cross commercial or BCN commercial members.

Instead, when billing for those members, continue to do the following:

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

Prior authorization information

As a reminder, you must request prior authorization for Spravato using the NovoLogix® web tool when it is administered in outpatient settings for members with the following coverage:

- Blue Cross commercial

  Note: Blue Cross and Blue Shield Federal Employee Program® members and UAW Retiree Medical Benefits Trust non-Medicare members don't participate in the standard prior authorization program. To determine whether other Blue Cross groups participate in the standard prior authorization program, refer to the **Specialty Pharmacy Prior Authorization Master Opt-in/out Group List**.
- Medicare Plus Blue℠
- BCN commercial
- BCN Advantage℠

Accessing the NovoLogix tool

The NovoLogix web tool 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.

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.

Starting Jan. 1, 2022, we'll change how we cover some drugs

We're making some changes to how we cover some drugs on the Clinical, Custom, Custom Select and Preferred Drug Lists starting Jan. 1, 2022. We'll send letters to affected members and their groups and providers.

Changes are being made to make sure that members receive safe, high-quality care that meets their needs.

Clinical, Custom and Custom Select Drug lists

Drugs on the Clinical and Custom Drug lists that won't be covered

We'll no longer cover the following drugs. Unless noted, both the brand name and available generic equivalents won't be covered. If a member fills a prescription for one of these drugs on or after Jan. 1, 2022, he or she will be responsible for the full cost.

The drugs that won't be covered are listed along with the covered preferred alternatives that have similar effectiveness, quality and safety. When pharmacies fill prescriptions with preferred alternatives, the generic equivalents are dispensed, if available. The example brand names of preferred alternatives are provided for reference. Additional coverage requirements may apply for preferred alternatives, such as prior authorization.

Drugs that won't be covered	Common use or drug class	Preferred alternatives
Asmanex®/HFA	Asthma	Arnuity® Ellipta®, Flovent® HFA/Diskus®, Pulmicort®/Flexhaler, Qvar® Redihaler®
Bevespi® Aerosphere®	Chronic obstructive pulmonary disease	Anoro® Ellipta®, Stiolto® Respimat®
Dulera®		Advair® HFA/Diskus®, Breo® Ellipta®, Symbicort®
Incruse® Ellipta®, Tudorza® Pressair®		Spiriva®/Respimat®
Extavia®, Plegridy®	Multiple sclerosis	Avonex®, Bafiertam®, Betaseron®, Copaxone®, Kesimpta®, Tecfidera®, Vumerity®
Invokana®, Invokamet®/XR, Qtern®, Steglatro®, Segluromet®	Diabetes	Farxiga®, Glyxambi®, Jardiance®, Synjardy XR®, Trijardy XR®, Xigduo XR®
Granix®, Neupogen®	Neutropenia	Nivestym®, Zarxio®
Oxycontin®, oxycodone ER[1]	Pain	Butrans®, Duragesic®, MS Contin®, Opana ER®, Ultram ER®, Xtampza ER®, Zohydro ER®
Movantik®, Relistor® tablet	Constipation	Amitiza®, Linzess®, Symproic®
Siliq®	Autoimmune conditions (such as plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, Rinvoq®, Skyrizi®, Stelara®, Tremfya®, Xeljanz®/XR

[1]Authorized brand alternatives (for example. authorized generics) are drugs that are considered brand-name drugs and don't have generic equivalents. These drugs are the same as the brand-name drugs but are not true generic drugs. The respective brand copayment will apply for these drugs.

Please see Drug lists, continued on Page 25

Drug lists, *continued from Page 24*

Drugs on Custom Drug list that will have a higher copayment

The following brand-name drugs will have a higher copayment, starting Jan. 1, 2022. We've listed each along with the preferred alternatives that have similar effectiveness, quality and safety, but lower copays. When pharmacies fill prescriptions with preferred alternatives, the generic equivalents are dispensed, if available. The example brand names of preferred alternatives are provided for reference. Additional coverage requirements may apply for preferred alternatives, such as prior authorization.

Nonpreferred drugs that will have a higher copayment or won't be covered for members with a closed prescription drug benefit	Common use or drug class	Preferred alternatives
Actemra®, Cimzia®, Taltz®	Autoimmune conditions (such as plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, Rinvoq®, Skyrizi®, Stelara®, Tremfya®, Xeljanz®/XR
Gilenya®, Mayzent®, Rebif®	Multiple sclerosis	Avonex®, Bafiertam®, Betaseron®, Copaxone®, Kesimpta®, Tecfidera®, Vumerity®
Ajovy®	Migraine prevention	Aimovig®, Emgality®
Fulphila®, Udenyca®, Ziextenzo®	Neutropenia	Neulasta®, Nyvepria®
Leukine®		Nivestym®, Zarxio®
Nutropin AQ Nuspin®	Growth hormone	Genotropin®, Norditropin® FlexPro®
Orenitram ER®, Tracleer® suspension, Tyvaso®, Uptravi®, Ventavis®	Pulmonary hypertension	Adcirca®, Adempas®, Letairis®, Opsumit®, Revatio®, Tracleer® tablet
Viokace®	Pancreatic enzyme	Creon®, Zenpep®

Drugs on the Custom Select Drug List that won't be covered

We'll no longer cover the following brand-name and generic drugs. Unless noted, both the brand name and available generic equivalents won't be covered. If a member fills a prescription for one of these drugs on or after Jan. 1, 2022, he or she will be responsible for the full cost.

The drugs that won't be covered are listed along with the covered preferred alternatives that have similar effectiveness, quality and safety. When pharmacies fill prescriptions for preferred alternatives, the generic equivalents are dispensed, if available. The example brand names of preferred alternatives are provided for reference. Additional coverage requirements may apply for preferred alternatives, such as prior authorization.

Please see Drug lists, continued on Page 26

Drug lists, *continued from Page 25*

Drugs that won't be covered	Common use or drug class	Preferred alternatives
Asmanex®/HFA	Asthma	Arnuity® Ellipta®, Flovent® HFA/Diskus®, Pulmicort®/Flexhaler®, Qvar® Redihaler®
Dulera®	Chronic obstructive pulmonary disease	Advair® HFA/Diskus®, Breo® Ellipta®, Symbicort®
Incruse® Ellipta®, Tudorza® Pressair®		Spiriva®/Respimat®
Invokana®, Invokamet®/XR, Qtern®, Segluromet®, Steglatro®	Diabetes	Farxiga®, Glyxambi®, Jardiance®, Synjardy XR®, Trijardy XR®, Xigduo XR®
Oxycontin®, oxycodone ER[1]	Pain	Butrans®, Duragesic®, MS Contin®, Opana ER®, Ultram ER®, Xtampza ER®, Zohydro ER®
Siliq®	Autoimmune conditions (such as plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, Rinvoq®, Skyrizi®, Stelara®, Tremfya®, Xeljanz®/XR

[1]Authorized brand alternatives (for example. authorized generics) are drugs that are considered brand-name drugs and don't have generic equivalents. These drugs are the same as the brand-name drugs but are not true generic drugs. The respective brand copayment will apply for these drugs.

Drugs on the Custom Select Drug List that will have a higher copayment

The following brand-name drugs will have a higher copayment, starting Jan. 1, 2022. We've listed each along with the preferred alternatives that have similar effectiveness, quality and safety, but lower copays. When pharmacies fill prescriptions for preferred alternatives, the generic equivalents are dispensed, if available. The example brand names of preferred alternatives are provided for reference. Additional coverage requirements may apply for preferred alternatives, such as prior authorization.

Nonpreferred drugs that will have a higher copayment	Common use or drug class	Preferred alternatives
Actemra®, Cimzia®, Taltz®	Autoimmune conditions (such as plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, Rinvoq®, Skyrizi®, Stelara®, Tremfya®, Xeljanz®/XR
Ajovy®	Migraine prevention	Aimovig®, Emgality®
Fulphila®, Udenyca®, Ziextenzo®	Neutropenia	Neulasta®, Nyvepria®
Leukine®		Nivestym®, Zarxio®
Nutropin AQ Nuspin®	Growth hormone	Genotropin®, Norditropin® FlexPro®
Orenitram ER®, Tracleer® suspension, Tyvaso®, Uptravi®, Ventavis®	Pulmonary hypertension	Adcirca®, Adempas®, Letairis®, Opsumit®, Revatio®, Tracleer® tablet

Please see Drug lists, continued on Page 27

Drug lists, *continued from Page 26*

Preferred Drug list

Drugs on the Preferred Drug List that won't be covered

We'll no longer cover the following drugs. Unless noted, both the brand name and available generic equivalents won't be covered. If a member fills a prescription for one of these drugs on or after Jan. 1, 2022, he or she will be responsible for the full cost.

The drugs that won't be covered are listed along with the covered preferred alternatives that have similar effectiveness, quality and safety. When pharmacies fill prescriptions with preferred alternatives, the generic equivalents are dispensed, if available. The example brand names of preferred alternatives are provided for reference. Additional coverage requirements may apply for preferred alternatives, such as prior authorization.

Drugs that won't be covered	Common use or drug class	Preferred alternatives
Alvesco®, Asmanex®/HFA, Qvar®	Asthma	Enbrel®, Humira®, Otezla®, Rinvoq®, Skyrizi®, Stelara®, Tremfya®, Xeljanz®/XR
Bevespi® Aerosphere®	Chronic obstructive pulmonary disease	Anoro® Ellipta®, Stiolto® Respimat®
Dulera®		Advair® HFA/Diskus®, Breo® Ellipta®, Symbicort®
Incruse® Ellipta®		Spiriva®/Respimat®
Extavia®, Plegridy®	Multiple Sclerosis	Avonex®, Bafiertam®, Betaseron®, Copaxone®, Kesimpta®, Ponvory®, Tecfidera®, Vumerity®
Invokana®, Invokamet®/XR, Segluromet®, Steglatro®, Steglujan®	Diabetes	Farxiga®, Glyxambi®, Jardiance®, Synjardy XR®, Trijardy XR®, Xigduo XR®
Oxycontin®, oxycodone ER[1]	Pain	Butrans®, Duragesic®, MS Contin®, Opana ER®, Ultram ER®, Xtampza ER®, Zohydro ER®
Relistor®	Constipation	Linzess®, Movantik®, Symproic®
Siliq®	Autoimmune conditions (such as plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, Rinvoq®, Skyrizi®, Stelara®, Tremfya®, Xeljanz®/XR
Ztlido®	Topical anesthetics	Lidoderm®

[1]Authorized brand alternatives (for example, authorized generics) are drugs that are considered brand-name drugs and don't have generic equivalents. These drugs are the same as the brand-name drugs but are not true generic drugs. The respective brand cost share will apply for these drugs.

Please see Drug lists, continued on Page 28

Drug lists, *continued from Page 27*

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

The following brand-name drugs will have a higher copayment, starting Jan. 1, 2022. We've listed each along with the preferred alternatives that have similar effectiveness, quality and safety, but lower copays. When pharmacies fill prescriptions with preferred alternatives, the generic equivalents are dispensed, if available. The example brand names of preferred alternatives are provided for reference. Additional coverage requirements may apply for preferred alternatives, such as prior authorization.

Nonpreferred drugs that will have a higher copayment	Common use or drug class	Preferred alternatives
Actemra®, Cimzia®, Taltz®	Autoimmune conditions (such as plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, Rinvoq®, Skyrizi®, Stelara®, Tremfya®, Xeljanz®/XR
Ajovy®	Migraine prevention	Aimovig®, Emgality®
Aubagio®, Gilenya®, Mayzent®, Rebif®, Zeposia®	Multiple sclerosis	Avonex®, Bafiertam®, Betaseron®, Copaxone®, Kesimpta®, Ponvory®, Tecfidera®, Vumerity®
Baxdela®	Antibiotics	Avelox®, Cipro/XR®, Floxin®, Levaquin®
Cayston®	Cystic fibrosis	Tobi®
Combipatch®	Menopause symptoms	Activella®, Climara®, Fem-HRT®, Minivelle®, Vagifem®, Vivelle-Dot®
Daytrana®, Dyanavel XR®, Quillichew ER®, Quillivant XR®	Attention deficit hyperactivity disorder	Adderall®/XR*, Aptensio XR®, Concerta®, Focalin®/XR*, Metadate CD®*, Methylin®, Mydayis®, Ritalin® LA/SR, Vyvanse® *can be opened and sprinkled on applesauce
Depo-estradiol®	Estrogens	Climara®, Estrace®, Minivelle®, Vagifem®, Vivelle-Dot®
Diacomit®	Anticonvulsants	Depakote®, Onfi®, Topamax®
Fetzima®	Antidepressants	A generic SSRI/SNRI (such as, Celexa®, Cymbalta®, Effexor/XR®, Pristiq®, Prozac®, Zoloft®, etc.), Wellbutrin/SR/XL®
Fragmin®	Anticoagulants	Lovenox®
Fulphila®, Ziextenzo®	Neutropenia	Neulasta®, Nyvepria®
Leukine®		Nivestym®, Zarxio®

Please see Drug lists, continued on Page 29

Drug lists, *continued from Page 28*

Nonpreferred drugs that will have a higher copayment	Common use or drug class	Preferred alternatives
Gelnique®	Urinary antispasmodics	Detrol/LA®, Ditropan/XL®, Enablex®, Sanctura/XR®, Vesicare®
K-PHOS Original®	Potassium replacement	Generic potassium replacement products (such as, K-Lor®, Klor-Con packet®, K-Sol®, Potassium Chloride®, K-Tab®)
Latuda®	Antipsychotics	Abilify®, Clozaril®, Geodon®, Invega®, Risperdal®, Seroquel®/XR, Zyprexa®
Lipofen®	Lipid lowering	Antara®, Fenoglide®, Lofibra®, Lopid®, Tricor®, Trilipix®
Lupaneta® pack	Endometriosis	Lupron Depot® 3.75mg, 11.25mg plus Aygestin®
Natesto®	Testosterone replacement	Androderm®, Androgel®, Android®, Axiron®, Delatestryl®, Depo-Testosterone®, Testim®, Testred®
Novarel®	Infertility	Cetrotide®, generic ganirelix acetate, Ovidrel®, Pregnyl®
Odactra®, Ragwitek®	Allergen-specific immunotherapy	Accolate®, Clarinex®, Flonase®, Nasalide®, Nasonex®, over-the-counter Claritin®, over-the-counter Nasacort®, over-the-counter Zyrtec®, Singulair®, Xyzal®
Pancreaze®, Viokace®	Pancreatic enzyme	Creon®, Zenpep®
Phoslyra®	Phosphate binder	Phoslo®, Renagel®, Renvela®
Prevymis®	Antiviral	Valcyte®
Purixan®	Immunosuppressant	generic mercaptopurine tablets
Rectiv®	Miscellaneous gastrointestinal agent	Nitro-Bid® ointment
Revlimid®	Immunomodulators	Thalomid®

Please see Drug lists, continued on Page 30

Drug lists, *continued from Page 29*

Nonpreferred drugs that will have a higher copayment	Common use or drug class	Preferred alternatives
Savella®	Fibromyalgia	Generic SSRI/SNRI (such as, Celexa®, Cymbalta®, Effexor/XR®, Pristiq®, Prozac®, Zoloft®, etc.), generic TCA (Aventyl®, Elavil®, Sinequan®, Tofranil®, etc.), Flexeril®, Neurontin®, Ultram®
Solu-cortef®	Corticosteroids	Hydrocortisone®, Decadron®, Deltasone®
Talicia®	H. pylori infection	Prevacid® plus Amoxil® plus Biaxin/XL®; tetracycline plus Flagyl® plus over-the-counter bismuth subsalicylate; Prilosec® plus Amoxil® plus Biaxin/XL®
Tracleer® suspension, Tyvaso®, Uptravi®	Pulmonary hypertension	Adcirca®, Adempas®, Letairis®, Opsumit®, Revatio®, Tracleer® tablet
Trulance®	Constipation	Linzess®, Movantik®, Symproic®
Valchlor®	Immunosuppressant	8-Mop®, Zolinza®
Varubi®	Antiemetic	Emend®, Kytril®, Zofran/ODT®
Verquvo	Heart conditions	Entresto®
Vosevi®, Zepatier®	Hepatitis C	Epclusa®, Harvoni®
Xifaxan® 200mg	Anti-infective	Bactrim DS, Vibramycin, Zithromax
Xifaxan® 550mg	Miscellaneous gastrointestinal agent	For IBS-D: Bentyl®, Imodium®, Levbid®, Levsin®, generic SSRI (Celexa®, Paxil®, Zoloft®, etc.), generic TCA (Elavil®, Sinequan®, Tofranil®, etc.) For hepatic encephalopathy: lactulose solution
Yupelri®	Chronic obstructive pulmonary disease	Spiriva®/Respimat®

Pharmacy News

Blue Cross enhances tools for electronically prescribing medications and submitting prior authorizations

Blue Cross Blue Shield of Michigan and Blue Care Network are committed to enhancing its electronic processes across the health care spectrum, including the processes used by prescribers.

As part of our transition to OptumRx as our new pharmacy benefit manager, we're making some improvements to our provider-facing tools to assist with prescribing and submitting prior authorizations electronically. These enhancements will primarily take place behind the scenes and won't have a major effect on how providers prescribe and submit prior authorizations or check on patients' benefits.

As you read in a September-October *BCN Provider News* **article**, the move from Express Scripts, Inc. to OptumRx will take place **Jan. 1, 2022**, for commercial individual and group members, and Jan. 1, 2023, for Medicare Advantage individual and group members.

Continue to use your current electronic medical record system or CoverMyMeds® to submit electronic prior authorizations for Blue Cross and Blue Care Network members. Keep in mind that the BIN number changes to 610011, effective Jan. 1, 2022, for all Blue Cross and BCN commercial members.

Electronic prior authorization, or ePA, replaces faxing and phone calls so you can focus less on administrative tasks and more on patient care. For more information on ePA and CoverMyMeds, see our **ePA flyer**.

Also, continue to use electronic medical records for electronic prescribing and real-time prescription benefit checks. **Note:** You may have heard of a tool called PreCheck MyScript. This is an internal name that OptumRx uses for its real-time benefit check connectivity and programing with electronic medical record systems. From a provider perspective, the interface will look and feel much the same as what providers currently use with Express Scripts.

Once we launch Availity, our new secure provider portal, we'll also provide a link to Prompt PA, another resource that can be used to submit electronic prior authorization requests for pharmacy benefit drugs.

By using tools like these, physicians get patient-specific pharmacy information up front. And the better physicians and patients understand the medication options and costs at the point of prescribing, the more likely patients are to fill prescriptions and adhere to their medication regimen.

The Pharmacy team is communicating about these enhancements at various provider-facing forums, including regional medical director meetings, BCN business administrator meetings and network performance improvement meetings.

If you have any questions, call the Pharmacy Help Desk at 1-800-437-3803.

eviCore to use its clinical editing software with BCN radiation oncology claims starting Nov. 1

Starting Nov. 1, 2021, eviCore healthcare® will use its Claims Studio℠ clinical editing software for radiation oncology claims for BCN commercial and BCN Advantage℠ members.

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***.

We first communicated about this in the article **eviCore to use its clinical editing software with BCN radiation oncology claims starting fourth quarter 2021**, on page 35 of the September-October 2021 issue of *BCN Provider News*. Refer to that article for the details about this change.

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:

- Transitional care management denials
- Assistant surgeon claim denials and documentation expectations
- Multiple evaluation and management services on the same day

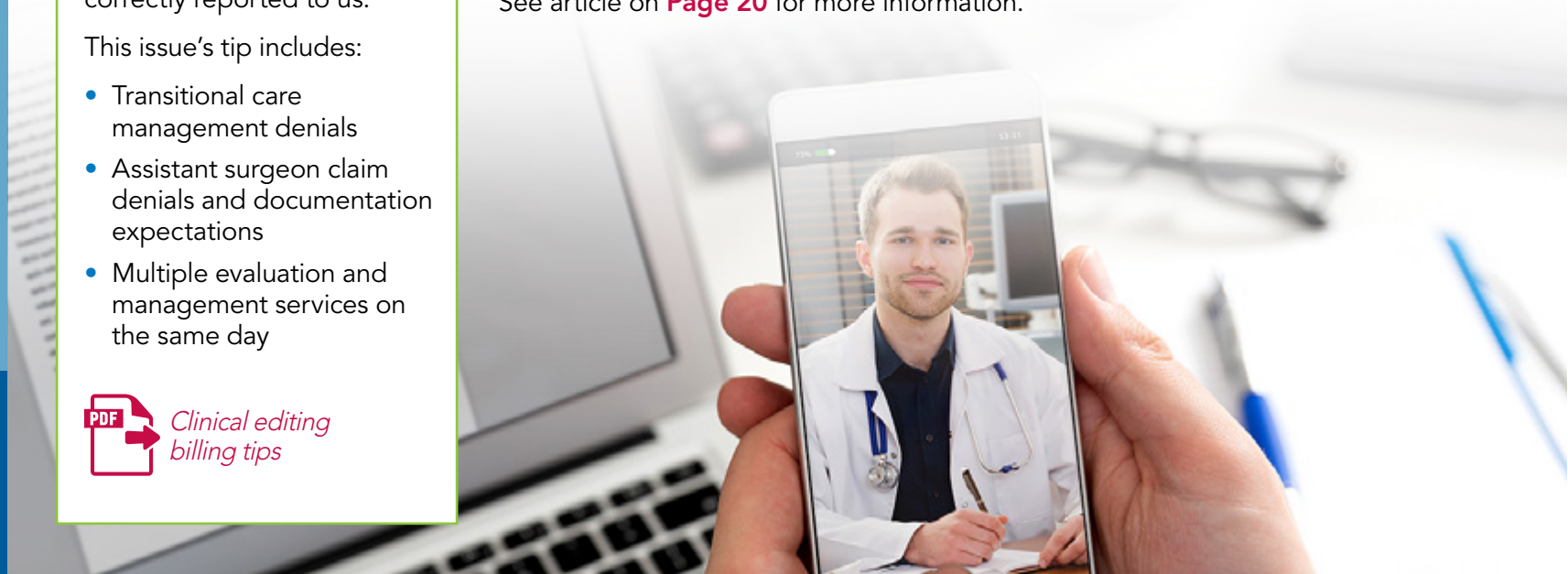
Clinical editing billing tips

COVID-19: Billing change for IOP services provided through telehealth for some members

For dates of service on or after Oct. 1, 2021, you should no longer include procedure code Q3014 on claims for behavioral health intensive outpatient program services provided through telemedicine for BCN commercial members, all BCN Advantage℠ members and select Blue Cross commercial group members.

Instead, you should bill revenue code 0905 or 0906 with modifier GT or 95.

See article on **Page 20** for more information.



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

We're offering additional 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. Physicians and coders will be available to answer questions.

Action item

Sign up now for live, monthly, lunchtime webinars.

Click on a link below to sign up for a live webinar:

Session date	Topic	Led by	Sign-up link
Wednesday, Nov. 17	Coding scenarios for primary care and specialty	Coder	**Register here**
Thursday, Dec. 9	Evaluation and management coding tips	Coder	**Register here**

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

Session date	On-demand webinar
April 20	Acute conditions reported in the outpatient setting
May 19	Morbid (severe) obesity
June 17	Major depression
July 20	Diabetes with complication
Aug. 18	Renal disease
Sept. 23	Malignant neoplasm

Access to the training site differs 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 modules in two ways:

- Look in the course catalog under *Quality management*.
- Enter "lunch and learn" in the search box at the top of the screen.

More information

- If you need help creating your login ID or navigating the site, email ProviderTraining@bcbsm.com.
- If you have questions about the sessions, contact April Boyce at aboyce@bcbsm.com.
- If you have questions about registration, email Patricia Scarlett at pscarlett@bcbsm.com.

Prior authorization requirements expanding for Medicare Plus Blue, BCN commercial and BCN Advantage members on Jan. 1

We're expanding our prior authorization requirements for Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ members. For the procedure codes outlined below, you'll need to complete questionnaires in the e-referral system when you submit prior authorization requests for dates of service on or after Jan. 1, 2022.

We'll update various documents to reflect this change before Jan. 1.

For Medicare Plus Blue members

Most of the procedure codes below already require prior authorization for BCN commercial and BCN Advantage members. This requirement is new for Medicare Plus Blue for requests submitted for dates of service on or after Jan. 1.

Category	Procedure codes
Blepharoplasty and repair of brow ptosis	*15822, *15823, *67900, *67901, *67902, *67903, *67904, *67906, *67908
Cosmetic or reconstructive surgery	*20912, *21210, *30465, *67909, *67911
Rhinoplasty	*30460, *30462

For BCN commercial and BCN Advantage members

The procedure codes below currently require prior authorization for BCN commercial and BCN Advantage, but they aren't currently associated with a questionnaire in the e-referral system. For dates of service on or after Jan. 1, you'll need to complete a questionnaire when you request prior authorization for these codes.

Category	Procedure codes
Cosmetic or reconstructive surgery	*20912, *30465

For Medicare Plus Blue, BCN commercial and BCN Advantage members

For requests submitted for dates of service on or after Jan. 1, these procedure codes will require prior authorization for Medicare Plus Blue, BCN commercial and BCN Advantage members.

Category	Procedure codes
Blepharoplasty of the lower lid	*15820(1), *15821(1)
Cardiac devices	*33285, *33340
Cardiac ablation	*93653, *93654, *93656
Thyroid surgeries	*60210, *60212, *60220, *60225, *60240, *60252, *60254, *60260, *60270, *60271
Vein ablation and related services	*36473, *36474, *36482, *36483
Septoplasty	*30520

(1)This procedure code currently requires prior authorization for BCN commercial and BCN Advantage members. For dates of service on or after Jan. 1, 2022, this code will be associated with the new *Blepharoplasty of the lower lid* questionnaire. (For dates of service prior to Jan 1, 2022, this code is associated with the *Cosmetic or reconstructive surgery* questionnaire.)

Referral Roundup

Bariatric surgery won't require prior authorization for BCN members starting Jan. 1

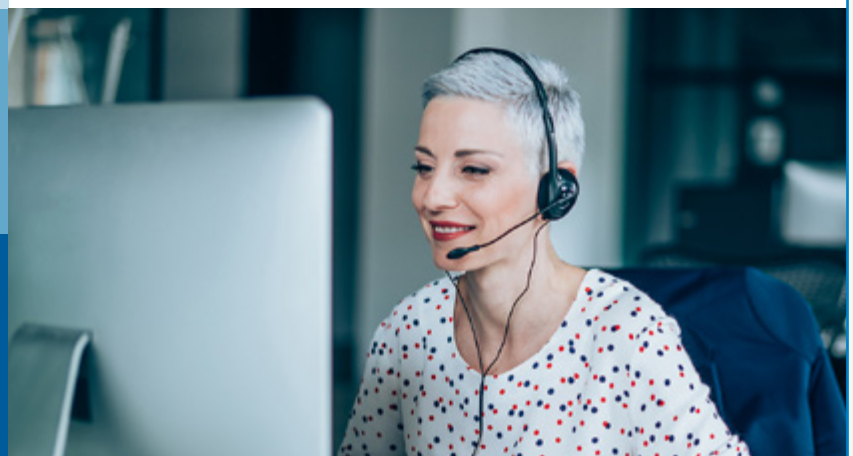
For dates of service on or after Jan. 1, 2022, bariatric surgery won't require prior authorization for BCN commercial and BCN Advantage℠ members.

For surgeries that occur in 2022:

- Standard global referral requirements will apply. This means a global referral is required for BCN commercial members whose primary care providers are part of a medical care group based in the East or Southeast region. Referrals aren't required for other BCN members.
- Plan notification will be required for all BCN commercial and BCN Advantage members. Plan notification alerts BCN to a scheduled service and is used for claims processing. No clinical documentation is required. Plan notification must be submitted before services are provided.

We encourage providers to use facilities that are designated as Blue Distinction Centers for Bariatric Surgery. You can identify hospitals with this distinction using the Blue Cross and Blue Shield Association **Blue Distinction Center Finder** or the **Find a Doctor** tool on **bcbsm.com**.

We'll update the *BCN Provider Manual* and related documents to reflect the change in the prior authorization requirement. Prior authorization is still required for bariatric surgery for dates of service through Dec. 31, 2021.



AIM to ask for clinical information for BCN commercial radiology and cardiology prior authorization requests, starting Jan. 1

Starting Jan. 1, 2022, AIM Specialty Health® may ask for clinical information for prior authorization requests submitted for Blue Care Network commercial members for the following services:

- All outpatient high-technology radiology procedures
- Some outpatient cardiology procedures — specifically, diagnostic cardiac angiography and percutaneous coronary intervention

AIM may request the additional information as part of the prior authorization process. You'll need to submit documentation from the member's medical record that verifies the member's condition.

AIM will review and use the clinical information to determine the clinical appropriateness of the request. AIM is initiating this as part of its ongoing quality improvement efforts.

If the information you provide doesn't support the medical necessity of the request, AIM may deny it.

This won't apply to prior authorization requests submitted for Blue Cross commercial, Medicare Plus Blue℠ or BCN Advantage℠ members.

AIM is an independent company that manages authorization requests for high-technology radiology and other services for many Blue Cross and BCN members.

You can find information about AIM's requirements related to services for BCN members on our **ereferrals.bcbsm.com** website, on the **BCN AIM-Managed Procedures webpage**.

Updated questionnaires in the e-referral system

We updated questionnaires in the e-referral system in July and August. We also added and updated the corresponding preview questionnaires on the **ereferrals.bcbsm.com** website.

Updated questionnaires

We updated the following questionnaires:

- On July 11, 2021, we updated the *Enteral nutrition* questionnaire for pediatric and adult BCN commercial and BCN Advantage℠ members.

  For questionnaires submitted on or after July 11, 2021, approved authorization requests for this service are valid for six months. (For questionnaires submitted on or before July 10, approved authorization requests were valid for three months.)
- On July 25, 2021, we updated these questionnaires for adult and pediatric BCN commercial and BCN Advantage members:
  - *Out-of-network providers*
  - *Sleep studies*
- On Aug. 29, 2021, we updated these questionnaires:
  - *Orthognathic surgery* — For adult and pediatric BCN commercial and BCN Advantage members
  - *Vascular embolization or occlusion of hepatic tumors (TACE/RFA)* — For adult Medicare Plus Blue℠, BCN commercial and BCN Advantage members. This questionnaire now opens for procedure code *75894, and it continues to open for procedure codes *37242 and *37243.

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 so you can 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.

New questionnaires open in the e-referral system

We added the following questionnaires in the e-referral system in September for BCN commercial and BCN Advantage℠ members:

- *Cognitive rehabilitation:* Opens for adult and pediatric members
- *Hypoglossal nerve stimulator – condition trigger:* Opens for members ages 10 through 21
- *Hypoglossal nerve stimulator — adolescent or young adult:* Opens for members ages 18 through 21
- *Hypoglossal nerve stimulator — adolescents with Down syndrome:* Opens for members ages 10 through 21 who have Down syndrome
- *Hypoglossal nerve stimulator — adults:* Opens for members ages 22 and older

We've also added preview questionnaires 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 so you can prepare your answers ahead of time.

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

Authorization criteria and medical policies

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

Referral Roundup

We're developing a provider satisfaction survey with Turning Point

Action item
Share your feedback with TurningPoint if you receive a survey in the mail.

Blue Cross Blue Shield of Michigan and Blue Care Network are working with TurningPoint Healthcare Solutions LLC to develop a provider satisfaction survey.

TurningPoint will send the survey to providers who have submitted authorization requests for musculoskeletal procedures and related services. The survey will give these providers the opportunity to provide feedback on the TurningPoint musculoskeletal surgical quality and safety management program.

TurningPoint will send the survey by email by the end of the year.

We'll communicate the distribution timeline for the surveys in future provider communications.

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**.

Updated TurningPoint medical policies for musculoskeletal procedures and related services

TurningPoint Healthcare Solutions LLC updated various medical policies for musculoskeletal procedures and related services based on feedback from the provider community. The updated policies went into effect July 26, 2021.

To view the updated policies, access the TurningPoint Provider Portal and click *Help* in the menu at the top of the screen.

Criteria used to make determinations on authorization requests

As a reminder, TurningPoint uses the following criteria to make determinations on authorization requests for musculoskeletal and pain management procedures:

- **For Blue Cross commercial and BCN commercial members:** TurningPoint applies medical policy guidelines for musculoskeletal and pain management procedures that Blue Cross Blue Shield of Michigan, Blue Care Network and TurningPoint agreed on.
- **For Medicare Plus Blue℠ and BCN Advantage℠ members:** TurningPoint applies the Medicare national coverage determinations and Medicare local coverage determinations.

If there is no Medicare NCD or LCD, TurningPoint applies medical policy guidelines for musculoskeletal and pain management procedures that Blue Cross, BCN and TurningPoint agreed on.

Additional information

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***.

TurningPoint to review sites of care for total hip and knee surgeries for some members

For dates of service on or after Jan. 3, 2022, TurningPoint Healthcare Solutions LLC will review the site of care for total hip and knee surgeries as part of each authorization determination. Based on medical necessity review, TurningPoint may approve authorization requests for select total hip and knee cases only when scheduled in an outpatient setting.

This applies to members with the following coverage:

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

If TurningPoint approves an authorization for a hip or knee surgery in an outpatient setting and the member experiences a change in condition that requires an inpatient admission, you'll need to submit an authorization request for the inpatient admission (procedure code *99222) through the e-referral system; see the "Submit an inpatient authorization" section of the ***e-referral User Guide*** for more information. Blue Cross or BCN will review the request using InterQual® criteria.

Performing total hip and knee surgeries in outpatient settings is supported by both evidence-based guidelines and the Centers for Medicare & Medicaid Services.

For more information about the TurningPoint musculoskeletal surgical quality and safety management program, see these pages on the **ereferrals.bcbsm.com** website:

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

How BCN members' swallow studies are managed

Here's important information to know about swallow studies for BCN commercial and BCN Advantage℠ members:

- eviCore healthcare manages authorizations for procedure codes *92507 and *92508, as speech therapy services. Submit prior authorization requests through the eviCore provider portal. Refer to the document **eviCore Management Program Frequently Asked Questions** for information on how to submit those requests.
- BCN's Utilization Management department manages other swallow-related services:
  - Swallow evaluations (procedure code *92610) and swallow studies (procedure codes *92611 through *92617) require plan notification only.
  - Swallow therapy (procedure code *92526) requires authorization. Submit prior authorization requests through the e-referral system or by calling 1-800-392-2512.

We're updating the ***BCN referral and authorization requirements for Michigan providers*** document to clarify how these services are managed.

Submit prior authorization requests for commercial SNF admissions through the e-referral system

What you need to know

- Skilled nursing facilities will need to submit prior authorization requests through the e-referral system, staring in January.
- Sign up now to use the e-referral system.
- Refer to training tools linked in this article.

Beginning Jan. 1, 2022, we'll require skilled nursing facilities to submit prior authorization requests through the e-referral system and not by fax. This applies to requests for our Blue Cross and Blue Care Network commercial members for:

- Initial admissions
- Additional days

We first encouraged SNF providers to submit commercial prior authorization requests through the e referral system on Dec. 1, 2020.

Many SNFs have complied, but others are still faxing the requests.

What's changing

Starting Jan. 1:

- We'll stop accepting faxed requests as a general practice.
- We'll accept faxes **only** for urgent requests when the e-referral system isn't available. In those instances, fax the form using the instructions on the document titled ***e-referral system planned downtimes and what to do***.

We won't accept a faxed form for a non-urgent admission when the e-referral system **is** available. We'll notify you by fax or phone that you must submit the request through the e-referral system.

Sign up now to use the e-referral system

To prepare for this change, it's important that SNFs sign up **now** for access to the e-referral system. Don't wait to sign up; it may take some time to get access.

You'll also need to learn how to use the e-referral system so you're comfortable with it when this change goes into effect.

Everything you need to know is on our **ereferrals.bcbsm.com** website:

- To sign up for the e-referral system: Follow the instructions on the **Sign Up or Change a User page**.
- To learn how to use the e-referral system: Refer to the **Training Tools** page, where you'll find the **e-referral User Guide** and **Online self-paced learning modules**.

On the Training Tools page, scroll down to the "e-referral Overview for Skilled Nursing Facilities presentation" heading and access these resources:

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

Remember these tips

For tips on how to make it easier to use the e-referral system when submitting commercial SNF prior authorization requests, refer to the article we published in the May-June 2021 issue of *BCN Provider News*, on Page 38, titled **Tips for submitting commercial SNF requests using the e-referral system**.

Please see e-referral system, continued on Page 42

e-referral system, *continued from Page 41*

Earlier communications about this change

In 2020, we communicated about submitting these requests through the e-referral system through these articles:

- **Skilled nursing facilities to follow new process to submit authorization requests for Blue Cross, BCN commercial members** (*The Record*, Sept. 2020)
- **Commercial SNF authorization requests to be submitted through the e-referral system starting later this year** (*BCN Provider News*, page 36, Sept.-Oct. 2020)

In these articles, we encouraged SNF providers to sign up for and start using the e referral system while faxing was still an option.

We also communicated about this through a web-DENIS message and a news item on our **ereferrals.bcbsm.com** website.

As a reminder, naviHealth manages prior authorization requests for SNF admissions for our Medicare Plus Blue℠ and BCN Advantage℠ members.

CareCentrix home health care program: Updated training resources, new and updated documents available

We've updated training resources and add new documents for CareCentrix®, a company that manages prior authorizations for home health care services for Medicare Plus Blue℠ and BCN Advantage℠ members.

Where to find CareCentrix home health care resources:

You can find the training resources and links to the documents related to this program on the **ereferrals.bcbsm.com** website.

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

Index

BCN Provider *News*

Feedback

W005497

INDEX: November-December 2021