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2021 *BCN Provider News* Archives

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In Microsoft Edge, click the *Content* icon in the toolbar and select *List view* to display the issue dates. In Google Chrome, click the *Document outline* icon in the left-hand column to display the issue dates. Click an issue date to go to a specific issue.

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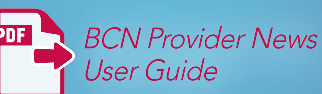

BCN Provider News User Guide

Some reminders about Healthy *Blue* Living physical exams and qualification forms

Each Healthy *Blue* Living℠ HMO member is required to visit his or her primary care physician for an exam within 90 days of enrollment or renewal. Providers can schedule a physical exam for Healthy *Blue* Living HMO members any time throughout the year. If last year's physical was in March, for example, the member can get a physical in January.

There are no limits on how many times a member can schedule a physical exam. BCN encourages each member to see his or her PCP well before the deadline and will accept a qualification form from an office visit occurring up to 180 days prior to the member's renewal date.

Billing for the exam

Providers should use the appropriate ICD diagnosis as the primary diagnosis when billing for the initial or subsequent examination and for the initial assessment for members participating in the Wellness Rewards Tracking program.

Please see Physical, continued on Page 2

Get ready for Availity — Select an administrator

Blue Cross Blue Shield of Michigan and Blue Care Network will move to the Availity® provider portal later in 2021. If you're already an Availity user, you don't need to do anything to access Blue Cross and BCN information once it's available. If you're not currently using Availity, here's some information to help you prepare for the transition.

Choose a primary administrator

If your organization (office, practice or facility) doesn't currently participate with Availity, you'll need to select someone on your team to serve as the Availity primary administrator. The person selected for this role must be at least 18 years old. The primary administrator will handle access for other users, which will speed up their enrollment process. Every organization is required to have one primary administrator.

Select someone who knows each team member's access

Please see Availity, continued on Page 3

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Physical, *continued from Page 1*

Use ICD-10 code Z00.00 or Z00.01. Additional diagnoses may be reported for specific conditions (for example, high blood pressure). There is no member cost-sharing for the completion of the qualification form when the primary diagnosis reported is Z00.00 or Z00.01. There is no member cost-sharing for the office visit when the primary diagnosis is Z00.00 or if a preventive medical examination is reported.

Billing for the qualification form

Providers must file a claim to be paid for completing the Blue Care Network qualification form for a member covered by Healthy Blue Living or Healthy Blue Living HMO Basic℠ for members participating in BCN's Wellness Rewards Tracking program. Claims for completing the form should be billed in the amount of $40 using the CPT code *99080. Payment will be reflected on the remittance advice.

For detailed billing information for Healthy *Blue* Living:

1. Log into Provider Secured Services at **bcbsm.com/providers**.
2. Click *BCN Provider Publications and Resources*.
3. Click on *Billing/Claims* in the left navigation.
4. Click *Healthy Blue Living visits and forms* under the "Professional Claims – Billing Instructions" heading.

We've changed frequency for preventive screenings to a calendar year

We've changed the frequency for preventive screenings to a calendar year for BCN HMO℠ members to align with Blue Cross PPO plans and to allow members who deferred their screenings due to COVID-19, to have more flexibility in future scheduling.

This means members can schedule their routine screenings at any time during the year regardless of when they had the screening in the previous year.

This applies to preventive screenings that members schedule annually, such as mammograms.

Preventive screenings for BCN Advantage members continue to follow Centers for Medicare & Medicaid Services guidelines.

For details, see article in the **Sept-Oct issue** (Page 1).

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Availity *continued from Page 1*

needs, or create an internal process for the primary administrator to review and confirm access needs. The goal is to make sure team members have access only to the roles and permissions they need to do their jobs.

A primary administrator who controls access helps safeguard patient information, maintains compliance with federal privacy and security laws and reduces opportunities for fraud and abuse. This ensures that your biller can status claims, your referral coordinator can submit authorization requests and the Availity experience is streamlined to focus on the tools these team members need.

And, your primary administrator will be able to add team members or change access needs with just a few keystrokes. This will replace having to fax a form for every change.

The primary administrator can have help

While each organization can only have one primary administrator who has access to all administrative functions, you can also delegate others to handle specific roles. They include:

- **Administrator assistant** — This individual can make changes on behalf of the organization, but not on behalf of users. An example could be enrolling the organization in electronic funds transfer.
- **User administrator** — This individual can make changes on behalf of users, but not the organization. This includes adding or deleting users and changing user roles.

Please see Availity, continued on Page 4

Get ready for Availity — Technical requirements

Blue Cross Blue Shield of Michigan and Blue Care Network will move to the Availity® provider portal later in 2021. We want your organization to have the best experience when using Availity. For a smooth transition, you should have the following:

- A high-speed internet connection
- Google Chrome as your browser (Chrome is the preferred browser, but Microsoft Edge, version 79 or higher, and Firefox® are also supported. Internet Explorer®, version 11.0 or higher, is supported but not recommended.)
- The ability to enable pop-up windows, allow JavaScript and allow images to load automatically
- 1024 x 768 pixels or greater screen resolution
- Up-to-date antivirus software
- The latest version of Adobe® Reader, to view PDF documents

Tip: The latest Availity technical requirements are available on the **Availity website**. Scroll down and click on the *Requirements* tab.

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Availity *continued from Page 3*

- **Administrator reports** — This individual can pull Availity reports on behalf of the organization, such as user activity reports or transaction reports.

Start thinking about the administrator structure that will work best for your organization, so you'll be able to register in the coming months. Availity will make the administration tasks easy with training, forums and reports.

Questions?

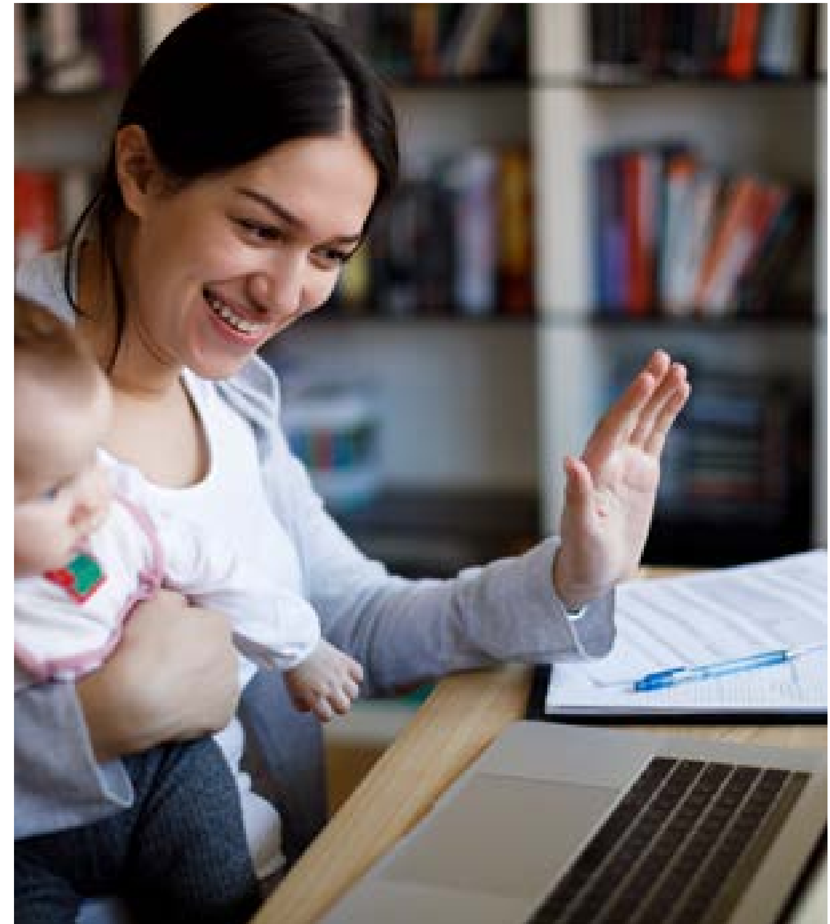
We have a ***Frequently Asked Questions*** document about our move to Availity. If you have a question, check here first to see if it's already been answered. If it hasn't, you can submit your question to *ProviderPortalQuestions@bcbsm.com* so we can consider adding it to the FAQ document. If you need immediate assistance or have a question specific to a certain member or situation, use our website resources or contact Provider Inquiry.

Web resources:

- Log in as a provider at **bcbsm.com**.
- Find prior authorization information for Michigan providers at **ereferrals.bcbsm.com**.
- Find prior authorization information for non-Michigan providers and medical policy information by going to **bcbsm.com/providers** and clicking on ***Quick Links***.

Provider Inquiry numbers are available at **bcbsm.com/providers**. Click on ***Contact Us***. Then, click on the type of provider you are; then click *Provider Inquiry*.

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



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**)

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Ascension to be network provider for Blue HPN in Southeast Michigan

As published in the **October *Record***, Blue Cross Blue Shield of Michigan will offer health plans that use a new network called Blue High Performance Network℠, or Blue HPN℠. Starting in January 2021, Ascension will be the network provider for Blue HPN in Southeast Michigan.

Blue Cross health plans with Blue HPN are EPO plan types, which means services are covered within the Blue HPN network. Members who have health plans with Blue HPN in Southeast Michigan can see certain contracted Ascension health care providers for services and will only have to pay the plan's out-of-pocket expenses. They will also be able to see HPN providers throughout the country, when they go out of state. If they see a non-Ascension health care provider, they'll be responsible for the costs (except for emergency services and urgent care).

You'll know that a member has selected the Blue HPN plan by their Blue Cross ID card or in web-DENIS when you check eligibility.

One important item to note on the card is the plan type. You'll see the letters 'EPO' in that area. EPO plan types require members to stay within the network for their plan and don't allow for out-of-network coverage (with some exceptions).

If you see "HPN" in the suitcase on the member ID card, you need to be part of the Blue HPN network to serve that member.

We're here for you — virtually

Blue Cross Blue Shield of Michigan and Blue Care Network's provider consultants are here to serve our provider community.

We recognize this has been a challenging year. Although we've been unable to meet with you in person for the last several months, consultants continue to work hard to assist providers virtually.

We're still here to help meet your education and training needs, and to help clarify medical policy and contract information. We encourage you to use our self-service tools and provider inquiry phone numbers when you need help with claims. When your issue isn't resolved through these channels, **contact** your consultant and provide the interaction number given to you by the provider inquiry representative.

We offer individualized training as needed, but we also offer many topics on our provider training site.

To learn about what we offer to all providers, log on to Provider Secured Services at **bcbsm.com**.

For Blue Cross

1. Click on *BCBSM Provider Publications and Resources*.
2. Click on *BCBSM Newsletters and Resources*.
3. Click on *Provider Training in the left navigation*.

For BCN

1. Click on *BCN Provider Publications and Resources*.
2. Click on *Learning opportunities*.

While we continue to encourage virtual visits, we'll consider an in-person visit if your need is urgent. Call your consultant to request a visit so we can share our safety requirements.

See our **flyer** for Blue Cross and BCN contact information and the role of your provider consultant.

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How to request BCN fee schedules

We've set up a new mailbox, feeschedule@bcbsm.com, for providers to request copies of Blue Care Network fee schedules. Fee schedules are reviewed and updated annually.

When you email us, you'll need the following information:

- A copy of your signed licensing agreement (You can request a copy of the licensing agreement from customer service or by calling Provider Inquiry at 1-800-344-8525. There's a link to a recent licensing agreement in the Claims chapter of the *BCN Provider Manual*, in the section titled, "Pricing and fees.")
- Type 2 NPI
- Tax ID number
- Primary practice address
- Specialty
- Medical Care Group affiliation

If you have questions about the fee schedule, contact your provider consultant.

Note: BCN only provides fee schedules to providers who participate on our network. If you are not currently contracted and would like to become a participating provider, go to **bcbsm.com/providers** and click *Join our network*, or contact Provider Enrollment at 1-800-822-2761.

Blue Care Network celebrates latest results awarded from the National Committee for Quality Assurance

Blue Care Network received a commendable status for its commercial HMO and Medicare HMO product lines, and an accredited status for the HMO Marketplace Exchange product line (for this category the products receive accredited or not accredited), scoring 50 out of 50 points from National Committee for Quality Assurance.

The score combined the 50 points for the 2020 NCQA standards with previous HEDIS (Healthcare Effectiveness Data and Information Set) and CAHPS (Consumer Assessment of Healthcare Providers and Systems) scores, which are also used as part of the NCQA measures.

An NCQA accreditation shows our customers and members how we're improving operational efficiencies; satisfying state requirements and employer needs; keeping members healthy; and demonstrating our commitment to quality.

"This year BCN received 50 out of 50 points from NCQA for the standards, which is a major accomplishment," said Belinda Bolton, director, Quality Management. "I'm so grateful for this team. For the past three years, they have performed above and beyond expectations to ensure a successful survey outcome."

After the survey team finished, they applauded the Quality Management team and the entire organization on an excellent survey based on a variety of tasks, including a strong and knowledgeable staff; well-organized files; and for demonstrating an outstanding response to the COVID crisis to ensure continuity of care, just to name a few.

For 2022, the Quality Management team is diligently working toward survey accreditation preparation for the PPO lines of business.

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New provider contract management system will require providers to type their names before adding electronic signatures

Blue Cross Blue Shield of Michigan and Blue Care Network are moving to a new contract management system before the end of 2020. We'll continue to send agreements to provider offices by email for their signature using DocuSign. However, before signing, the provider must type in his or her name. This is especially important for larger group practices using the same email address who regularly add new providers.

If you don't type your name before signing, the contract won't automatically populate the provider name and the document will need to be resigned.

Learn to conduct a physical exam using telehealth

Blue Cross Blue Shield of Michigan is offering training to help providers do an effective virtual physical examination. The training is conducted by Gretchen C. Goltz, D.O., C.P.E. She's a medical director at Blue Cross and Blue Care Network.

Dr. Goltz says it's possible to do a relatively thorough physical exam with audio and visual telemedicine.

In the recorded webinar, Dr. Goltz covers the following parts of the physical exam:

- Head, eyes, ears, nose, throat
- Skin
- Cardiopulmonary
- Abdominal and genitourinary
- Musculoskeletal
- Neurological

Click on the link to see the **video.**

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Online Training

Sign up for training webinars

Provider Experience is continuing its series of training webinars for health care providers and staff. The webinars are designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

Here's information on the upcoming training webinars:

Webinar name	Date and time	Registration
Blue Cross 201 – Claims Basics – Professional	Wednesday, Feb. 3, 2021 10 to 11 a.m.	Click here to register
Blue Cross 201 – Claims Basics – Professional	Wednesday, Feb. 3, 2021 2 to 3 p.m.	Click here to register
Autism Overview	Thursday, Feb. 4, 2021 10 to 11 a.m.	Click here to register
Autism Overview	Thursday, Feb. 4, 2021 2 to 3 p.m.	Click here to register
Autism Overview	Tuesday, Feb. 10, 2021 10 to 11 a.m	Click here to register
Autism Overview	Tuesday, Feb. 10, 2021 2 to 3 p.m.	Click here to register
Blue Cross 201 – Claims Basics – Professional	Tuesday, March 2, 2021 10 to 11 a.m.	Click here to register
Blue Cross 201 – Claims Basics – Professional	Tuesday, March 2, 2021 2 to 3 p.m.	Click here to register

The Blue Cross 201 webinar provides an in-depth learning opportunity and builds on information shared in our Blue Cross 101: Understanding the Basics webinar. This session reviews the processes and tools available when resolving common issues with claims.

The Autism Overview webinar reviews current processes related to delivering services for members with autism.

Recordings of previous webinars are available on Provider Secured Services on the Blue Cross Provider Publications and Resources or BCN Provider Publications and Resources pages as follows.

Please see Webinar, continued on Page 9

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Blue Cross Provider Publications and Resources

1. Log in to Provider Secured Services at **bcbsm.com**.
2. Click *BCBSM Provider Publications and Resources.*
3. Click *BCBSM Newsletters and Resources.*
4. Click *Provider Training.*
5. In the Featured Links section of the page, check out 2020 Provider Training Webinars.

You can also get more information about online training, presentations and videos by clicking on the E-Learning icon at the top of the page.

BCN Provider Publications and Resources

1. Log in to Provider Secured Services at **bcbsm.com**.
2. Go to *BCN Provider Publications and Resources.*
3. Under Other Resources, click on *Learning Opportunities.*
4. Find the most recent webinars under *2020 Provider Training Webinars*

As additional training webinars become available, we'll provide notices through web-DENIS, *The Record* and *BCN Provider News.*

Reminder: Direct reimbursement available to athletic trainers, for physical medicine services on or after Jan. 1

Athletic trainers will have the opportunity to participate in Blue Cross Blue Shield of Michigan's Traditional and TRUST PPO networks as well as BCN HMO℠, starting Jan. 1, 2021.

Athletic trainers can find enrollment forms and practitioner agreements on **bcbsm.com/providers**. To find enrollment information, click on *Join Our Network*. Specific qualification requirements are identified within each agreement.

See the full article in the **November-December 2020** issue (Page 10) for details.

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Professional associations can help office staff

If you're a biller, a referral coordinator, an office manager or provide general office assistance in a medical environment, you may want to consider the benefits of joining a professional association. These organizations focus on the type of work you do and often provide:

- Education and communication including conferences, webinars and forums focused on your job skills
- Networking so you can consult with others on common concerns
- Certification opportunities or job resources to help you move forward in your career

As a service to you, we're providing contact information for some local and national groups you may want to explore further. Please note that Blue Cross Blue Shield of Michigan and Blue Care Network do not endorse any specific professional association, have not reviewed their websites and are not responsible for their content.

Association	Michigan Revenue Cycle Association (MRCA)	Healthcare Financial Management Association (HFMA)	Michigan Medical Group Management Association (MiMGMA)	Michigan Medical Billers Association (MMBA)
About our association	Our mission is to provide ongoing mentorship, communication and education to and for our organization members and others in support of the health care revenue cycle; strengthen the role of health care revenue cycle professionals to promote recognition for professional excellence, promote ethics and quality processes while maintaining fiscal responsibility.	Membership gives you access to industry news, education resources (such as access to HFMA's education portal, online programs, webinars and other education opportunities). There are also a number of certifications related to health care finance which are included with the cost of membership.	We offer members a variety of benefits, including educational conferences, monthly member webinars and on- demand educational opportunities, regular updates on legislative and reimbursement issues affecting practices, as well opportunities for ACMPE and AAPC CE credits.	We offer education on changes in insurance, treatments and billing for medical providers.
Target Audience	Those involved in medical claims revenue cycle.	Health care finance colleagues in health systems, insurance organizations, vendor/technology companies and students at universities interested in pursuing careers in healthcare finance	Ambulatory medical practice executives, clinicians and management staff	Medical practices of all specialties and facilities Coders, billers, providers and billing organizations
Educational opportunities	Monthly webinars	Recorded webinars and programs are available to members online. The following upcoming chapter event is also scheduled on Jan. 20, 2021 1:00-3:00 p.m. Eastern time: Be a Hero, HFMA Michigan Great Lakes 2021 Women in Healthcare Leadership Event	Monthly webinars for members only. A spring conference is planned for April 29-30th at the Soaring Eagle Casino. The fall Conference is scheduled for Sept. 30-Oct. 1 at Shanty Creek Resort. Third Party Payer Day 2021 is Nov. 5, 2021 at the Soaring Eagle Casino.	Six chapters across the state with in person and virtual meetings; we offering CEUs for meetings with a wide variety of speakers and topics Annual Expo in East Lansing May 18, 2021
For additional Information	Visit our website https://www.mrcaonline.org/ or contact Membership Chair Renee Sheneman at Renee.Sheneman@mclaren.org	Visit our website: hfmaemc.com (chapter website) and HFMA.org (national website) or contact Membership Director Ariana Raymond at Ariana.raymond@trinity-health.org or Chapter President Nancy Smith at smithnly@mercyhealth.com. There is a 30-day free trial membership available.	Contact info@mimgma.org or call 1-800-314-7602. Executive Director Debra O'Shea, CMPE can be reached at doshea@epoxyhealth.com. Memberships are available for: 1) practice members 2) dual membership option with National MGMA and 3) faculty, student and affiliates.	Contact info@mmbaonline.org Annual membership renewal effective January to December each year.

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CareCentrix to manage authorizations for home health care for Medicare Advantage members

Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with CareCentrix® to manage authorization of home health care for Medicare Advantage members.

Providers will need to request prior authorization from CareCentrix for Medicare Plus Blue℠ PPO and BCN Advantage℠ members for home health care, for dates of service on or after March 1, 2021.

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

Submitting prior authorization requests

Primary care providers, acute care providers, post-acute care providers and home health care agencies will be able to submit requests online through the CareCentrix portal, by phone, by fax and through AllScripts®.

How this benefits your patients

This home health care program is designed to:

- Reduce the length of stay in inpatient facilities
- Lower the chance of hospital readmission
- Assist with the transition from hospital to home
- Provide a home-based center of care

Claims and appeals

Home health agencies will continue to submit claims, claims questions and appeals to Blue Cross Blue Shield of Michigan.

If providers don't obtain authorization for home health care from CareCentrix, claims may be denied.

Next steps

In future newsletter articles and web-DENIS messages, we'll provide more information about CareCentrix and this change, including:

- How to access the portal and request prior authorization
- How to sign up for training webinars
- How to access resources and support

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CMS approves next generation sequencing for certain cancer patients covered by Medicare Advantage plans

The Centers for Medicare & Medicaid Services has determined next generation sequencing is a covered service as a diagnostic laboratory test for patients with germline (inherited) ovarian or breast cancer when performed in a CLIA-certified laboratory, ordered by a treating physician and when specific requirements are met.

The CMS decision is retroactive to Jan. 27, 2020, and affects all Medicare Advantage plans, including Medicare Plus Blue PPO℠ and BCN Advantage℠. The implementation date for claims processing is November 13, 2020.

Next generation sequencing is one technique that can measure one or more genetic variations as a laboratory diagnostic test, such as when used as a companion in vitro diagnostic test.

The decision memo is available on the **CMS website**.

Reminder: Medicare Advantage members transitioning to a new diabetic management program

BCN Advantage℠ and Medicare Plus Blue℠ PPO members currently in the Fit4D diabetic management program managed by Cecilia Health have been transitioned to Livongo for diabetic management services, starting in October. Members enrolled in Fit4D will complete their programs before being offered the new program.

See the full article in the November-December ***BCN Provider News*** (Page 15).

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Medicare Part B medical specialty drug prior authorization list is changing in January 2021

For dates of service on or after Jan. 1, 2021, the following CAR-T medications will be managed by Blue Cross Blue Shield of Michigan and Blue Care Network under the medical benefit for Medicare Plus Blue℠ PPO and BCN Advantage℠ members. (For dates of service before Jan. 1, 2021, CAR-T cell therapy is covered under Original Medicare.)

- Yescarta® (axicabtagene ciloleucel), HCPCS code Q2041
- Kymriah® (tisagenlecleucel), HCPCS code Q2042
- Tecartus™ (brexucabtagene autoleucel), HCPCS code J9999

You must submit prior authorization requests for outpatient CAR-T therapy drugs before providing the service.

Submit prior authorization requests, **including all relevant clinical documentation**, using one of these methods:

- Enter the request in the NovoLogix® online tool. For more information about entering requests in NovoLogix, see the NovoLogix section below.
- Fax the request to the Pharmacy Part B Help Desk at 1-866-392-6465.

Note: Prior authorization for CAR-T drugs is **not** managed by AIM Specialty Health®.

If you have questions about this, please email MASRX@bcbsm.com.

We're also adding a medication to the *Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue℠ PPO and BCN Advantage℠ members*. The following specialty medication will require prior authorization through NovoLogix for dates of service on or after Jan. 1, 2021, when the drug is administered by a health care professional in

a provider office, at the member's home, in an off-campus outpatient hospital or in an ambulatory surgical center (place of service 11, 12, 19, 22 and 24):

- Viltepso™ (viltolarsen), HCPCS codes J3490, J3590

How to bill

For Medicare Plus Blue and BCN Advantage, we require authorization for all outpatient places of service when you bill these medications as a professional service or as an outpatient facility service:

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

Submit authorization through NovoLogix

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

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

List of requirements

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

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Get ready for annual visits for your Medicare Advantage patients

In the new year, you'll start seeing new and existing BCN Advantage℠ patients for their Welcome to Medicare visits, annual wellness visits or annual physical exams. Here's some important information about these different visits to help you prepare:

- New BCN Advantage members should be scheduling their Welcome to Medicare preventive visit, also known as the initial preventive examination, and their annual physical exams.
- Existing BCN Advantage members should begin scheduling their annual wellness visit and the more comprehensive annual physical exam.

Welcome to Medicare visit

This preventive visit is sometimes referred to as the initial preventive examination. This is a one-time appointment for new Medicare patients to be scheduled within their first 12 months of enrollment. Medicare pays for one Welcome to Medicare visit per member, per lifetime.

This visit is a great way to get up-to-date information on health screenings, shot records, family medical history and other preventive care services. These visits can be scheduled at the same time or coordinated with the patient's annual physical exam to get the best picture of your patient's health.

The Welcome to Medicare visit will include a health risk assessment and self-reported information from your patient to be completed before or during the visit. For more information about health risk assessments, visit **Framework for Patient-Centered Health Risk Assessments** on the Centers for Disease Control and Prevention website.

During this visit, you should:

- Perform a health risk assessment.
- Record your patient's medical and social history (like alcohol or tobacco use, diet and activity level).

- Check height, weight and blood pressure.
- Calculate body mass index.
- Perform a simple vision test.
- Review potential risk for depression and patient level of safety.
- Offer to talk about creating advance directives.
- Provide education on preventive services and prescription of appropriate services.
- Create a screening schedule (checklist) for appropriate preventive services.
- Give flu and pneumococcal shots, and referrals for other care, if needed.

Please see Annual Visits, continued on Page 15

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Annual Visits *continued from Page 14*

Billing code for Welcome to Medicare visit, also called initial preventive physical examination
G0402

Annual wellness visit

The annual wellness visit is a chance for you to develop or update your patient's personalized prevention plan based on his or her current health situation and risk factors. A health risk assessment is also part of the annual wellness visit. It includes self-reported information from your patient to be completed before or during the visit.

Medicare will cover an annual wellness visit every 12 months for patients who've been enrolled in Medicare for longer than 12 months. Patients can schedule their annual wellness visit on the same day or coordinate it with their routine physical exam (see below) to help give you a complete view of their health.

Services at the annual wellness visit include:

- Health risk assessment
- Review of medical and family history
- Develop or update a list of current providers and prescriptions
- Height, weight, blood pressure and other routine measurements
- Detection of any cognitive impairment
- Personalized health advice
- A list of risk factors and treatment options
- Educate on preventive services and prescribe appropriate services
- A review and update of the screening schedule (checklist) for appropriate preventive services
- Advance care planning

Billing codes for annual wellness visits, which include a personalized prevention plan of service
G0438 — First visit AWV, can only be billed one time, 12 months after a G0402 (IPPE)
G0439 — Annual wellness visit (subsequent)
Note: G0438 or G0439 must not be billed within 12 months or previous billing of a G0402 (IPPE)

Routine physical exam

This exam is typically covered annually by the patient's Medicare Advantage health care plan. These exams are part of preventive services that aren't part of the Welcome to Medicare or annual wellness visit.

Routine physical exams are used to get information about the patient's medical and family history, and perform a head-to-toe assessment with a hands-on examination to assess your patient's health and address any abnormalities or signs of disease. Routine physical exams should include the following:

- A visual inspection
- Palpitation
- Auscultation
- Manual examination

Billing codes for annual exams or physicals
New or established patient *99386 (40-64 years old) *99387 (65 years and older)

Care plans

These preventive visits are an excellent opportunity for you and your patients to plan their care for the year. Care plans should include a schedule for preventive services and health screenings, many of which are required annual services to meet Healthcare Effectiveness Data and Information Set, commonly known as HEDIS® specifications.

Please see Annual Visits, continued on Page 16

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Annual Visits *continued from Page 15*

You'll need to recommend and prescribe — or refer your patient —preventive services that apply to his or her care plan. Some examples of preventive services include:

- Colon cancer screening
  - o FOBT yearly
  - o Sigmoidoscopy every five years
  - o Colonoscopy every 10 years
  - o Cologuard every three years
- Breast cancer screening
  - o Mammography every two years
- Osteoporosis screening
  - o Bone mineral density testing for women older than 65 and men older than 70
  - o Recommended every two to 10 years, depending on risk factors
  - o Medicare pays for the screening every two years; more often if medically necessary

Comprehensive diabetes care

- o A1c blood sugar screening to diagnose diabetes — every three years if test is normal; once diagnosed, two to four times per year to monitor treatment response
- o Urine microalbumin screening — yearly
- o Retinal eye exam — every other year if negative or every year if positive

These visits also provide an opportunity to review or create a risk assessment for your patients, including a full list of their long-term chronic conditions. This will help your patients take advantage of disease and care management programs, as well as prevention initiatives.

These visits benefit both you and your patient by:

- Uncovering care management opportunities
- Identifying practice patterns
- Managing patient medications better
- Reducing avoidable hospital admissions

For more information on risk adjustment and HEDIS best practices, refer to our online provider manuals.

Note: BCN Advantage only reimburses one evaluation and management code on a date of service.

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

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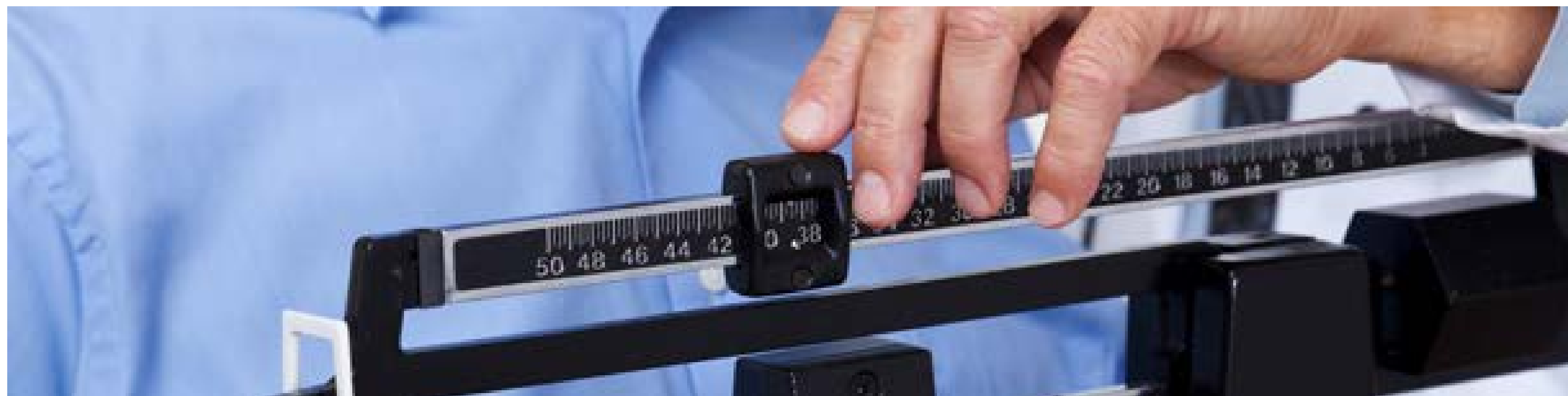

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Help patients get annual health screenings

As the new year approaches, Blue Care Network is preparing for annual HEDIS® medical record reviews. BCN team members will be contacting provider offices from January to May to request medical records. As always, we appreciate your cooperation and partnership in making HEDIS 2021 (measurement year 2020) a success.

As part of our joint effort in making this happen, here's a checklist to help patients take care of their heath.

- Get an early start with patients in 2021. Get a BMI on every patient. Note that all patients under 20 years old need a BMI percentage, height and weight measure.
- For children ages 3 to 17, complete counseling for nutrition. Complete checklist verifying nutrition discussion and counseling for physical activity. Recommend patients exercise one hour per day; complete checklist verifying discussion of physical activity.
- For diabetics, complete the following: HbA1c, nephropathy monitoring (urine for protein or on ACE/ARB medications, or renal diagnosis), controlled blood pressure (≤139/89), diabetic eye exam. Schedule follow-up visits as results indicate.
- For patients with hypertension, follow-up on medication regimen; document lifestyle changes and blood pressure to ensure appropriate management. A controlled blood pressure is 139/89 or lower.
- For members discharged from an inpatient setting, complete a medication reconciliation within 30 days of discharge.
- Review history and order colon cancer screening test, if needed (age 50 to 75, colonoscopy every 10 years). For patients that refuse a colonoscopy, suggest they complete an FOBT or FIT-DNA test.
- For all females between age 50 and 74, order a mammogram (if they haven't completed one in the last 24 months) and cervical cancer screening age 21 to 64 (if they haven't had one in three or five years). Patients must be 30 years old on the date of service of the PAP/HPV to meet the five-year interval requirement.
- Talk to every patient about the need for physical exercise — 30 minutes a day.
- For seniors, assess the following: fall risk, safe environment, incontinence management and immunizations.
- Schedule a depression assessment.
- Childhood and adolescent immunizations: Check immunization record on MCIR and schedule visits to have complete and timely immunizations.
- Adult immunizations: Check immunization record and schedule visits to have complete and timely immunizations.

Blue Care Network appreciates your efforts to keep our members healthy.

For information on preventive services, call the Clinical Data Operations HEDIS message line at 1-855-228-8543.

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February focus is on heart health

In support of American Heart Month in February, Blue Care Network is reminding providers to screen patients for conditions that can affect heart health. BCN supports Michigan Quality Improvement Consortium guidelines, including those for screening and management of high cholesterol, high blood pressure, overweight and obesity and tobacco control.

High blood pressure is a serious condition that can lead to coronary heart disease, kidney disease and stroke. About one in three adults in the United States has hypertension that usually starts from the ages of 35 to 50, according to the Centers for Disease Control and Prevention. There are no symptoms or warning signs and it can affect anyone regardless of race, age or gender.

Risk factors that can't be controlled

- Age
- Family history of early heart disease
- Race and ethnicity

Risk factors that can be controlled by the member with guidance from the provider

- High cholesterol (high LDL or "bad" cholesterol)
- Low HDL ("good" cholesterol)
- Smoking
- High blood pressure
- Diabetes
- Obesity, overweight
- Physical inactivity
- Diet

Factors that determine LDL ("bad") cholesterol level

- Heredity
- Diet
- Weight
- Physical activity and exercise
- Age and gender
- Alcohol
- Stress

Refer to the MQIC guidelines for **lipid screening and management** and **Management of overweight and obesity in adults** for more information.

Providers can also refer members to the **National Heart Lung and Blood Institute** website for information about heart disease.

Medical policy updates

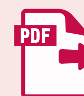
Blue Care Network's medical policy updates are posted on Provider Secured Services. Go to BCN Provider Publications and Resources and click *Medical Policy Manual*. Recent updates to the medical policies include:

Noncovered services

- Home monitoring device for age-related macular degeneration
- Gene expression profiling for cutaneous melanoma

Covered services

- Genetic testing — Noninvasive prenatal screening for fetal aneuploides, microdeletions and twin zygosity using cell-free fetal DNA
- Amniotic membrane and amniotic fluid
- Intravitreal and punctum corticosteroid implants
- Transcatheter aortic valve implantation for aortic stenosis
- Home cardiorespiratory monitoring — Pediatric
- Intensity-modulated radiation therapy, or IMRT: Central nervous system tumors
- Sleep disorders, diagnosis and medical management
- Transcatheter arterial chemoembolization of hepatic tumors, or TACE
- Urinary biomarkers for bladder cancer
- Genetic testing — BRAF mutation in selecting melanoma patients for targeted therapy
- Implantable cardioverter defibrillator, or ICD, including subcutaneous ICD
- Prostatic urethral lift procedure for the treatment of BPH



Medical Policy Updates

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We've made changes to BCN's Behavioral Health Incentive Program

Blue Care Network is making changes to some of the incentive opportunities in the 2021 Behavioral Health Incentive Program.

- The engagement phase of the HEDIS measure, Alcohol and Other Substance Use Disorders, will be payable to psychiatrists along with the initiation phase, which was added for 2020.
- Psychiatrists who deliver medication-assisted treatment to patients diagnosed with opioid use disorder will receive an incentive based on each patient treated with naltrexone or buprenorphine. (Methadone isn't part of this incentive opportunity.)
- Psychiatrists who participate with a primary care practice to offer the Psychiatric Consult Collaborative Care Model, will be eligible for a per-practice bonus of $2,500 when they contract with primary care providers or physician organizations.

We're discontinuing the incentive for the acute phase of Antidepressant Medication Management but will continue to offer an incentive for the continuation phase.

Log in to Provider Secured Services at **bcbsm.com** to review the program brochure and flyer for details.

- Go to BCN Provider Publications and Resources.
- Click *Behavioral Health* under Other resources in the left-hand navigation.
- The BHIP booklet and program flyer are listed under the Behavioral Health Incentive Program heading.

Guidelines for billing collaborative care

The Collaborative Care Model, also known as CoCM, is a benefit for all our members, including seniors and Blue Care Network members, who see a primary care provider who uses this model. There are no member cost-sharing requirements for the use of CoCM.

Keep in mind that there are some specific billing requirements when using this model. Neither the behavioral health care manager nor the psychiatrist submits claims for CoCM services. The PCP bills for services provided by the care team over a calendar-month service period.

See details outlined in the article on **Page 33** in the Billing section.

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Quality corner: Antidepressant medication management

What is the antidepressant medication management measure, according to the Healthcare Effectiveness Data and Information Set guidelines?

The percentage of members 18 years or older with a diagnosis of major depression who are newly treated with antidepressant medication, and who remained on the medication for at least:

- 84 days for the acute treatment phase
- 180 days for the continuous treatment phase

Why is it important?

Major depressive disorder[1]:

- Can impair daily activities, as well as disrupt eating habits, sleep patterns and concentration
- Affects nearly 15 million adults in the United States
- Results in lost work productivity
- Can lead to suicide or attempted suicide

How can I ensure my patients adhere?

Know the common barriers to adherence[2]:

- Regimen complexity
- Medication beliefs
- Cost

Educating your patients is very important. Advise them on when and how antidepressants should be taken, and how long they can expect to take them. Be prepared for questions about cost as well. Please remember that the members pay the least for drugs on the lowest tier of their drug list. Drugs on higher tiers cost the member more and may require prior authorization.

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References
1 http://www.qualitymeasures.ahrq.gov/content.aspx?id=48934&search=antidepressant+medication+management
2 http://adhereforhealth.org/wp-content/uploads/pdf/RAND_TR765_AReviewofBarrierstoMedicationAdherenceAFrameworkforDrivingPolicyOptions.pdf

We send reminders to patients to adhere to ADHD follow-up visits

We occasionally sending letters to encourage members whose children have received a prescription for attention deficit hyperactivity disorder medication to see their physicians for follow-up visits as outlined in the ADHD HEDIS® measure.

Children 6 to 12 years old should see a physician within 30 days of first being prescribed medication to treat ADHD. If they stay on the medication for at least 210 days, they should have two follow-up visits within nine months after the initiation phase.

We also send letters to remind physicians to schedule the follow-up visits as noted in HEDIS measure.

Physicians may need to adjust a medication dose or discuss strategies to alleviate side effects. We also encourage you to coordinate care with other behavioral health physicians or primary care doctors who are seeing your patients.

Telehealth visits are acceptable for the continuation and maintenance phase visits. However, only one of the two visits may be a telephone visit.

See the HEDIS tip sheet PDF below for HEDIS hints for patient education and coding tips.

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Criteria corner

Blue Care Network uses Change Healthcare's InterQual Level of Care when conducting admission and concurrent review activities for acute care hospitals. To ensure that providers and health plans understand the application of the criteria and Local Rules, BCN provides clarification from Change Healthcare on various topics.

Question:

The footnote for InterQual's Substance *Use Disorders — Inpatient Rehabilitation — Episode Day 1 — Clinical Findings — Intoxication* say that the intoxication effects are due to "recent ingestion" of substance(s)." Does this mean that the member must have been intoxicated at the time of admission to inpatient rehabilitation or (if stepping down from) inpatient detoxification, or does it mean that the member generally exhibits the intoxication symptoms when they've used or are intoxicated?

For example, if a member is stepping down from inpatient detoxification to inpatient rehabilitation level of care, not having used in three to four days but generally demonstrates the symptoms of intoxication when using, does this count toward the criteria point?

Answer:

The criteria point in question means that the patient must have used just before or been intoxicated at the time of admission to the current level of care (inpatient rehabilitation).

Question:

For InterQual's *Adult/Geriatric Psychiatry — Partial Hospital Program — Episode Week 1 — Admission — Functional Impairment — Severe and change in baseline within last month — Job or school performance impaired — Suspended or terminated* criteria point, can this include Family Medical Leave Act time to enter treatment to address behavioral or emotional issues, especially if not a punitive measure from the employer?

For example, if the member's job was not at risk due to performance problems related to behavioral or emotional issues, but he or she takes FMLA time to enter treatment, would this count toward the criteria point?

Answer:

Yes, FMLA can be used to meet this criteria point. Criteria point "Rapid deterioration in functional ability" may also be appropriate in this example, as the member had to leave work to seek treatment.

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HEDIS 2020 results

Due to the COVID-19 pandemic, the Centers for Medicare & Medicaid Services suspended the requirement for HEDIS® reporting for Medicare and Marketplace products that are typically due June 15, 2020, for the 2019 measurement year. The National Committee for Quality Assurance continued to require reporting for commercial plans but allowed the use of HEDIS 2019 reported results for hybrid measures.

HEDIS is the most widely used set of performance measures in the managed care industry, and is used by the NCQA for accreditation. It's also part of an integrated system to establish accountability in managed care organizations. It was originally designed to address private employers' needs as purchasers of health care and has been adopted for use by public purchasers, regulators and consumers. It's also used by CMS for their star ratings.

Blue Care Network noted the following areas of improvement in 2020 (measurement year 2019):

Commercial

- Weight assessment and counseling for nutrition and physical activity for children/adolescents — Physical activity counseling
- Antidepressant medication management — Effective acute and continuation phase treatment
- Avoidance of antibiotic treatment in adults with acute bronchitis/ bronchiolitis
- Breast cancer screening
- Childhood immunizations — Combo 10
- Follow-up after emergency department visit for mental illness — 7 and 30 day
- Follow-up after emergency department visit for alcohol and other drug abuse or dependence — 7 and 30 day
- Use of imaging studies for low back pain
- Use of opioid from multiple prescribers and pharmacies

- Follow-up care for children prescribed ADHD medication — Continuation and maintenance phase
- Medication management for people with asthma – Medication compliance 75%
- Pharmacotherapy management of COPD exacerbation — Bronchodilators and systemic corticosteroid
- Prenatal and postpartum care — Postpartum care
- Use of first-line psychosocial care for children and adolescents on antipsychotics
- Statin therapy for patients with cardiovascular disease — Therapy and adherence
- Statin therapy for patients with diabetes — Therapy and adherence
- Non-recommended cervical cancer screening in adolescent females
- Plan all-cause readmission
- Emergency department utilization
- Well-child visits in the third, fourth, fifth and sixth years of life

Please see HEDIS results, continued on Page 23

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HEDIS results *continued from Page 22*

Thank you to all our affiliated practitioners for providing quality care to our members and allowing access to conduct medical record reviews for HEDIS and various audits.

Primary care practitioners can still find opportunities to provide aggressive intervention in the management and care of our members with diabetes and high blood pressure, and in ordering procedures for breast, cervical and colorectal cancer screening.

We're actively involved in activities throughout the year that positively affect our HEDIS rates, including:

- Physician Quality Rewards Program which is tied to some of the HEDIS measures
- Health e-Blue℠ website
- Member gaps in care letters
- Member outreach reminder telephone calls
- Member and physician education through publications
- Member health fairs
- Care management calls and letters
- Member incentive programs
- HEDIS interventions
- HEDIS/CAHPS summit meetings

We look forward to working with you to promote continued improvement in all areas of patient care.

If you'd like more information about HEDIS, call Clinical Data Operations at 1-855-228-8543.

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2020 HEDIS results

Help patients get annual health screenings

As the new year approaches, Blue Care Network is preparing for annual HEDIS® medical record reviews. BCN team members will be contacting provider offices from January to May to request medical records. As always, we appreciate your cooperation and partnership in making HEDIS 2020 a success.

As part of our joint effort in making this happen, we're providing a checklist to help patients take care of their heath. See article on **Page 17** for the checklist.

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We cover Skyrizi and Tegsedi under the pharmacy benefit for Blue Cross' PPO and BCN HMO members

We've changed how we cover Skyrizi® and Tegsedi® for Blue Cross' PPO (commercial) and BCN HMO℠ (commercial) members, effective Oct. 8, 2020.

Blue Cross Blue Shield of Michigan's PPO and Blue Care Network HMO plans are no longer covering the following medications under the medical benefit. Instead, they're covered under the pharmacy benefit.

- Skyrizi (risankizumab-rzaa), HCPCS codes C9399, J3590
- Tegsedi (inotersen), HCPCS codes C9399, J3490

Coverage for these drugs has moved to the pharmacy benefit because the drugs can be safely and conveniently self-administered in the member's home.

These drugs will continue to require prior authorization and are available through pharmacies that dispense specialty drugs, including AllianceRx Walgreens Prime Specialty Pharmacy.

We've contacted members affected by this change and advised them to talk to their doctors about prescribing these medications for purchase from a pharmacy.

Providers who administer these medications to their patients on or after Oct. 8, 2020, will be responsible for the cost.

Both drugs require prior authorization

There are no changes to the management of these therapies.

- Both Skyrizi and Tegsedi continue to require prior authorization. For information about submitting prior authorization requests, continue reading.
- For Skyrizi, quantity limits continue to apply.
- For Tegsedi, documentation requirements continue to apply.

Submitting prior authorization requests

Providers can submit prior authorization requests for these drugs as follows:

- **Electronically:** Through CoverMyMeds® or another free ePA tool, such as Surescripts® or ExpressPAth®. See **Save time and submit your prior authorization requests electronically for pharmacy benefit drugs** for more information.
- **By phone:** Call 1-800-437-3803.
- **By fax:** Call the Pharmacy Clinical Help Desk at 1-800-437-3803 to obtain the pertinent medication request form, which you can then submit by fax.

Please see Pharmacy Benefits, continued on Page 25

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Pharmacy Benefits *continued from Page 24*

- o **For Blue Cross' PPO members:** Fax the medication request form to 1-866-601-4425.
- o **For BCN HMO members**: Fax the medication request form to 1-877-442-3778.

- **By written request:** Mail a written request to:
  Blue Cross Blue Shield of Michigan
  Attention: Pharmacy Services
  Mail Code 512
  600 E. Lafayette Blvd.
  Detroit, MI 48226-2998

List of requirements

To view requirements for Skyrizi, Tegsedi and other drugs covered under the pharmacy benefit, see the Blue Cross and BCN **Prior authorization and step therapy coverage criteria** document. This document is available from the following pages on the **ereferrals.bcbsm.com** website.

- **Blue Cross Pharmacy Benefit Drugs**
- **BCN Pharmacy Benefit Drugs**

For a list of requirements related to drugs covered under the medical benefit, see the ***Blue Cross and BCN utilization management medical drug list for Blue Cross PPO (commercial) and BCN HMO (commercial) members*** document.

Quarterly update: Requirements changed for some commercial medical benefit drugs

During July, August and September 2020, we updated authorization requirements, site-of-care requirements, or both, for BCN HMO℠ members, for the following medical drugs:

HCPCS code	Brand name	Generic name
J3490*	Viltepso™	viltolarsen
J3590*	Tecartus™	brexucabtagene
J3590*	Uplizna™	inebilizumab-cdon

* Will become a unique code

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

Additional notes

Authorization requirements apply only to groups that currently participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit.

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

Blue Cross Blue Shield of Michigan and Blue Care Network encourage proper utilization of high-cost medications that are covered under the medical benefit. As part of this effort, we maintain a comprehensive list of requirements for both Blue Cross' PPO (commercial) and BCN HMO (commercial) members.

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We added more vaccines to the pharmacy benefit

We added the following Hepatitis B vaccines to the pharmacy benefit for eligible Blue Cross Blue Shield of Michigan and Blue Care Network commercial non-Medicare members, starting Dec. 1, 2020:

- Energix™-B
- Heplisav-B®
- Recombivax HB®

This allows participating pharmacies to bill through the pharmacy claims processing system.

The program covers the same vaccines offered under the Vaccine Affiliation program. These vaccines are now billed under the medical benefit. Listed below are the vaccines and age requirements covered under the pharmacy benefits plan:

Vaccine	Common name	Age requirements
Influenza virus	Flu	None
Havrix®	Hepatitis A	None
Vaqta®	Hepatitis A	None
Twinrix®	Hepatitis A and B	None
Energix™-B (effective 12/1/20)	**Hepatitis B**	**None**
Heplisav-B® (effective 12/1/20)	**Hepatitis B**	**None**
Recombivax HB® (effective 12/1/20)	**Hepatitis B**	**None**
Gardasil®9	HPV	9 to 45 years old
M-M-R® II	Measles, mumps, rubella	None
Menveo®	Meningitis	None
Menactra®	Meningitis	None
Menomune®	Meningitis	None
Trumenba®	Meningococcal B	None
Bexsero®	Meningococcal B	None
Ipol®	Polio	None
Pneumovax 23	Pneumonia	None
Pneumococcal (PCV7)	Pneumonia	None
Prevnar 13®	Pneumonia	65 and older
Shingrix®	Shingles	50 and older
Boostrix®	Tetanus, diphtheria, whooping cough	None
Adacel®	Tetanus, diphtheria, whooping cough	None
TDVax®	Tetanus, diphtheria booster	None
Tenivac®	Tetanus, diphtheria booster	None
Varivax®	Varicella (chickenpox)	None

Please see Vaccines, continued on Page 27

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Vaccines, *continued from Page 26*

Vaccines for Blue Cross members can be processed under both pharmacy benefits and medical plans, but only one plan can be billed per claim. Both plans require a qualified administrator at a Blue Cross participating pharmacy or medical office to give the vaccine.

Qualified pharmacists giving the vaccine can bill the member's pharmacy benefits plan or the member's medical plan when the pharmacy participates in the medical Vaccine Affiliation program.

Participating medical offices giving the vaccine should bill the member's medical plan.

Most Blue Cross commercial members with prescription drug coverage are eligible. Most of the vaccines will be covered with no cost share to members if their benefits meet the coverage criteria.

Grandfathered and retiree opt-out groups won't be part of this program. These groups will maintain their current vaccine coverage under their medical benefit.

Most Blue Cross and BCN members can search for a participating retail pharmacy by logging in to their member account at **bcbsm.com**. After logging in:

- Hover the mouse over *My Coverage* in the blue bar at the top of the page.
- Select *Prescription* from the drop-down menu.

Scroll down to *Where to go for care* and click on *Find a pharmacy*. The link will take members directly to Express Scripts®.

Medicare Part B medical specialty drug prior authorization list is changing in January

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

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Michigan law prohibits 'surprise billing'

As of Oct. 22, 2020, Michigan state law prohibits surprise billing by nonparticipating professional providers in Michigan for emergency services and some non-emergency services provided on and after this date. Surprise billing is already prohibited for participating providers.

"Surprise billing" refers to instances where a member unknowingly receives care from a nonparticipating provider and later receives an unexpected bill for the difference between the insurer's payment and what the provider charges.

Nonparticipating professional providers in Michigan will no longer be able to balance bill members in the following scenarios outlined in the law:

- Covered emergency services at a participating or nonparticipating health facility
- Covered non-emergency services at a participating health facility when at least one of the following events occurs:
  - The patient doesn't have the ability or opportunity to choose a participating provider
  - The nonparticipating provider doesn't provide the required advanced written disclosure notice to the member of the service's estimated costs and notice of the right to seek care from a participating provider (see **Public Act 235**)
- A health care service at a participating health facility for a patient who was a admitted to the hospital within 72 hours after receiving a health care service in the hospital's emergency room

For the above scenarios, the law defines the benchmark rate that these nonparticipating providers must now accept as payment in full. The benchmark rate is defined as the greater of the following (excluding any in-network cost sharing):

- The median amount negotiated by the patient's carrier for the region and provider specialty
- 150% of the Medicare fee-for-service amount listed on the fee schedule for the health care service provided

Members are responsible for any in-network cost-sharing requirements.

If you have questions, contact Provider Inquiry at the appropriate number below:

- Blue Cross Blue Shield of Michigan
  - Physicians and other professional providers of care: 1-800-344-8525
  - Hospital and facility providers: 1-800-249-5103
- Blue Care Network
  - Professional providers: 1-800-344-8525
  - Ancillary and facility providers: 1-800-249-5103

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 tips include:

- Billing for monthly monitoring and management codes
- Clinical editing appeal submission reminders

Clinical editing billing tips

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Facilities can't bill for separate labs when using point-of-care testing for blood gas analysis

When blood analysis is completed by point-of-care testing in an inpatient hospital setting, Blue Cross Blue Shield of Michigan and Blue Care Network will only pay for the primary charge, per time and date of service, that the blood was analyzed, but not for other associated or separately billed labs. Separate labs should be zero priced when billed and will be considered a provider write off.

This policy is effective Jan. 1, 2021, for Blue Cross' PPO members, Medicare Plus Blue℠ PPO, BCN HMO℠ (commercial) and BCN Advantage℠.

Background

Blood gas analysis performed by point-of-care testing, or utilization of a blood gas analyzer, is prescribed by a physician, or a non-physician practitioner, to provide quick laboratory testing using one sample of blood to achieve multiple test results within minutes and can affect the treatment and management of the patient. This billing policy isn't intended to affect provider decision-making or patient care. Providers are expected to apply medical judgment when caring for all members.

The following is a list of common point-of-care testing or blood gas analyzer devices that result an array of labs, and are covered by this billing policy:

- Abbott handheld I-Stat Machine
- epoc® blood analysis system
- Radiometer

The following is a list of commonly associated, but separately billed labs. These include, but are not limited to:

- Electrolytes (for example, sodium, potassium, chloride)
- Lactate/lactic acid
- Ionized calcium
- Creatinine and urea nitrogen
- Hemoglobin and hematocrit
- Glucose

Coverage decisions announced for additional COVID-19 testing codes

The American Medical Association announced four new CPT* codes for COVID-19 that were effective Aug. 10, 2020.

Blue Cross Blue Shield of Michigan and Blue Care Network are not covering these codes for our PPO commercial and BCN HMO℠ commercial plans. However, they are covered by our Medicare Advantage plans — Medicare Plus Blue℠ PPO and BCN Advantage℠. The codes are: *0225U, *0226U, *86408 and *86409.

These codes have been added to our **COVID-19 patient testing recommendations for physicians** document. You can find this document on our public website at **bcbsm.com/coronavirus** and through Provider Secured Services at **bcbsm.com**.

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Blue Cross doesn't reimburse for drugs that are experimental, starting in January

Blue Cross Blue Shield of Michigan and Blue Care Network won't reimburse providers for experimental and investigational drugs. This payment policy is effective Jan. 1, 2021 and applies to all claims reported for Blue Cross' PPO, Medicare Plus Blue℠ PPO, BCN HMO℠ (commercial) and BCN Advantage℠.

When you bill these types of drugs on a UB-04 for inpatient services, use the correct revenue code and modifiers necessary for experimental drug use. Use revenue code 0256 — experimental drugs, and the appropriate Advance Beneficiary Notice of Noncoverage modifier (GA, GX, GY, GZ).

Health care providers may not bill members for such services unless, prior to the services, all of these requirements are met:

- You provide the member with a cost estimate of the service.
- You have the member confirm in writing that he or she assumes financial responsibility for the service.
- The member understands that Blue Cross won't reimburse the provider for the service.

Facilities should prorate daily respiratory therapy services, starting Jan. 1

Blue Cross Blue Shield of Michigan and Blue Care Network will require facilities to prorate daily respiratory therapy services by hours used, not to exceed 24 hours in a single day. This billing rule is effective Jan 1, 2021, for members of Blue Cross' PPO, Medicare Plus Blue℠ PPO, BCN HMO℠ (commercial) and BCN Advantage. It applies to an inpatient setting only.

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

- All types of ventilators
- Continuous positive airway pressure (CPAP)
- Bilevel positive airway pressure (BIPAP)
- All types of oxygen

Billing example

On a single day of service, a patient is on the ventilator for five hours and then is weaned to CPAP for the remaining 19 hours of the day. Previously, services were billed at a daily rate regardless of hours used. New billing should reflect only those hours used for each modality.

Background

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

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Reminder about billing for COVID-19 testing

With the increase in COVID-19 cases that we're seeing across Michigan and the United States, we want to remind our health care providers about Blue Cross Blue Shield of Michigan and Blue Care Network's policy when it comes to COVID-19 testing.

Blue Cross and BCN will cover the cost of member COVID-19 testing that:

- Is ordered by a qualified health professional who determines testing is medically appropriate using judgment in accordance with accepted standards of current medical practice
- Has met the necessary regulatory approval through the FDA or falls within one of the other categories of tests required to be covered by the Families First or CARES Acts.

The test orders must show medical necessity. The only exception is for patients with Medicare Advantage coverage who are allowed one COVID-19 test without an order from a health professional in accordance with the Centers for Medicare & Medicaid Services policy.

Blue Cross and BCN cover preoperative COVID-19 testing for procedures conducted in hospital operating rooms and ambulatory surgical facilities. Aerosol-generating procedures are also appropriate for preoperative COVID-19 testing regardless of the location performed, such as oral surgery in an office setting.

It's important to note that Blue Cross and BCN policy does not cover workplace or screening tests. This includes testing to:

- Participate in sports
- Return to work or school
- Qualify for admission to armed services, residential facilities, for example
- Engage in research
- Accommodate requests for routine testing due to general concerns or a desire to get tested prior to family gatherings, such as vacations

If a patient wants to get testing that their health plan won't cover, you can direct them to **Michigan.gov/coronavirus** to find a site that offers free COVID-19 testing.

For more information, please see the **COVID-19 patient testing recommendations** document. It's available on our public website at **bcbsm.com/coronavirus** and by logging in as a provider at **bcbsm.com** and clicking on *Coronavirus (COVID-19)*.

Sleep studies may receive a clinical edit

In accordance with the Centers for Medicare & Medicaid, a patient may be entitled to a comprehensive sleep evaluation within a year prior to participating in a sleep study. Blue Care Network supports the appropriate monitoring of those patients. If you receive an edit you believe is incorrect, please submit a clinical editing appeal.

As a reminder, Blue Care Network has a medical policy for sleep studies that includes CPT and HCPCS codes *95782, *95783, *95800, *95805, *95806, *95807, *95808, *95810, *95811, E0486, G0398, G0399, *95801, A7047, E0485, E1399, and G0400.

Please follow the guidelines and preauthorization requirements outlined in the medical policy.

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New clinical editing resource helps you correct billing errors

We've posted a new billing tips resource, titled *Clinical Edits: What You Need to Do and What Documentation is Needed*, in the Provider Secured Services area of **bcbsm.com**. It's expected to provide a clearer understanding of the clinical edits you may encounter and how to resolve them.

To find it, follow these steps:

1. After logging in to Provider Secured Services at **bcbsm.com**, click *BCN Provider Publications and Resources.*
2. Click *Billing/Claims* under Popular links in the left-hand navigation.
3. Under Clinical Editing Resources, click *Clinical edits: What you need to do and what documentation is needed.*

Once you open the document, you can use the keyword search function (Ctrl + F) to search for keywords found on your voucher. Here's a screenshot of a portion of the new resource:

Description	What next?	Appeal Documentation
Assistant Surgeon Policy – Surgeon who assists with surgical procedure. Not all procedures need an assistant so additional reimbursement for the surgical assistants is denied	No further action since this is reimbursement policy based on American College of Surgeons guidelines.	Operative response indicating the need for the surgical assistance. The work the assistant surgeon performed should be documented in the surgical record.
Anesthesia Not Eligible – An anesthesiologist bills for non-anesthesia procedures. The daim line is denied.	No further action since this is reimbursement policy. Anesthesia service is not necessary for the procedure performed.	Complete documentation of anesthesia service provided. Appeal only if the procedure performed requires anesthesia service.

The document provides a description of our clinical editing policies. We follow nationally recognized rules and guidelines from the Centers for Medicare & Medicaid Services, current procedural terminology codes and guidance from professional practitioner associations and societies. **Note**: The rules aren't all-encompassing and are intended to provide additional guidance and understanding of clinical edits.

The document also outlines your options for correcting billing errors. We offer advice on how to proceed to correct a claim or submit an appeal and specify the required appeal documentation.

In addition to *Clinical Edits: What You Need to Do and What Documentation is Needed*, you'll find another useful document on the site: *EX codes: Recommendations Regarding Appeal or Resubmission (BCN)*. It offers a description of EX codes and recommendations on whether you should appeal or resubmit.

Keep in mind that there are many online medical billing and coding resources that can help you understand correct coding guidelines. Accurate claim submission and medical record documentation are crucial to correct reimbursement.

As a reminder, clinical editing is an integral part of our payment policy and you'll need to use the established guidelines for resolving medical and benefit policy questions.

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Guidelines for billing collaborative care

The Collaborative Care Model, also known as CoCM, is a benefit for all our members, including seniors and Blue Care Network members, who see a primary care physician who uses this model. There are no member cost-sharing requirements for the use of CoCM.

As you may have read in a **September *Record* article**, this integrated behavioral care model allows a primary care physician to more effectively treat patients with behavioral health conditions, such as depression and anxiety.

This model requires three provider types, working together as a team and focusing on the following responsibilities:

- A primary care physician, who retains responsibility for patient treatment plans and billing.
- A behavioral health care manager, who works closely with the patient, administers screening assessments, conducts weekly systematic case reviews with a consulting psychiatrist and serves as a liaison between the PCP and the consulting psychiatrist.
- A consulting psychiatrist, who consults with the care manager each week to review the patient's response to treatment and their behavioral screening results. The psychiatrist doesn't meet with the patient as part of this model.

Keep in mind that there are some specific billing requirements when using this model. Neither the behavioral health care manager nor the psychiatrist submit claims for CoCM services. The primary care physician bills for services provided by the care team over a calendar-month service period.

Billing basics

- Bill per member, per calendar month.
- For each month, bill for the time spent by all clinical team members but don't duplicate shared time. For example, if the care manager and psychiatrist meet for 10 minutes, you would bill for 10 minutes in total, not 10 minutes for the care manager and another 10 minutes for the psychiatrist.
- There must be a separate initiating billable visit with the PCP prior to billing CoCM codes for patients not seen within one year. This visit includes establishing a relationship with the patient, assessing the patient prior to referral, and obtaining patient consent to consult with specialists. (Consent may be verbal or written but must be documented in the electronic health record.)
- CoCM services may be billed alone or with a claim for another billable visit; however, CoCM services cannot be billed in the same calendar month as general behavioral health integration.
- Can bill both CoCM services and provider-delivered care management claims if both types of services are rendered.

Billing codes for commercial members:

Provider location	Code	Month	Time threshold
Any location	*99492	Initial month	36 to 70 minutes
	*99493	Subsequent month(s)	31 to 60 minutes
	*99494	Add-on code	16 to 30 minutes

Billing codes for patients with Medicare, a Medicare Advantage plan or Medicaid:

Provider location	Code	Month	Time threshold
Non-FQHC/ RHC	*99492	Initial month	36 to 70 minutes
	*99493	Subsequent month(s)	31 to 60 minutes
	*99494	Add-on code	16 to 30 minutes
FQHC/RHC	G0512	Initial month	70 minutes
		Subsequent month(s)	60 minutes

Although CoCM has been a Blue Cross and BCN benefit since 2017, we're working to expand its use through training and support opportunities, as well as with incentives. Contact your physician organization if your practice is interested in learning more about training opportunities or incentives for using this model.

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Evaluation and management changes for 2021

Changes will be effective in CPT for reporting requirements, beginning Jan. 1, 2021. These changes will affect the appropriate level of office evaluation and management codes. Blue Care Network is prepared for the changes and want to make sure providers are educated on the updated guidelines. The following highlights some of the major components that make up the evaluation and management service.

An E&M should be reported based on the level of medical decision-making or the total time for E&M services performed on the date of the encounter.

Medical decision-making will still be assigned levels of straightforward, low, moderate and high. As defined by the American Medical Association, these levels are based on three elements:

- The number and complexity of problems that are addressed during the encounter
- The amount or complexity of data to be reviewed and analyzed
- The risk of complications, morbidity, or mortality of patient management decisions made at the visit, associated with the patient's problems, the diagnostic procedures and treatments

There are clearly defined guidelines that describe each of these elements in detail to determine the level for the encounter.

Under the new evaluation and management guidelines, time may be used to select the code level regardless of how much of that time was spent with counseling or coordination of care. The new guidelines define the time by the service descriptors. The physician or other qualified health care professional time includes the following activities defined by AMA, when performed:

- Preparing to see the patient (review of tests)
- Obtaining or reviewing separately obtained history
- Performing a medically appropriate examination or evaluation
- Counseling and educating the patient, family or caregiver
- Ordering medications, tests or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient, family or caregiver
- Care coordination (not separately reported)

E/M	Total time
*99201	Deleted
*99202	15 to 29 minutes
*99203	30 to 44 minutes
*99204	45 to 59 minutes
*99205	60 to 74 minutes (for services greater than 75 minutes, see prolonged services)
*99211	Minimal
*99212	10 to 19 minutes
*99213	20 to 29 minutes
*99214	30 to 39 minutes
*99215	40 to 54 minutes (for services greater than 55 minutes, see prolonged services)

The evaluation and management changes don't affect other rules for E&M reporting, for example, an E&M the same day as a minor or major procedure, during a post-op period or decision-making for surgery. Please review all the changes related to E&M services in preparation for the upcoming year.

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We've updated questionnaires in the e-referral system

We use our authorization criteria, our medical policies and your answers to the questionnaires in the e-referral system when making utilization management determinations on your authorization requests.

In September and October:

- We updated six questionnaires in the e-referral system.
- We removed one questionnaire from the e-referral system.

When we update or remove questionnaires, we also update or remove the corresponding preview questionnaires on the **ereferrals.bcbsm.com** website.

Updated questionnaires

- **Endoscopy, upper gastrointestinal, for gastroesophageal reflux disease:** On Sept. 27, we updated the list of procedure codes for which providers must complete this questionnaire for BCN HMO℠ and BCN Advantage℠ members.

  Starting Sept. 27, providers must complete this questionnaire for these procedure codes: *43191, *43192, *43193, *43195, *43196, *43197, *43198, *43200, *43201, *43202, *43214, *43231, *43233, *43235, *43237, *43238, *43239, *43241, *43242, *43248, *43249, *43250, *43253, and *43259

  Providers no longer need to complete the questionnaire for these procedure codes: *43180 and *43254.

- **Sacral nerve neuromodulation/stimulation:** On Oct. 11, we updated this questionnaire for Medicare Plus Blue℠ PPO, BCN HMO and BCN Advantage members.
- **Breast implant management:** On Oct. 25, we updated this questionnaire for BCN HMO and BCN Advantage members.
- **Breast reconstruction:** On Oct. 25, we updated this questionnaire for BCN HMO and BCN Advantage members.
- **Breast reduction:** On Oct. 25, we updated this questionnaire for BCN HMO and BCN Advantage members.
- **Orthognathic surgery:** On Oct. 25, we updated this questionnaire for BCN HMO and BCN Advantage members.

Removed questionnaire

On Sept. 27, we removed the **Lumbar spine surgery, minimally invasive** questionnaire for BCN Advantage members. The e-referral system now automatically approves requests for code G0276.

Preview questionnaires

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

To find the preview questionnaires:

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

Authorization criteria and medical policies

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

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Reminder: Providers must submit authorization requests to TurningPoint for musculoskeletal procedures for most members

As we reported in the November-December issue of ***BCN Provider News*** (Page 46), TurningPoint Healthcare Solutions LLC has expanded its surgical quality and safety management program for dates of service on or after Jan. 1, 2021.

You now need to submit authorization requests for orthopedic, pain management and spinal procedures to TurningPoint for the following groups and members:

- Blue Cross' PPO — All fully insured groups and select self-funded groups
- Medicare Plus Blue℠ PPO members
- BCN HMO℠ members
- BCN Advantage℠ members

Some important reminders

- Facilities should have an authorization number before scheduling surgery. The ordering physician or provider office must secure the authorization and provide the authorization number to the facility.
- For inpatient professional claims, include only the procedure codes TurningPoint authorized on claims for musculoskeletal procedures.
- For procedures that are affected by the Jan. 1 program expansion, TurningPoint began accepting authorization requests on Dec. 1, 2020.
- You have until April 30, 2021, to submit retroactive authorization requests to eviCore healthcare® for:
    - o Spinal procedures for Blue Cross' PPO fully insured groups and Medicare Plus Blue members for dates of service before Jan. 1
    - o Pain management procedures for Blue Cross' fully insured groups with PPO coverage, select PPO self-funded groups with Blue Cross coverage, all Medicare Plus Blue members, all BCN HMO members and all BCN Advantage members for dates of service prior to Jan. 1

Webinar training

We'll continue to offer webinar training for providers, facilities and clinical staff. Use the links below to register for webinars.

Professional provider training — Includes information about TurningPoint's clinical model and operational changes, along with information about using the TurningPoint provider portal.

Date	Time	Registration
Jan. 5, 2021	10 to 11:30 a.m.	Click **here** to register
Jan. 6, 2021	12 to 1:30 p.m.	Click **here** to register
Jan. 14, 2021	2 to 3:30 p.m.	Click **here** to register

Facility training — Includes information about TurningPoint's clinical model and operational changes and the facility verification process.

Date	Time	Registration
Jan. 5, 2021	2 to 3:30 p.m.	Click **here** to register
Jan. 12, 2021	12 to 1:30 p.m.	Click **here** to register

Portal training — Includes information about using the TurningPoint provider portal.

Date	Time	Registration
Jan. 7, 2021	10 to 11 a.m.	Click **here** to register
Jan. 13, 2021	2 to 3 p.m.	Click **here** to register

Where to find more information

For more information about TurningPoint, see the following pages on the **ereferrals.bcbsm.com** website:

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

To view the lists of codes for which TurningPoint manages authorizations, see the ***Musculoskeletal procedure codes that require authorization by TurningPoint*** document.

For detailed information, see the ***Musculoskeletal procedure authorizations: Frequently asked questions for providers*** document.

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Reminder: We're expanding our cardiology services authorization program with AIM Specialty Health for some members

Starting Jan. 1, 2021, we're adding some cardiology services that will require authorization by AIM Specialty Health® for certain commercial and Medicare Advantage members.

The services include cardiac implantable devices and arterial ultrasound for dates of service on or after Jan. 1, 2021. Please refer to the article in the **November-December 2020** issue (Page 44) for more information.

Inpatient medical hospital peer-to-peer review request process changing for Blue Cross and BCN members

Effective Jan. 4, 2021, Blue Cross Blue Shield of Michigan will no longer accept peer-to-peer requests for Medicare Plus Blue℠ members regarding inpatient medical hospital admission denials.

Facilities are encouraged to follow the two-level provider appeal process for Medicare Plus Blue to reevaluate the denial decision on an inpatient admission request. See the Contracted MI Provider Acute Inpatient Admission Appeals section in the **Medicare Plus Blue℠ PPO Manual.**

BCN commercial, BCN Advantage℠ and Blue Cross' commercial PPO are still accepting peer-to-peer review requests. For those members, facilities must submit peer-to-peer review requests within seven days of the date the authorization request was denied. We're updating the document **How to request a peer-to-peer review with a Blue Cross or BCN medical director** to reflect the changes in the process for all lines of business. This document can be found on our **ereferrals.bcbsm.com** website on these webpages:

- **BCN Authorization Requirements & Criteria** webpage – look under the "Referral and authorization information" heading
- **Blue Cross Authorization Requirements & Criteria** webpage – in both the Blue Cross' PPO and Medicare Plus Blue PPO sections of the page

Before submitting prior authorization requests for inpatient hospital admissions, Blue Cross and BCN encourage hospitals to provide all clinical documentation needed to validate medical necessity criteria.

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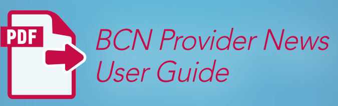

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We're providing $0 cost sharing for COVID-19 vaccine coverage

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

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

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

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

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

Feedback | Subscribe

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

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Availity will bring new online search and favoriting capabilities

What you need to know

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

Availity will bring new online search and favoriting capabilities

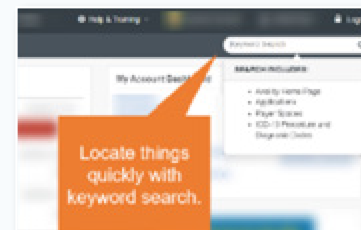
When Blue Cross Blue Shield of Michigan and Blue Care Network move to the Availity® provider portal later in 2021, you'll notice some updated features that will help you find what you need faster. Here's a preview of the two capabilities that will be available on Availity.

Search

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

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

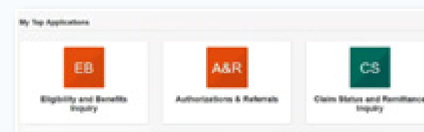
The search feature isn't case sensitive, but you'll need to spell the word correctly for the system to find it. So, if you remember seeing a resource or an announcement, but don't remember where it was, type in a keyword and Availity will help you find it.



Favoriting

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

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



Please see Availity, continued on Page 3

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Questions?

If you have questions about the move to Availity, check our ***Frequently Asked Questions*** document first. If your question isn't answered there, submit it to ProviderPortalQuestions@bcbsm.com so we can consider adding it to the FAQ document. If you need immediate assistance or have a question specific to a certain member or situation, use our website resources or contact Provider Inquiry.

Web resources:

- Log in as a provider at **bcbsm.com**.
- Find prior authorization information for Michigan providers at **ereferrals.bcbsm.com**.
- Find prior authorization information for non-Michigan providers and medical policy information by going to **bcbsm.com/providers** and clicking on ***Quick Links***.

Provider Inquiry numbers are available at **bcbsm.com/providers**. Click on ***Contact Us***. Then, click on the type of provider you are; then click *Provider Inquiry*.

Previous articles about Availity

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

- New, secure provider website coming in 2021 (**September – October 2020 issue**)
- Availity multi-payer provider portal brings advantages to providers (**November-December 2020 issue**)
- Many online tools will continue after move to Availity in 2021 (**November-December 2020 issue**)
- Get ready for Availity — Select an administrator (**January-February 2021 issue**)

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

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

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

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

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

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

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

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

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

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Clinical review decisions are based solely on appropriateness of care

Utilization decisions regarding care and service are based solely on the appropriateness of care prescribed in relation to each member's medical or behavioral health condition.

Blue Care Network's clinical review staff doesn't have financial arrangements that encourage denial of coverage or service that would result in underutilization.

BCN-employed clinical staff and physicians don't receive bonuses or incentives based on their review decisions.

Review decisions are based strictly on medical necessity within the limits of a member's plan coverage.

BCN medical directors are a resource for physicians

Plan medical directors work throughout the state with affiliated practitioners and providers to ensure appropriate care and service for Blue Care Network members. They:

- Provide clinical support for utilization management activities, including investigation and adjudication of individual cases
- Assist in the design, development, implementation and assessment of clinical protocols, practice guidelines and criteria that support the appropriate use of clinical resources
- Adjudicate provider appeals
- Work with physicians and other health care providers to improve clinical outcomes, appropriate use of clinical resources, access to services, effectiveness of care and costs
- Serve as a liaison with the physician community

Providers may discuss decisions with BCN physician reviewers

Blue Care Network demonstrates its commitment to a fair and thorough process of determining utilization by working collaboratively with participating physicians. BCN's plan medical directors may contact the treating health care practitioner for additional information about any review deemed necessary. When BCN doesn't approve a request, we send written notification to the appropriate practitioners and providers, and the member. The notification includes the reason the service wasn't approved as well as the phone number of BCN's plan medical directors to discuss the decision.

If you're a practitioner and would like to discuss a denial of an authorization request with one of our plan medical directors, request a phone appointment by following the process outlined in the document titled **How to request a peer-to-peer review with a BCN medical director**.

To discuss an urgent case after normal business hours, call 1-800-851-3904. This number is for non-behavioral health cases only.

How to obtain a copy of utilization management criteria

Upon request, Blue Care Network provides the criteria used in the decision-making process for a specific authorization request. For a copy, call Utilization Management at 1-800-392-2512 from 8:30 a.m. to 5 p.m. Monday through Friday.

You can also fax your request to us. First, complete the **BCN Criteria Request Form** (found on **ereferrals.bcbsm.com**) and fax it to 1-800-675-7278. (Note: This applies to non-behavioral health authorizations requests only.)

The process for requesting utilization management criteria is also available in the Care management chapter of the *BCN Provider Manual*.

Due to licensing restrictions, we can't distribute complete copies of the InterQual® criteria to all practitioners and providers. However, all contracted hospitals have the electronic version of the criteria as part of BCN's licensing agreement.

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How to request a member transfer

In some circumstances, a primary care provider can request that a member be removed from his or her practice and assigned to another primary care physician. This applies to both BCN HMO℠ (commercial) and BCN Advantage℠ members.

Submit a Member Transfer Request Form

The member's current primary care provider must complete and submit the *Member Transfer Request Form* to BCN.

The form is on the last page of a frequently asked questions document and is available on BCN's Forms page:

1. Visit **bcbsm.com/providers**.
2. Log in to Provider Secured Services.
3. Scroll down and click *BCN Provider Publications and Resources*, on the right.
4. Click *Forms*.
5. Click *Member Transfer FAQ and Request Form*, under the "Member transfer" heading.

You'll also find a link to the *Member Transfer FAQ and Request Form* on the Health e-Blue℠ home page and in the BCN System of Managed Care chapter of the *BCN Provider Manual*.

Criteria for requesting a member transfer

Review the FAQ to make sure your request meets the member transfer criteria. The criteria involve a member's:

- Financial obligations
- Behavior
- Geographic distance from the physician office
- Seeing a primary care physician in a different office
- Lack of response to outreach by your office

The FAQ also outlines details for submitting the request and your responsibilities once the request has been submitted.

Remember, BCN must approve the request before the member can be transferred.

BCN staff available to our members for utilization management issues

Did you know that we're available for our members (your patients) to discuss utilization management issues at least eight hours a day during normal business hours?

We accept inbound collect or toll-free calls; we return calls the same day or the next business day.

Our staff members identify themselves by name, title and organization when receiving or returning calls. We also provide language assistance free of charge to discuss utilization management issues with our members. We offer TTY assistance for the hearing impaired.

Tell your patients to call the number on the back of their member ID card for information about our communication services.

See related article, "Behavioral health providers may discuss decisions with BCN physician reviewers," **Page 15**.

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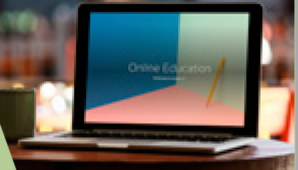

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Sign up for training webinars

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

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

Here's information on the upcoming training webinars:

Webinar name	Date and time	Registration
Blue Cross 201 – Claims Basics – Professional	Tuesday, March 2, 2021 10 to 11 a.m.	**Click here** to register.
Blue Cross 201 – Claims Basics – Professional	Tuesday, March 2, 2021 2 to 3 p.m.	**Click here** to register.

Recordings of previous webinars are available on Provider Secured Services, on the *Blue Cross Provider Publications and Resources* or *BCN Provider Publications and Resources* pages as follows.

Blue Cross Provider Publications and Resources

1. Log in to Provider Secured Services.
2. Click on *BCBSM Provider Publications and Resources*.
3. Click on *BCBSM Newsletters and Resources*.
4. Click on *Provider Training*.
5. In the *Featured Links* section of the page, check out *2020 Provider Training Webinars*.

You can also get more information about online training, presentations and videos by clicking on the E-Learning icon at the top of the page.

BCN Provider Publications and Resources

1. Log in to Provider Secured Services.
2. Go to *BCN Provider Publications and Resources*.
3. Under *Other Resources*, click on *Learning Opportunities*.
4. Find the most recent webinars under *2020 Provider Training Webinars*.

As additional training webinars become available, we'll provide notices through web-DENIS, *The Record* and *BCN Provider News*.

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

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

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

The program will be reassessed every 12 months.

To receive this additional reimbursement, follow these steps:

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

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

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

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

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

The alphanumeric subscriber IDs (de-identified IDs, which appear on subscribers' member ID cards) are being implemented to avoid duplication with existing Social Security numbers, align with other health plans and to automate manual processes formerly used to correct the duplicate numbers.

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

We're migrating to a new platform for electronic transmissions

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

Questions can be sent to: **EDIMigration@bcbsm.com**

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

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

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

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

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

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

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

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

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

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

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

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

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

The CPT codes are:

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

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

Controlling Blood Pressure

Advanced Illness and Frailty Exclusions Guide

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

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

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

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

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

See full article on **Page 24**.

Gain insights from CAHPS research on improving the patient experience

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

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

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

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

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

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

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

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

BCN Advantage uses Medicare funds to pay doctors, hospitals, pharmacies, clinics and other health care providers to provide care to patients eligible for Medicare benefits. Sometimes, providers and patients misuse Medicare resources, leaving less money to help people who need care. This misuse falls in the following categories: fraud, waste, or abuse.

Definition of fraud

Fraud is intentional deceit or misrepresentation of the truth that results in some extra cost to the health care system. Fraud schemes range from those committed by individuals acting alone to broad-based activities by institutions or groups of individuals. Seldom do these schemes target only one insurer or the public or private sector exclusively. Most are simultaneously defrauding several private and public sector victims, including Medicare and Medicaid.

Health care fraud is defined in Title 18, United States Code (U.S.C.) § 1347, as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

This definition applies to health care programs such as Medicare and Medicaid.

Definition of abuse

Abuse occurs when a provider or a patient behaves in a way that is inconsistent with sound business or medical practices, resulting in an unnecessary cost to the Medicare program. Abusive practices can involve payment for services that aren't medically necessary or that fail to meet professionally recognized standards for health care.

Differences between fraud and abuse

Fraud is distinguished from abuse in that there is clear evidence that fraudulent acts were committed knowingly and intentionally. Abusive practices, on the other hand, may not be intentional or it may be impossible to show that intent existed. Although these types of practices may initially be classified as abusive, they may develop into fraud if there is evidence that the provider or patient was intentionally conducting an abusive practice.

Definition of waste

Waste describes the outcome from practices that result in unnecessary costs to the health care system, but generally do not involve intentional or criminally negligent actions.

Waste can result from poor or inefficient billing or treatment methods, for example.

Minimizing fraud, waste and abuse means the federal government, through contracted insurers such as BCN Advantage, can provide more care to more people and make the Medicare program stronger. Together, all of us can work to find, report and investigate fraud, waste and abuse.

Fraud, waste and abuse prevention

See our policy and applicable laws on web-DENIS under *BCN Provider Publications and Resources*. Click on *Policies and Information* and then *Detection and Prevention of Fraud, Waste and Abuse Policy*. Information on fraud, waste and abuse can also be found in the *BCN Provider Manual*.

BCN Advantage HMO-POS℠ and BCN Advantage HMO℠ providers and members can report fraud and abuse to the anti-fraud hotline for Blue Cross Blue Shield of Michigan at 1-888-650-8136.

You may also contact the Office of Health Services Inspector General one of the following ways:

Phone: 1-800-HHS-TIPS (1-800-447-8477)

Online: **Medicare.gov/fraud**.

Mail: Office of Inspector General
Attention: OIG Hotline Operations
P.O. Box 23489
Washington, D.C. 20026

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Medical policy updates

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

Noncovered services

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

Covered services

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

Medical Policy Updates

Know member rights and responsibilities

Blue Care Network members have certain rights and responsibilities. Providers should be aware of these rights.

Members have a right to:

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

Members have a responsibility to:

- Supply information (to the extent possible) complete and accurate information Blue Care Network and providers need in order to provide care
- Comply with the plans and instructions for care that they have agreed to with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals

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Quality improvement program information available upon request

We provide you with ongoing information about our quality improvement programs and clinical practice guidelines through this newsletter. Approved clinical practice guidelines and the health plans QI program are available to all Blue Care Network primary care physicians, primary care groups and specialists upon request.

Copies of the complete guidelines are available on our secure provider portal. To access the guidelines:

- Log in to Provider Secured Services.
- Click on *BCN Provider Publications and Resources*.
- Click on *Clinical Practice Guidelines*.

The Michigan Quality Improvement Consortium guidelines are also available on the **MQIC website**. BCN promotes the development, approval, distribution, monitoring and revision of uniform evidence-based clinical practice guidelines and preventive care guidelines for practitioners. We use MQIC guidelines to support these efforts. These guidelines facilitate the delivery of quality care and the reduction in variability in physician practice and medical care delivery.

Our Quality Improvement Program encourages adherence to MQIC guidelines and offers interventions focusing on improving health outcomes for BCN members. Some examples include member and provider incentives, reminder mailings, telephone reminders, newsletter articles and educational materials. We use medical record reviews and quality studies to monitor compliance with the guidelines.

Helping patients with medication management

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

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

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

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

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

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Quality corner: Primary care physician contact

Primary care physician contact occurs when the behavioral health provider and the primary care physician reach out to one another to discuss the patient's health. This may occur when the patient has a new evaluation, begins treatment or therapy, starts a new medication, has a significant change in condition or experiences a comorbid issue.

Unfortunately, contact between behavioral health providers and PCPs isn't widespread,[1] especially when compared with other specialties.

Why is it important?

Collaboration is important to improve outcomes, since up at least 70% of visits to primary care physicians may be due to psychological issues.[2] Underlying psychological problems can also complicate and contribute to physical problems, such as obesity, hypertension and chronic pain.[3] When regular contact occurs between behavioral health and primary care doctors, providers can ensure the greatest impact and value for patient health.

Working with the PCPs in your area likely will increase your referrals from that medical group and can lead to more collegial relationships which can decrease burnout.

Meaningful contact

Contact should be meaningful. This includes a behavioral health assessment, rudimentary treatment plan and member specific recommendations. Sometimes having a "curbside" consult with primary care physicians can enhance your understanding of the interventions they're recommending and help PCPs understand and incorporate the interventions you're attempting with the patient.

References

1 http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf

2 http://www.bhintegration.org/services/primary care.aspx

3 http://www.bhintegration.org/services/primary care.aspx

Crisis care is important for our members

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

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

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

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

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

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Behavioral health providers may discuss decisions with BCN physician reviewers

Blue Care Network is committed to a fair and thorough process of determining utilization by working collaboratively with its participating behavioral health practitioners.

BCN's behavioral health physician reviewers may contact practitioners for additional information about their patients during their review of all levels of care, patient admissions, additional hospital days and requests for services that require medical policy and benefit interpretations.

When BCN doesn't approve a service request, we send written notification to the requesting practitioner. The notification includes the reason the service wasn't approved and a phone number for BCN's behavioral health physician.

Practitioners may discuss any decision with a BCN behavioral health physician reviewer. Call Behavioral Health at 1-877-293-2788 Monday through Friday, from 8 a.m. to 5 p.m. To discuss an urgent case with a BCN behavioral health physician reviewer after normal business hours, call 1-800-482-5982.

How to obtain a copy of behavioral health criteria

Upon practitioner request, BCN will provide you with the behavioral health criteria used in our decision-making process. Call 1-877-293-2788 to request a copy.

Criteria corner

Blue Care Network uses Change Healthcare's InterQual Level of Care when conducting admission and concurrent review activities for acute care hospitals. To make sure that providers and health plans understand the application of the criteria and Local Rules, BCN provides clarification from Change Healthcare on various topics.

Question:

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

Answer:

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

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

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

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

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

For these drugs:

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

What you need to know

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

Additional information

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

Pediatric members are defined as one of the following:

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

More about the authorization requirements

- These authorization requirements apply only to groups that currently participate in the commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit.
- Authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.

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

How to submit authorization requests

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

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

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

Lists of requirements

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

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

What you need to know

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

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

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

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

Through participating pharmacies

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

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

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

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

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Through durable medical equipment providers

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

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

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

What this change means

This change affects members as follows:

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

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

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

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Waste avoidance program expansion starts March 1 for commercial members

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

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

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

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

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

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

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

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

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

Lists of requirements

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

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

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

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Quarterly update: Requirements changed for some commercial medical benefit drugs

Blue Cross Blue Shield of Michigan and Blue Care Network encourage proper utilization of high-cost medications that are covered under the medical benefit. As part of this effort, we maintain a comprehensive list of requirements for both Blue Cross commercial and BCN commercial members.

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

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

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

These authorization requirements apply only to groups that currently participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit.

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

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

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

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

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

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

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

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

Preferred and nonpreferred products for most members

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

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

Additional preferred and nonpreferred products for most commercial members

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

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

Additional preferred and nonpreferred products for Medicare Advantage members

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

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

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

Submitting requests for prior authorization

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

- **For select preferred products:** These products require prior authorization through AIM Specialty Health. Submit the request through the **AIM *Provider Portal*** or by calling the AIM Contact Center at 1-844-377-1278. For information about registering for and accessing the portal, see the **Frequently asked questions** page on the AIM website.
- **For nonpreferred products — for members who must take nonpreferred products:** These products have authorization requirements. Submit the prior authorization request through the NovoLogix online tool. NovoLogix offers real-time status checks and immediate approvals for certain medications. If you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix. If you need to request access to Provider Secured Services, complete the **Provider Secured Access Application** form and fax it to the number on the form.

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

Lists of requirements

See the following lists to view requirements for these products:

For commercial members, see:

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

For Medicare Advantage members, see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**.

We'll update the requirements lists with the new information before April 1, 2021.

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

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

This is a change for some requests:

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

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

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

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

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

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

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

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

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

April 15 changes

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

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

April 22 changes

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

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

These requirements don't apply to:

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

How to submit authorization requests

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

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

For information about registering for and accessing the AIM *ProviderPortal*, see the **Frequently asked questions** page on the AIM website.

More about the authorization requirements

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

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

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

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

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

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

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

What you need to know

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

Changes to the Preferred Drug List

The following are changes to the Preferred Drug List that were effective Jan. 1, 2021

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

We'll no longer cover the following brand name and generic drugs. If a member fills a prescription for one of these drugs on or after Jan. 1, 2021, he or she will be responsible for the full cost. The drugs that won't be covered are listed along with the preferred alternatives that have similar effectiveness, quality and safety. Unless noted, both the brand name and available generic equivalents won't be covered. The example brand names of preferred alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs that won't be covered	Common use/drug class	Preferred alternatives
Airduo Respiclick®, fluticasone-salmeterol[1] (authorized generic for Airduo Respiclick® by A-S MEDICATION, TEVA)	Bronchospasm	fluticasone/salmeterol (by Prasco, Proficient Rx), Advair HFA®, Breo Ellipta®, Dulera®, Symbicort®
Amitiza®	Constipation	Linzess®, Trulance®
Aptiom®	Anticonvulsants	Tegretol/XR®, Topamax®, Trileptal®, Lyrica® Vimpat®
Bunavail®	Opioid use disorder	Suboxone®, Subutex®, Zubsolv®
Calquence®	Cancer	Imbruvica®, Venclexta®
Ciloxan® 0.3% ointment	Ophthalmic anti-infective	Ciloxan® drops, Garamycin®, Ocuflox®, Quixin®, Vigamox®, Zymaxid®
Cosentyxv®	Autoimmune conditions (such as plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, Skyrizi®, Stelara® 45mg, 90mg, Taltz®, Tremfya®, Xeljanz/ XR®
Crinone® 4%	Progestin	Aygestin®, Megace®, Prometrium®, Provera®
Crinone® 8%	Infertility	Endometrin®
Cutaquig®, Gammaked®, Hizentra® vials	Immune globulin	Gammagard liquid®, Gamunex-C®, Xembify®

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Preferred Drug List changes, *continued from Page 26*

Drugs that won't be covered	Common use/drug class	Preferred alternatives
Ecoza®, Xolegel®	Topical antifungal	Loprox®, Naftin®, Nizoral®, Oxistat®, Spectazole®
Elestrin®	Estrogen	Divigel®
Epiduo® Forte	Acne	Amzeeq®, Benzaclin®, Cleocin-T®, clindamycin phosphate 1% gel (NDCs other than 68682046275), erythromycin gel, Retin-A®
Firvanq® (brand)	Anti-infective	Firvanq® (generic), Vancocin®
Humalog Jr Kwikpen® (brand)	Diabetes	insulin lispro junior[1] (nonpreferred brand copay applies)
Inderal XL®, Innopran XL®	Cardiovascular conditions	Inderal®/LA, Inderide®
Intrarosa®	Menopause symptoms	Climara®, Estrace®, Estring®, Premarin® cream, tablets, Vagifem®
Jentadueto®, Jentadueto XR®	Diabetes	metformin (Glucophage®/XR) plus a DPP-4 inhibitor (Januvia®), Janumet®, Janumet® XR
Lastacaft®, Pazeo®	Ophthalmic anti-allergy	Elestat®, Opticrom®, Optivar®, Pataday®, Zerviate®
Moviprep® (brand)	Bowel preparation	Clenpiq®, Colyte®, Golytely®, Nulytely®, Peg-Prep®, Prepopik®, Suprep®
Mytesi®	Antidiarrheal	Imodium®, Lomotil®
Neulasta®, Udenyca®	Hematopoietic agent	Fulphila®, Ziextenzo®
Nexium® DR packets	Gastrointestinal reflux	Aciphex® tablet, Nexium®, Prevacid®, Prilosec® capsule, Protonix® tablet
Nucynta®	Pain (opioid)	Norco®, morphine sulfate immediate release, oxycodone immediate release, Percocet® , Ultracet®, Ultram®
Nucynta ER®	Pain (opioid)	Butrans®, Duragesic®, Exalgo®, Hysingla ER® (nonpreferred brand copay applies), MS Contin®, Opana ER®, Oxycontin® (nonpreferred brand copay applies)
Otrexup®	Immunosuppressant	Rasuvo®
Praluent®	High cholesterol	Repatha®
ProAir® Respiclick®, Ventolin® HFA, albuterol sulfate HFA[1] (authorized generic for Ventolin HFA® by A-S Medication, Prasco)	Bronchospasm	albuterol sulfate HFA (by Cipla, Par, Perrigo, Proficient Rx, and Teva)
Proctofoam-HC®	Hemorrhoidal preparation	Analpram-HC®, Cortenema®, Pramosone®, Proctocort®

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Drugs that won't be covered	Common use/drug class	Preferred alternatives
Qtern®	Diabetes	Glyxambi®, Steglujan®
Soma®, Soma® compound with aspirin, Soma® compound with codeine	Muscle relaxant	Flexeril®, Norflex®Robaxin®, Parafon Forte DSC®, Zanaflex®
Tradjenta®	Diabetes	Januvia®
Zuplenz®	Antiemetic	Kytril®, Zofran®, Zofran® ODT

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

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

The brand-name drugs that have a higher copayment are listed along with the preferred alternatives that have similar effectiveness, quality and safety. The example brand names of preferred alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Nonpreferred drugs that will have a higher copayment	Common use/drug class	Preferred alternatives
Alrex®, Bepreve®	Ophthalmic anti-allergy	Elestat®, Opticrom®, Optivar®, Pataday®, Zerviate®
Ilevro®, Prolensa®	Ophthalmic anti-inflammatory	Acularv, Bromdayv, Ocufenv, Voltarenv ophthalmic solution
Oraceav	Anti-infective	Adoxa®, Doryx®, Minocin®, tetracycline, Vibramycin®
Qbrexzav	Hyperhidrosis	Antiperspirant products are available over the counter

Drugs on the Preferred Drug List that will have quantity limits

These drugs have changes to the amount that can be filled.

Drug		PPO and HMO	
		Preferred Drug List	New quantity limit
Oral meds	**Amerge**® (naratriptan) **Axert**® (almotriptan) **Frova**® (frovatriptan) **Imitrex**® (sumatriptan) **Maxalt**® (rizatriptan) **Relpax**® (eletriptan) **Zomig**® (zolmitriptan)	12 tablets per fill	12 tablets per 30 days
	Treximet® (sumatriptan/naproxen)	9 tablets per fill	12 tablets per 30 days

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Drug		PPO and HMO	
		Preferred Drug List	New quantity limit
	Emend® 40 mg, 80 mg (aprepitant)	None	4 capsules per 30 days
	Emend® 125 mg (aprepitant)	None	2 capsules per 30 days
	Emend® trifold pack (aprepitant)	None	2 packs (6 capsules) per 30 days
	Kytril® (granisetron)	None	60 tablets per 30 days
	Zofran®/Zofran® ODT (ondansetron)	None	120 tablets per 30 days
Injectable	**Imitrex®** (sumatriptan) Injection	6 injection per fill	12 injections/vials per 30 days
	Zembrace® (sumatriptan) injection	4 injection per 30 days	12 injections per 30 days
Nasal sprays	**Imitrex®**	6 units per fill	12 units per 30 days
	Onzetra™ Xsail® (sumatriptan) nasal spray	1 dose pack per 30 days	1 kit (8 pouches) per 30 days
	Zomig® (zolmitriptan) nasal spray	6 units per fill	12 units per 30 days

Changes to the Clinical, Custom and Custom Select Drug Lists

The following are changes to the Clinical, Custom and Custom Select Drug Lists that were effective Jan. 1, 2021.

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

We'll no longer cover the following brand-name and generic drugs. If a member fills a prescription for one of these drugs on or after Jan.1, 2021, he or she will be responsible for the full cost. The drugs that aren't covered are listed along with the preferred alternatives that have similar effectiveness, quality and safety. Unless noted, both the brand name and available generic equivalents aren't covered. The example brand names of preferred alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs that won't be covered	Common use/drug class	Preferred alternatives
Carac®, fluorouracil 0.5% cream[1]	Skin conditions	Aldara®, Efudex®, Tolak®
Cosentyx®	Autoimmune conditions (such as plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, methotrexate, Skyrizi®, Stelara® 45mg, 90mg, Taltz®, Tremfya®
Humalog Jr Kwikpen® (brand)	Diabetes	insulin lispro junior[1] (nonpreferred brand copay applies)
Inderal XL®, Innopran XL®	Cardiovascular conditions	Inderal®/LA, Inderide®
Onexton®	Acne	Duac®, Benzaclin®

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Drugs that won't be covered	Common use/drug class	Preferred alternatives
ProAir® Respiclick®, Ventolin HFA®, albuterol sulfate HFA[1] (authorized generic for Ventolin HFA®)	Bronchospasm	ProAir HFA®, Proventil HFA®
sodium sulfacetamide, sodium sulfacetamide/sulfur, sodium sulfacetamide/sulfur/urea (Drugs such as: Avar LS®, Plexion®, SSS 10-5®, Sulfacleanse 8-4®, Sumadan®, Sumaxin®, Sumaxin TS®)	Acne	Avar®, Avar-E®, Klaron®, Ovace®, Rosanil®
Soma®, Soma® compound with aspirin, Soma® compound with codeine	Muscle relaxant	Flexeril®, Norflex®, Robaxin®, Parafon Forte DSC®, Zanaflex®
Sprix®, ketorolac nasal spray[1]	Migraine	generic NSAID (such as Feldene®, Indocin® capsule, Lodine®, Mobic®, Motrin®, Naprosyn®, Voltaren®) generic triptan (such as Amerge®, Imitrex®, Maxalt®, Zomig®)
Zuplenz®	Antiemetic	Kytril®, Zofran®, Zofran® ODT

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

Drugs on the Custom Drug List that have a higher copayment

The brand-name drugs that have a higher copayment are listed along with the preferred alternatives that have similar effectiveness, quality and safety. The example brand names of preferred alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Nonpreferred drugs that will have a higher copayment	Common use/drug class	Preferred alternatives
Aldactazide® 50mg/50mg	Hypertension	Aldactazide® 25mg/25mg
Cortisporin® 1% ointment	Topical antibacterial	Bactroban® ointment; gentamicin cream, ointment
Cyclogyl® 1% 5mL (brand)	Eye dilation	Cyclogyl® 1% (generic)
Depo-Testosterone® (brand)	Testosterone replacement	Depo-Testosterone® (generic)
Diuril® suspension	Hypertension	Diuril® tablet
Hyper-Sal®	Lung decongestant/ moisturizer	sodium chloride inhalation (generic)

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Nonpreferred drugs that will have a higher copayment	Common use/drug class	Preferred alternatives
Medrol® 2mg	Steroid	Medrol® (generic strengths)
SSKI®	Thyroid conditions	strong iodine
Tobrex® ointment	Eye anti-infective	Tobrex® drops
Vibramycin® syrup	Anti-infective	Vibramycin® suspension
Zonalon® 30g (brand)	Skin conditions	Zonalon® 45g (generic)

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

We'll no longer cover the following brand name and generic drugs. If a member fills a prescription for one of these drugs on or after Jan. 1, 2021, he or she will be responsible for the full cost. The drugs that won't be covered are listed along with the preferred alternatives that have similar effectiveness, quality and safety. Unless noted, both the brand name and available generic equivalents aren't covered. The example brand names of preferred alternatives are provided for reference. When a prescription is filled, the generic equivalent is dispensed, if available.

Drugs that won't be covered	Common use/drug class	Preferred alternatives
Aranesp®, Epogen®	Anemia	Procrit®, Retacrit®
Cosentyx®	Autoimmune conditions (such as plaque psoriasis and psoriatic arthritis)	Enbrel®, Humira®, Otezla®, methotrexate, Skyrizi®, Stelara® 45mg, 90mg, Taltz®, Tremfya®
Harvoni® tablet, ledipasvir/ sofosbuvir tablet[1]	Hepatitis C	Epclusa®, Zepatier®
Humalog Jr Kwikpen® (brand)	Diabetes	insulin lispro junior[1] (nonpreferred brand copay applies)
ProAir® Respiclick®, Ventolin HFA®, albuterol sulfate HFA[1] (authorized generic for Ventolin HFA®)	Bronchospasm	ProAir HFA®, Proventil HFA®
Soma®	Muscle relaxant	Flexeril®, Norflex®, Robaxin®, Parafon Forte DSC®, Zanaflex®
Sovaldi® tablet	Hepatitis C	Epclusa®, Zepatier®

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

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

These drugs have changes to the amount that can be filled.

Drug (generic)	BCN HMO current quantity limit		Blue Cross PPO current quantity limit		New quantity limit for all drug lists
	Custom Drug List	Custom Select Drug List	Custom Drug List / Clinical Drug List	Custom Select Drug List	
Amerge® (naratriptan) Axert® (almotriptan) Frova® (frovatriptan) Imitrex® (sumatriptan) Maxalt® (rizatriptan) Relpax® (eletriptan) Zomig® (zolmitriptan)	9 tablets per fill	9 tablets per fill	12 tablets per fill	9 tablets per 30 days	12 tablets per 30 days
Treximet® (sumatriptan/naproxen)	9 tablets per fill	Not covered	9 tablets per fill	Not covered	12 tablets per 30 days*
Imitrex® Injection (sumatriptan)	5 injections per fill	5 injections per fill	6 injections per fill	4 injections per 30 days	8 injections/vials per 30 days
Zembrace® injection (sumatriptan)	2 injections per fill	Not Covered	4 injections per 30 days	Not covered	8 injections per 30 days*
Imitrex® nasal spray (sumatriptan)	6 units per fill	6 units per fill	6 units per fill	6 units per fill	12 units per 30 days
Onzetra™ Xsail® nasal spray (sumatriptan)	1 dose kit per fill	Not covered	1 dose pack per 30 days	Not covered	1 kit (8 pouches) per 30 days*
Zomig® nasal spray (zolmitriptan)	6 units per fill	6 units per fill	6 units per fill	6 units per fill	12 units per 30 days
Emend® (aprepitant) 40mg	None				4 capsules per 30 days
Emend® (aprepitant) 80mg	4 capsules per fill	4 capsules per fill	None		
Emend® (aprepitant) 125mg	2 capsules per fill	2 capsules per fill	None		2 capsules per 30 days
Emend® (aprepitant) trifold pack	2 packs per fill	2 packs per fill	None		2 packs (6 tablets) per 30 days
Kytril® (granisetron)	12 tablets per fill	12 tablets per fill	None		60 tablets per 30 days

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Drug (generic)	BCN HMO current quantity limit		Blue Cross PPO current quantity limit		New quantity limit for all drug lists
	Custom Drug List	Custom Select Drug List	Custom Drug List / Clinical Drug List	Custom Select Drug List	
Sancuso®[3] (granisetron)	2 patches per fill	2 patches per fill	4 patches per 30 days	4 patches per 30 days	4 patches per 30 days
Zofran® and Zofran® ODT (ondansetron)	None				120 tablets per 30 days

*Doesn't apply to members on the Custom Select Drug List

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

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

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

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

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

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Drugs affected by this change

Here are the drugs that are subject to this change:

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

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

Lists of requirements

To view requirements for drugs covered under the **pharmacy benefit**, see the Blue Cross and **BCN Prior authorization and step therapy coverage criteria document**. This document is available from the following pages on the **ereferrals.bcbsm.com** website:

- **Blue Cross Pharmacy Benefit Drugs**
- **BCN Pharmacy Benefit Drugs**

For a list of requirements related to drugs covered under the **medical benefit**, see the **Blue Cross and BCN utilization management medical drug list for Blue Cross PPO (commercial) and BCN HMO (commercial) members** document.

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

Zostavax vaccine discontinued by the manufacturer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Clinical editing billing tips

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

This issue's tip includes:

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

Clinical editing billing tips

Clinical editing updates coming in June to outpatient claims

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

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

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

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

- CCI edits
- Evaluation and management services
- Radiology services

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

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

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

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

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New and updated questionnaires available in the e-referral system

We use our authorization criteria, our medical policies and your answers to the questionnaires in the e-referral system when making utilization management determinations on your authorization requests.

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

Updated and new questionnaires

We've updated the following questionnaires in December:

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

For both questionnaires:

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

In addition, we made these updates in November:

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

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

We updated the *Artificial heart, total* questionnaire.

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

Preview questionnaires

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

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

Authorization criteria and medical policies

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

What you need to know

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

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

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

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

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

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

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

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

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

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

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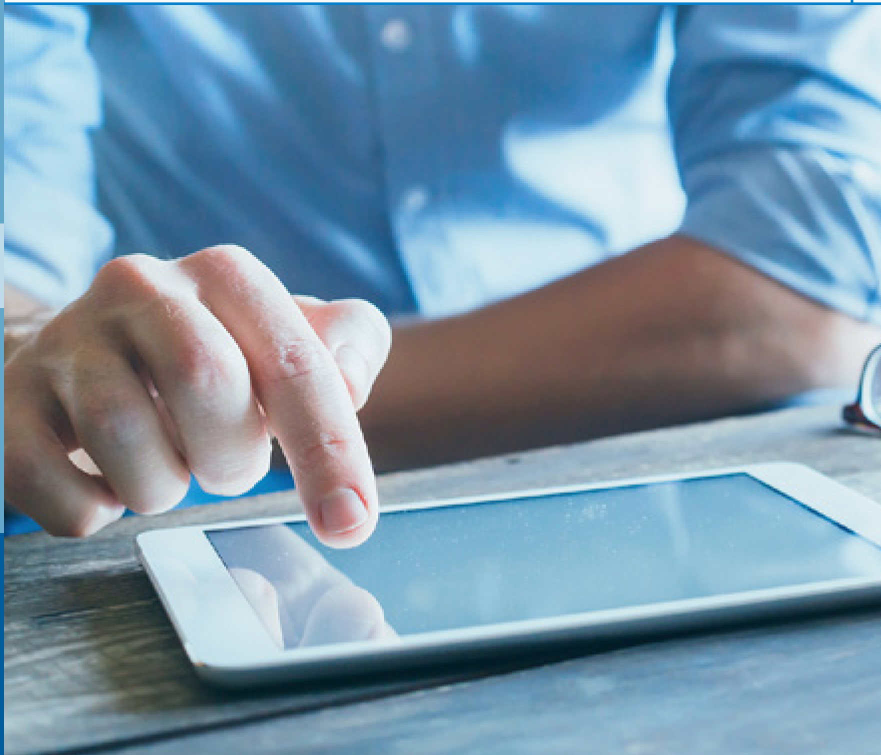

Check for messages in e-referral to finalize your pending requests

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

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

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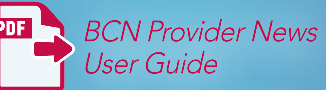
BCN Provider News User Guide

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

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

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

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

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

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

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

Please see BDC, continued on Page 2

Did you know?

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

Inside this issue…

5 We're postponing our move to Availity
11 Additional medications will require prior authorization for Medicare Advantage members
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Feedback | Subscribe

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

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BDC, *continued from Page 1*

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

Finding a BDC provider

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

To apply for designation

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

Reminder: Blue Elect Plus members don't need referrals

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

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

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

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

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

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

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

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

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

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

As a reminder, services are appropriate for telehealth when:

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

Telehealth includes asynchronous visits and remote patient monitoring

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

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

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

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

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

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

What you need to know

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

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Important information about our concierge medicine policy

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

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

About concierge medicine

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

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

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

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

Providers may charge a concierge fee if:

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

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

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

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

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

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

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

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

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

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

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

The move to Availity expected in late 2021 or early 2022

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

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

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

Questions?

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

New provider training website coming in 2021

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

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

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Online Training

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

We're continuing our series of training webinars for health care providers and staff. The webinars are designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

Here's information on the upcoming training webinars that review the processes and tools available when submitting facility claims:

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

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

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

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

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

Please see Training, continued on Page 7

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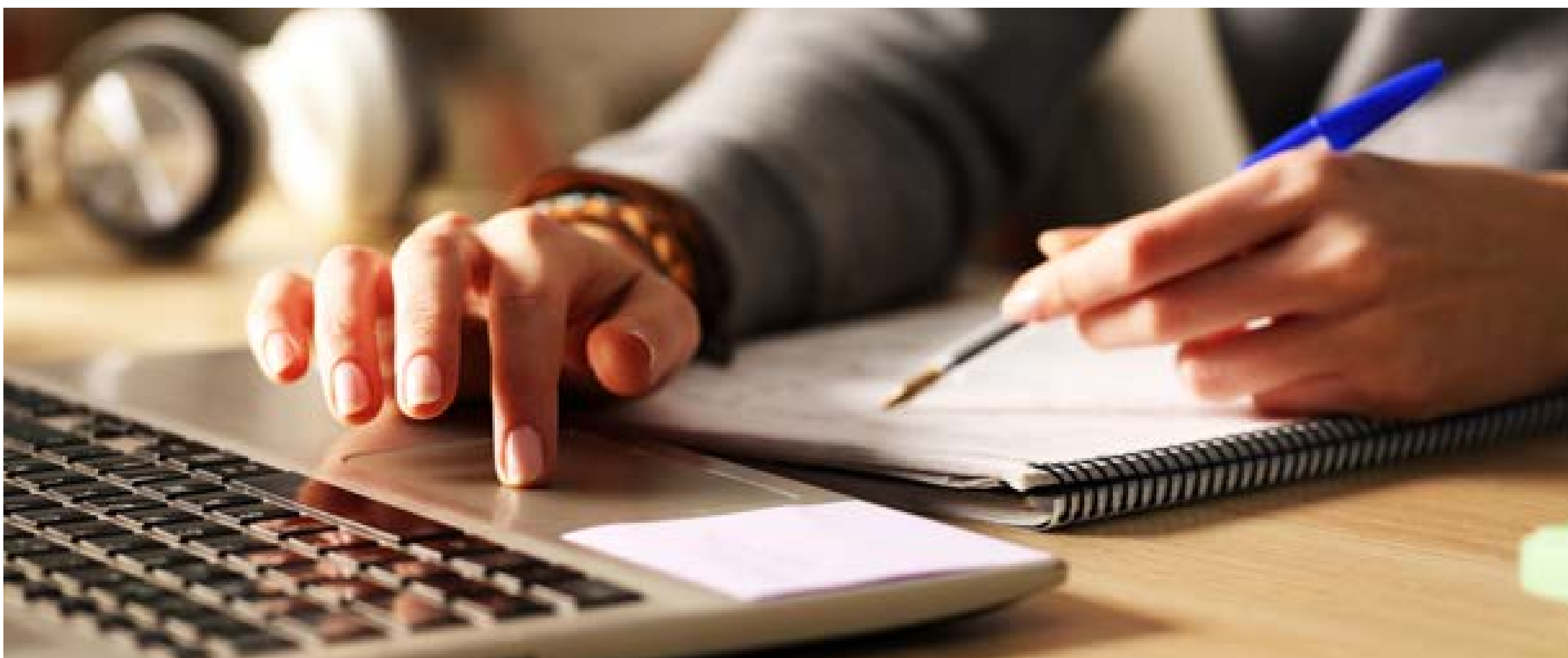

Blue Cross Provider Publications and Resources

1. Log in to Provider Secured Services.
2. Click on *BCBSM Provider Publications and Resources*.
3. Click on *BCBSM Newsletters and Resources*.
4. Click on *Provider Training*.
5. In the *Provider Event Presentations* section of the page, check out *2021 Provider Training Webinars*.
6. To find video and eLearning modules, click on the E-Learning (Online training, presentations and videos) link under Quick access at the top of the page.

You can also get more information about online training, presentations and videos by clicking on the E-Learning icon at the top of the page.

BCN Provider Publications and Resources

1. Log in to Provider Secured Services.
2. Go to *BCN Provider Publications and Resources*.
3. Under *Other Resources*, click on *Learning Opportunities*.
4. Find the most recent webinars under *2020 Provider Training Webinars*.

As additional training webinars become available, we'll provide notices through web-DENIS, *The Record* and *BCN Provider News*.

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

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

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

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

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

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

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

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

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

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

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Providers must comply with access and availability guidelines

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

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

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

To find the manual:

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

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

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

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

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

Places of service that require authorization

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

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

Important reminder

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

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

List of requirements

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

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

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

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

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

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

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

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

How to submit appeals for BCN Advantage members

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

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

Advanced illness and frailty exclusions allowed for HEDIS star measures

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

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

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

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

Provider Star Measure Tip Sheet Advanced Illness

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

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

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

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

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

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Medication Reconciliation Post-Discharge tip sheet

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Breyanzi requires prior authorization for Medicare Advantage members

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

How to bill

For Medicare Plus Blue and BCN Advantage, we require authorization for all outpatient places of service when you bill these medications as a professional service or as an outpatient facility service:

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

Important reminder

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

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

List of requirements

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

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

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

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

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

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

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

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

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

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

Medicare Advantage cost sharing reminder

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

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

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

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

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

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Pilot program with naviHealth supports Medicare Advantage members after hospital discharge

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

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

The goal of the program is to reduce readmissions.

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

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

Patient navigators support members by:

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

Blue Cross and BCN patient experience survey launches in June

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

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

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

- Cardiologists
- Endocrinologists
- Nephrologists
- Oncologists
- Pulmonologists

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

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

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CareCentrix to manage authorizations for home health care for Medicare Advantage members

Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with CareCentrix® to manage the authorization of home health care for Medicare Advantage members.

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

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

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

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

The CareCentrix program will:

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

What you need to know

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

Please see Authorizations, continued on Page 18

Authorizations, *continued from Page 17*

Submitting prior authorization requests

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

Registering for webinar training

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

Click a link below to register.

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

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

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

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

Learning more about the CareCentrix home health care program

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

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Addressing implicit bias in health care can improve care delivery

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

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

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

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

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

Consider these examples:

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

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

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

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

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

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

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

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HEDIS and Star tip sheets updated for 2021

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

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

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

Accessing the tip sheets

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

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

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

Medical record guidelines policies require providers to maintain member records

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

Content of the medical record should include:

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

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

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

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

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

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

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

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

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

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

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

Medical policy updates

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

Covered services

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

Medical Policy Updates

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Criteria corner

Blue Care Network uses Change Healthcare's InterQual level of care when conducting admission and concurrent review activities for acute care hospitals. To ensure that providers and health plans understand the application of the criteria and local rules, BCN provides clarification from Change Healthcare on various topics.

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

Question:

Can metabolic encephalopathy be considered a new onset neurological disorder?

Answer:

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

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

Question:

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

Answer:

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

Question:

Can pain be considered a new onset neurological disorder?

Answer:

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

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

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

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

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Blue Care Network promotes continuity of care in some situations

Continuity of care services are available for the following members:

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

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

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

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

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

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

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

An active course of treatment is defined as:

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

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

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

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

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

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

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

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

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

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

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

ADHD

Diagnosis guidelines

Treatment guidelines

Depression

Primary care diagnosis guidelines

Treatment guidance update alert

Diabetes

Diabetes mellitus management guidelines

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

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Criteria corner

Blue Care Network uses Change Healthcare's InterQual level of care when conducting admission and concurrent review activities for acute care hospitals. To ensure that providers and health plans understand the application of the criteria and local rules, BCN provides clarification from Change Healthcare on various topics.

Question:

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

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

Answer:

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

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

Physicians can help patients find appropriate treatment for substance use disorder

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

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

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

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

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

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Blue Cross and BCN cover additional vaccines

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

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

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

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

Please see Vaccines, continued on Page 27

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Vaccines, *continued from Page 26*

Vaccine	Common name	Age requirement
PedvaxHIB®	Haemophilus influenzae type B	None
Havrix®	Hepatitis A	None
Vaqta®	Hepatitis A	None
Energix-B®	Hepatitis B	None
Heplisav-B®	Hepatitis B	None
Recombivax HB®	Hepatitis B	None
Twinrix®	Hepatitis A & B	None
Gardasil®9	HPV (Human papillomavirus)	9 to 45 years old
M-M-R® II	Measles, mumps, rubella	None
ProQuad®	Measles, mumps, rubella and varicella	None
Menveo®	Meningitis	None
Menactra®	Meningitis	None
Menomune®	Meningitis	None
Trumenba®	Meningococcal B	None
Bexsero®	Meningococcal B	None
Ipol®	Polio	None
Pneumovax 23	Pneumonia	None
Prevnar 13®	Pneumonia	65 and older
Rotarix®	Rotavirus	None
RotaTeq®	Rotavirus	None
Shingrix®	Shingle (Zoster)	50 and older
Boostrix®	Tdap (Tetanus, diphtheria and whooping cough, also known as pertussis)	None
Adacel®	Tdap	None
Vaxelis™	Tdap, inactivated poliovirus, haemophilus B, hepatitis B	None
Pediarix®	Tdap, hepatitis B, polio	None
Kinrix®	Tdap, polio	None
Quadracel® Tdap-IPV	Tdap, polio	None
Pentacel®	Tdap, polio, haemophilus influenzae type B	None
Diptheria and tetanus toxoids	Tetanus, diphtheria	None
Tenivac®	Tetanus, diphtheria	None
TDVax®	Tetanus, diphtheria	None
Varivax®	Varicella (chickenpox)	None

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

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

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

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

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

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

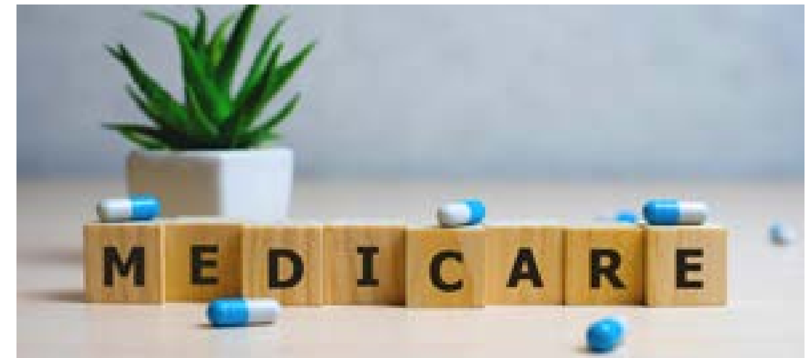
For more information about drugs covered under the medical benefit, see the following pages of our **ereferrals.bcbsm.com** website:

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

Breyanzi requires prior authorization for Medicare Advantage members

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

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



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

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

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

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

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

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

For dates of service on or after April 1:

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

What you need to know

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

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

Information for Blue Cross commercial members

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

Please see Preferred Products, continued on Page 30

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Preferred Products, *continued from Page 29*

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

Preferred and nonpreferred products for most members

We're designating the following products as preferred and nonpreferred for:

- Blue Cross commercial fully insured groups
- Blue Cross commercial members with individual coverage
- Medicare Plus Blue members
- BCN commercial members
- BCN Advantage members

Medication	Preferred products	Nonpreferred products
bevacizumab (reference product: Avastin®)	• Mvasi™ (bevacizumab-awwb), HCPCS code Q5107 • Zirabev® (bevacizumab-bvzr), HCPCS code Q5118	• Avastin® (bevacizumab), HCPCS code J9035
rituximab (reference product: Rituxan®)	• Ruxience™ (rituximab-pvvr), HCPCS code Q5119(1) • Riabni™ (rituximab-arrx), HCPCS code J3590[(1),(2)]	• Rituxan® (rituximab), HCPCS code J9312 • Truxima® (rituximab-abbs), HCPCS code Q5115
trastuzumab (reference product: Herceptin®)	• Kanjinti™ (trastuzumab-anns), HCPCS code Q5117 • Trazimera™ (trastuzumab-qyyp), HCPCS code Q5116	• Herceptin® (trastuzumab), HCPCS code J9355 • Herzuma® (trastuzumab-pkrb), HCPCS code Q5113 • Ogivri® (trastuzumab-dkst), HCPCS code Q5114 • Ontruzant® (trastuzumab-dttb), HCPCS code Q5112
filgrastim (reference product: Neupogen®)	• Nivestym® (filgrastim-aafi), HCPCS code Q5110 • Zarxio® (filgrastim-sndz), HCPCS code Q5101	• Neupogen® (filgrastim), HCPCS code J1442[(3),(4)] • Granix® (tbo-filgrastim), HCPCS code J1447[(3),(4)]

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

(2) Will become a unique code.

(3) For BCN commercial, Medicare Plus Blue and BCN Advantage members: For courses of treatment that start Oct. 1, 2020, through March 31, 2021, submit these requests to AIM. For courses of treatment that start on or after April 1, 2021, submit these requests through NovoLogix.

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

Please see Preferred Products, continued on Page 31

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Preferred Products, *continued from Page 30*

Additional preferred and nonpreferred products for most commercial members

We're designating the following products as preferred and nonpreferred for:

- Blue Cross commercial fully insured groups
- Blue Cross commercial members with individual coverage
- BCN commercial members

Medication	Preferred products	Nonpreferred products
pegfilgrastim (reference product: Neulasta®)	• Neulasta® / Neulasta® Onpro® (pegfilgrastim), HCPCS code J2505 • Nyvepria™ (pegfilgrastim-apgf), HCPCS code Q5122	• Fulphila® (pegfilgrastim-jmdb), HCPCS code Q5108 • Udenyca® (pegfilgrastim-cbqv), HCPCS code Q5111 • Ziextenzo™ (pegfilgrastim-bmez), HCPCS code Q5120

Additional preferred and nonpreferred products for Medicare Advantage members

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

Medication	Preferred products	Nonpreferred products
pegfilgrastim (reference product: Neulasta®)	• Neulasta® / Neulasta® Onpro® (pegfilgrastim), HCPCS code J2505 • Udenyca® (pegfilgrastim-cbqv), HCPCS code Q5111	• Fulphila® (pegfilgrastim-jmdb), HCPCS code Q5108 • Ziextenzo™ (pegfilgrastim-bmez), HCPCS code Q5120 • Nyvepria™ (pegfilgrastim-apgf), HCPCS code Q5122

Submitting requests for prior authorization

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

- **For preferred products:** These products require prior authorization through AIM. Submit the request through the **AIM provider portal** or by calling the AIM Contact Center at 1-844-377-1278. For information about registering for and accessing the *AIM ProviderPortal*, see the ***Frequently asked questions*** **page** on the AIM website.

  Exception: Ruxience and Riabni don't require authorization.

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

- **Nonpreferred products:** These products have authorization requirements. Submit the prior authorization request through NovoLogix. NovoLogix offers real-time status checks and immediate approvals for certain medications. If you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix. If you need to request access to Provider Secured Services, complete the ***Provider Secured Access Application*** form and fax it to the number on the form.

Please see Preferred Products, continued on Page 32

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Preferred Products, *continued from Page 31*

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

Lists of requirements

See the following lists to view requirements for these products.

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

We've updated the requirements lists with the new information.

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

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

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

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

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

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

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

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

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

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

Here are some other things you need to know:

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

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

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

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

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

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

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

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Billing policy and guidelines for intensity modulated radiation therapy

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

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

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

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

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

Reminder: Clinical editing updates coming in June to outpatient claims

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

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

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

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

Clinical editing billing tips

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

This issue's tip includes:

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

Clinical editing billing tips

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

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

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

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

A: The new policy pertains to inpatient only.

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

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

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

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

Q: Can these claims be audited?

A: Yes. Every claim is subject to audit.

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

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

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

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

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

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

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

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

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

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

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

Background

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

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

This applies to:

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

What you need to know

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How to attach clinical information to the request

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

Additional information about the questionnaires

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

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

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

CareCentrix to manage authorizations for home health care for Medicare Advantage members

Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with CareCentrix® to manage the authorization of home health care for Medicare Advantage members.

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

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

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

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

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

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

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

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

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

Training resources for SNFs

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

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

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

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

Important next steps

If you haven't done so already:

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

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

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

We've made questionnaire changes in the e-referral system

We use our authorization criteria, our medical policies and your answers to the questionnaires in the e-referral system when making utilization management determinations on your authorization requests.

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

New questionnaires

On Feb. 28, we added the following questionnaires:

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

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

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

On March 28, we added the following questionnaires:

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

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

- We replaced the *Chemical peels* questionnaire with the following two questionnaires for pediatric and adult BCN commercial and BCN Advantage members:
  - *Dermal chemical peel* — This questionnaire opens for procedure codes *15789 and *15793.
  - *Epidermal chemical peel* — This questionnaire opens for procedure codes *15788, *15792 and *17360.

What you need to know

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

Updated questionnaires

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

Removed questionnaire

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

Preview questionnaires

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

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

Authorization criteria and medical policies

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

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

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

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

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

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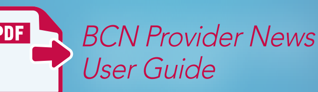

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Virtual Option for BCN plans reduces member cost for telehealth

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

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

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

What is a virtual visit?

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

Which telemedicine visits qualify for the lower member cost share?

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

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

Please see BCN Virtual Option continued on Page 2

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BCN Virtual Option, *continued from Page 1*

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

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

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

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

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

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

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

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

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Help Michigan reach COVID-19 vaccination benchmarks

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

How can you help?

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

Here's how Blue Cross and BCN are helping

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

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

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

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

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

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

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

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

What you need to know

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

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

Clinical information includes relevant information regarding the member's:

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

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

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

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

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

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

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

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

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We've transitioned to a new provider training site

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

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

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

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

Action item

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

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Medicare 2% sequestration moratorium extended to Dec. 31

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

Background information

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

The timeline of the suspensions is as follows:

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

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

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

We require prior authorization for Abecma for Medicare Advantage members

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

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

Places of service that require authorization

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

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

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

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

List of requirements

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

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Updates to the star measure on statin use

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

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

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

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

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

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

New measure exclusions

Patients with the following conditions are excluded from the measure.

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

Jemperli and Zynlonta require prior authorization for most members

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

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

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

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

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

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

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

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

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

As a reminder:

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

NovoLogix

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

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

List of requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Medical policy updates

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

Covered services

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

Noncovered services

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

Medical Policy Updates

Criteria corner

Blue Care Network uses Change Healthcare's InterQual Level of Care when conducting admission and concurrent review activities for acute care hospitals. To make sure that providers and health plans understand the application of the criteria and local rules, BCN provides clarification from Change Healthcare on various topics.

Question:

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

Answer:

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

Updates to the star measure on statin use

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

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

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Addressing health care disparities among people in the LGBTQ+ community

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

What you need to know

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

Background

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

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

LGBTQ+ health and disparities

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

Barriers to care

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

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

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

Please see LGBTQ+ community continued on Page 12

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LGBTQ+ community, *continued from Page 11*

What health care providers can do to support LGBTQ+ patients

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

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

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

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

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

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

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

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

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

For more information

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

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

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

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

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

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

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

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

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

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

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

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

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From the medical director: Diagnosing and treating ADHD

By Kristyn Gregory, D.O.

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

Diagnosis

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

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

Comorbidities and current recommendations

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

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

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

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

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

Please see From the medical director, continued on Page 15

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

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From the medical director, *continued from Page 14*

Treatment

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

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

Follow-up is critical

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

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

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

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Cosela and Pepaxto require prior authorization for most members

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

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

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

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

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

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

How to submit authorization requests

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

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

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

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

- For commercial members, see:
  - Standard commercial medical drug program: **Blue Cross and BCN utilization management medical drug list for Blue Cross PPO (commercial) and BCN HMO (commercial) members document**
  - Medical oncology drug program: **Medical oncology prior authorization list for Blue Cross PPO' (commercial) fully insured and BCN HMO (commercial) members**
- For Medicare Advantage members, see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**.

Jemperli and Zynlonta require prior authorization for most members

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

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

Submit prior authorization requests through AIM Specialty Health®.

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

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

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

How to submit authorization requests

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

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

More about the authorization requirements

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

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

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

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

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

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

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

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

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

Submitting National Drug Codes on claims

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

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

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

The NDC must be active on the date of service.

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

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

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Quarterly update:

Requirements changed for some commercial medical benefit drugs

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

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

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

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

List of requirements

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

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

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

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

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

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

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

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

Please see Preferred Drug List, continued on Page 21

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

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

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Use the correct HCPCS code for Spravato

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

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

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

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

Prior authorization information

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

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

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

Additional information

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

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

We require prior authorization for Abecma for Medicare Advantage members

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

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

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

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

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

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

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

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Clinical editing billing tips

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

This issue's tip includes:

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

Clinical editing billing tips

Use the correct HCPCS code for Spravato

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

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

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

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

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

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

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

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

Session date	Topic	Led by	Sign-up link
Tuesday, July 20	Diabetes with complications	Physician	Register here
Wednesday, Aug. 18	Renal disease	Physician	Register here
Thursday, Sept. 23	Malignant neoplasm	Physician	Register here
Tuesday, Oct. 12	Updates for ICD-10-CM	Coder	Register here
Wednesday, Nov. 17	Coding scenarios for primary care and specialty	Coder	Register here
Thursday, Dec. 9	E/M coding tips	Coder	Register here

If you have any questions about the sessions, contact April Boyce at aboyce@bcbsm.com. If you have questions regarding registration, email Patricia Scarlett at pscarlett@bcbsm.com.

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Use our ereferrals.bcbsm.com website to find information about referrals and authorizations

This article is part of a series we're publishing over the next few issues to refamiliarize you with the resources available on the ereferrals.bcbsm.com website.

Do you need the latest news we posted about referrals and authorizations?

Are you looking for authorization requirements and criteria?

Or are you new in your provider office role and need training in how to use the e-referral system?

All the information you need is one place. Our **ereferrals.bcbsm.com** website has a wealth of information you can use, including news, training and authorization and criteria information. The **ereferrals.bcbsm.com** website is separate from the e-referral system, where you log in to make a referral or request prior authorization.

Whether you're new or just haven't visited the site in a while, we want to remind you of what's available.

On the home page, the news items we post give you the latest information about referral and authorization requirements. You'll also find information on new requirements and utilization management programs.

You can view news articles by the month published and search the News Archive page for older news postings. Simply go to the search box at the top of the page and type what you're looking for into the box. Filters allow you to search the full site, or just BCN or Blue Cross. You can use the search feature to look for something specific anywhere on the site, not just in the news postings.

But there's much more to the website than the news postings. Here are some benefits of exploring the site.

- The site is public; you don't need to log in. Just go to **ereferrals.bcbsm.com**.
- The website has a filter so you can search for information specific to BCN or Blue Cross.
- It only contains information about referrals and authorizations, so if you're a referral coordinator, this may be the first place you check for information.
- The site includes information pertinent to all our members, including our commercial members (Blue Cross and BCN) and our Medicare Advantage members (Medicare Plus Blue and BCN Advantage).
- The site has a Blue Cross section (with Blue Cross commercial and Medicare Plus Blue information) and a BCN section (with BCN commercial and BCN Advantage information).
- You can find links to the *BCN Provider Manual* chapters that cover referral and authorization information. (BCN only)
  - Utilization Management chapter
  - BCN Advantage chapter
  - Behavioral Health chapter

  Note: There's no link to the Blue Cross PPO (commercial) Provider Manual from the **ereferrals.bcbsm.com** site, but you can find the manual here:
  - Visit **bcbsm.com/providers**.
  - Log in to Provider Secured Services
  - Click *Provider Manuals*.
  - Click *Blue Cross PPO Provider Manual*.

If you look at the left-hand navigation in either the Blue Cross or BCN section of the site, you'll see links to pages for specific types of services, including behavioral health, musculoskeletal and pharmacy services. In upcoming articles, we'll explore in more detail what those pages offer.

Tip

Need to process a referral or submit a prior authorization request?

Click *Login* at the top of the page to get to the e-referral system.

We've added and updated questionnaires in the e-referral system

We added and updated questionnaires in the e-referral system on May 9. We've also updated the corresponding preview questionnaires on the **ereferrals.bcbsm.com** website.

We use our authorization criteria, our medical policies and your answers to the questionnaires in the e-referral system when making utilization management determinations on your authorization requests.

New questionnaires

We added the following questionnaires:

- *Experimental and investigational services* — This questionnaire opens for adult BCN commercial and BCN Advantage℠ members for all procedure codes that are configured as experimental in our systems.
- *Medical formula for inborn errors of metabolism* — This questionnaire opens for adult and pediatric BCN commercial and BCN Advantage members for procedure codes B4157 and B4162 for certain diagnosis codes.
- *Not otherwise classified codes* — This questionnaire opens for adult and pediatric BCN commercial and BCN Advantage members for all procedure codes that are configured as not otherwise classified in our systems.

Updated questionnaires

We updated the following questionnaires:

- *Bariatric surgery 2* — For adult BCN Advantage members
- *Endoscopy, upper gastrointestinal, for GERD* — For adult BCN commercial and BCN Advantage members. This questionnaire no longer opens for procedure code *43201. It continues to open for all other procedure codes and all diagnoses listed in the **Endoscopy, upper gastrointestinal, for GERD** preview questionnaire.
- *Excess skin removal* — For adult BCN commercial and BCN Advantage members
- *Prostatic urethral lift* — For adult BCN commercial and BCN Advantage members. This questionnaire now opens for procedure code C9769. It continues to open for procedure codes *52441 and *52442.
- *Sacral nerve neuromodulation/stimulation* — For adult Medicare Plus Blue℠, BCN commercial and BCN Advantage members

Preview questionnaires

You can access preview questionnaires at **ereferrals.bcbsm.com**. They show the questions to help you prepare your answers ahead of time.

To find the preview questionnaires:

- For BCN: Click *BCN* and then click **Authorization Requirements & Criteria**. Scroll down and look under the "Authorization criteria and preview questionnaires" heading.
- For Medicare Plus Blue: Click *Blue Cross* and then click **Authorization Requirements & Criteria**. In the "Medicare Plus Blue PPO members" section, look under the "Authorization criteria and preview questionnaires - Medicare Plus Blue PPO" heading.

Authorization criteria and medical policies

The pertinent authorization criteria and medical policies are also available on the Authorization Requirements & Criteria page.

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Enhancing your experience with the TurningPoint surgical quality and safety management program

The Blue Cross Blue Shield of Michigan and Blue Care Network Utilization Management department is committed to enhancing your experience with the TurningPoint Healthcare Solutions LLC surgical quality and safety management program. Since we implemented the program, we've made the following enhancements based on provider feedback.

- Published the code substitutions that are available for musculoskeletal procedures
- Detailed the steps required to determine whether prior authorization is required for Blue Cross commercial members
- Simplified the process for requesting peer-to-peer conversations
- Clarified clinical documentation requirements
- Updated and added informational resources for the TurningPoint program

Code substitutions for musculoskeletal procedures

In some situations, you may not know which orthopedic or spinal procedure will be required in advance of a surgery, or the surgical plan may change intraoperatively. As a result, the procedure code TurningPoint authorized may not represent the procedure that was performed.

Prior to submitting claims for these procedures, you'll need to determine whether you can substitute the code for the procedure that was performed for the code TurningPoint authorized. If you can substitute the code, you won't need to contact TurningPoint to update the procedure coding.

To determine if the approved code allows substitutions and to view all codes that allow substitutions, see the **Musculoskeletal procedure code substitutions for orthopedic and spinal surgeries** document.

What you need to know

- To improve your experience with the TurningPoint program, we've published code substitutions that are available for musculoskeletal procedures.
- We've also simplified the process for requesting peer-to-peer conversations.

This document is available on the Musculoskeletal Services pages of our **ereferrals.bcbsm.com** website.

Process for requesting peer-to-peer conversations

The steps that lead to peer-to-peer conversations with TurningPoint vary depending on whether the member has coverage through a commercial or a Medicare Advantage product.

Commercial members

If TurningPoint denies an authorization request for a Blue Cross or BCN commercial member, you have two options for requesting reconsideration:

- You can ask TurningPoint to review additional clinical documentation, provide clarifying details that are pertinent to the request or both. Submit the documentation, details or both using one of the following:
  - TurningPoint Provider Portal
  - Fax (Include a cover sheet that identifies patient):
    - **313-879-5509** for joint and spine procedures
    - **313-483-7323** for pain management procedures
- You can call **1-833-217-9670** to request a peer-to-peer conversation to review the case with a physician. You'll need to provide three dates when you're available to meet. TurningPoint will schedule the conversation based on the dates you request.

Please see TurningPoint, continued on Page 27

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TurningPoint, *continued from Page 26*

You can request a reconsideration or a peer-to-peer conversation any time before providing services or filing an appeal with the health plan.

If you completed a reconsideration or peer-to-peer conversation and are dissatisfied with the decision, you may appeal.

Medicare Advantage members

Before denying an authorization request for a Medicare Plus Blue℠ or BCN Advantage℠ member, TurningPoint will make three attempts to notify you of their intent to deny any request that doesn't meet medical necessity criteria. As part of this notification, TurningPoint will offer to schedule a peer-to-peer conversation. You'll need to give TurningPoint three dates when you're available to meet. TurningPoint will schedule the conversation based on the dates you requested.

If TurningPoint is unable to contact you, they'll proceed with the authorization decision based on the information you provided with the authorization request.

Alternately, you can request a peer-to-peer conversation any time before providing services or filing an appeal.

For TurningPoint to consider information obtained during a peer-to-peer conversation when making an authorization determination, the peer-to-peer conversation must take place before the denial of an authorization request.

Note: If the peer-to-peer conversation takes place after TurningPoint denies the authorization request, TurningPoint can't reverse the denial. In such cases, the peer-to-peer conversation is for informational purposes only.

Clinical documentation requirements

We recently published updated information about the clinical documentation you must include when submitting prior authorization requests to TurningPoint Healthcare Solutions LLC.

We updated or added information related to the specific clinical documentation requirements for:

- Conservative therapies
- Body mass index
- Smoking status
- Surgical plan

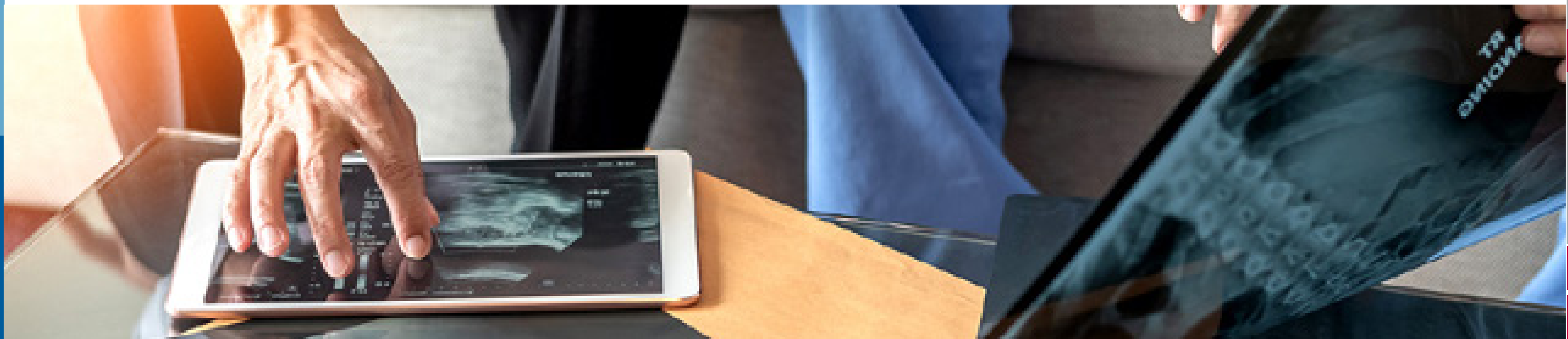
To view the updated requirements, see the **Clinical documentation requirements for musculoskeletal procedures** document. This document is available on the Musculoskeletal Services pages of our **ereferrals.bcbsm.com** website.

Resources for the TurningPoint program

Resources are available to help you navigate the TurningPoint musculoskeletal surgical quality and safety management program.

We update these resources on a regular basis to provide you with the most current information.

To learn more, see the *Resources for the TurningPoint musculoskeletal surgical quality and safety management program* article, **Page 28**.



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Resources for the TurningPoint musculoskeletal surgical quality and safety management program

We have resources to help you navigate the TurningPoint musculoskeletal surgical quality and safety management program. You can find them on the following pages of the **ereferrals.bcbsm.com website**:

- **Blue Cross Musculoskeletal Services**
- **BCN Musculoskeletal Services**

The most comprehensive resource is the **frequently asked questions** document. Here are a few of the things you'll find in the FAQ:

- How to submit authorization requests to TurningPoint through their portal, and by fax or phone
- How the peer-to-peer conversation process works
- Information related to submitting claims

Some resources you'll find on these pages:

- The list of orthopedic, pain management and spinal procedure codes that require prior authorization by TurningPoint
- The list of orthopedic and spinal procedure codes for which we allow code substitutions
- A document that walks through the steps to determine whether prior authorization is required for Blue Cross commercial members (This document is accessible only from the Blue Cross Musculoskeletal Services page.)
- Clinical documentation requirements for musculoskeletal procedures
- The *TurningPoint Provider Training Manual*
- Fax forms for requesting authorization for musculoskeletal procedures
- Recordings and presentations from the TurningPoint provider training sessions

We encourage you to take advantage of these resources.

As a reminder, TurningPoint manages authorizations for orthopedic, pain management and spinal procedures for the following:

- Blue Cross commercial* — All fully insured groups, select self-funded groups and all members with individual coverage
- Medicare Plus Blue℠ members
- BCN commercial members
- BCN Advantage℠ members

*To determine whether you need to submit prior authorization requests for Blue Cross commercial members, see the document titled **Determining whether Blue Cross commercial members require prior authorization for musculoskeletal surgeries and related procedures**.

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Refer our members only to in-network DME suppliers

When obtaining durable medical equipment, or DME, for our members, you must use suppliers who are part of the Blue Cross Blue Shield of Michigan or Blue Care Network supplier network. Your contract with us obligates you to do this. The only exceptions are for emergencies or for other situations described in the policies we publish.

Here are two guidelines to keep in mind:

- You must not refer to DME suppliers who are outside of our network.
- You must determine whether a particular DME supplier participates with the member's plan before referring the member.

How to identify an in-network DME supplier

Here's how to identify a DME supplier who is part of our network.

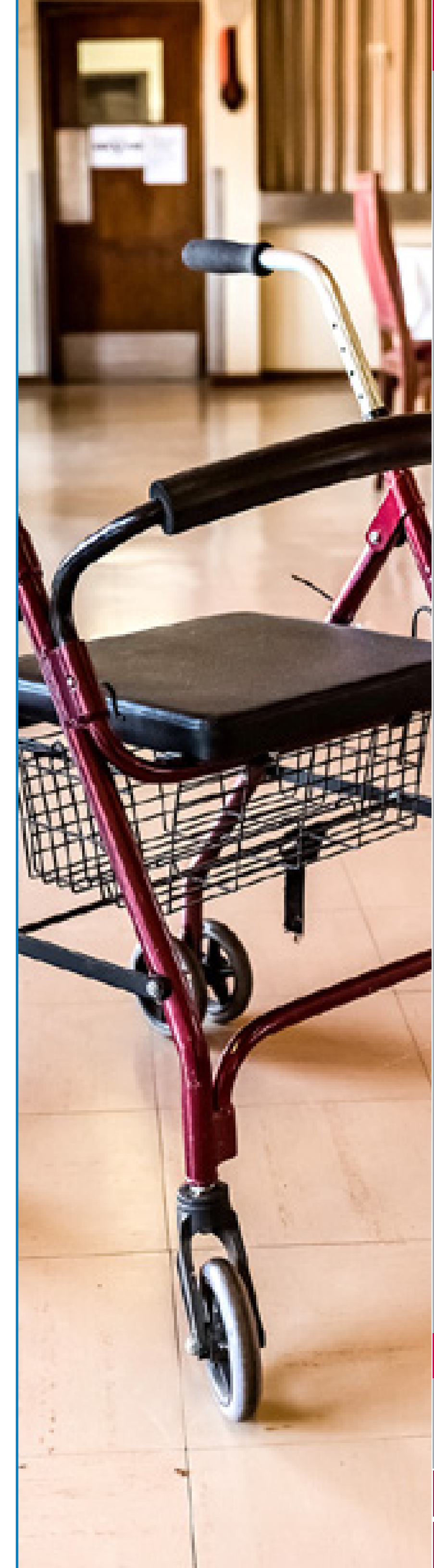
- **For certain Blue Cross commercial members**, find a supplier using the **Find a Doctor** tool on **bcbsm.com**. This applies only to Blue Cross commercial members who either:
  - Have coverage through the Michigan Public School Employees' Retirement System
  - Are Ford or General Motors salaried employees
- **For all other members**, use a supplier that's part of the Northwood, Inc., network. This applies to these members:
  - Blue Cross commercial members who do not have coverage through one of the groups referred to above.
  - Medicare Plus Blue℠ members
  - BCN commercial members
  - BCN Advantage℠ members

To identify a supplier in the Northwood network, call Northwood at 1-800-393-6432.

What happens when you use an out-of-network DME supplier

When you use out-of-network DME suppliers, members may be responsible for additional out-of-network cost sharing. They may also be subject to balance billing by the suppliers because the suppliers aren't in the Blue Cross or BCN network or aren't following medical necessity requirements for replenishing supplies.

Our goal is to partner with you to ensure that our members have convenient access to appropriate high-quality, cost-effective DME supplies that meet their clinical needs and that are covered by their plan.



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Choose the correct servicing provider in e-referral to avoid denied claims

What you need to know

- We've clarified the steps you should take to find the correct servicing provider in e-referral.
- Not all provider addresses are considered in network.
- Refer to our user guides for additional information.

To avoid issues or denied claims when you are submitting authorizations and referrals in e-referral, make sure you've selected the correct servicing provider. The provider you're looking for may be listed multiple times.

We've clarified the steps you should take:

1. When your servicing provider results are returned, select the listing based on where the member is going to see the provider.
2. If the provider has several listings with the same address, select the listing that also shows a group affiliation. If there are multiple group affiliations listed, make sure to choose the correct one.
3. Not all provider addresses are considered in network. If you select a listing that shows the provider is out of network ("Out" in the Network column), you will have to go through an out-of-network review.

This information can be found in the following sections of the e-referral user guides:

- ***e-referral User Guide***
  - Submit a global referral
  - Submit a referral
  - Submit an inpatient authorization
  - Submit an outpatient authorization
- ***Behavioral Health e-referral User Guide***
  - Submitting Higher Levels of Care Inpatient authorizations
  - Submitting Higher Levels of Care Outpatient authorizations
  - Submitting an Electroconvulsive Therapy Authorization
  - Submitting a Transcranial Magnetic Stimulation Authorization
  - Submitting a Neurofeedback Authorization
- ***Blue Cross® Physician Choice PPO e-referral User Guide***
  - Submit a Referral
  - Submit an Inpatient Authorization

You can also look in the ***e-referral Quick Guide*** under the Select provider/patient section.

Alacura's telephone number has changed for non-emergency air transport of commercial members

The telephone number for Alacura Medical Transport Management has changed to 1-844-425-2287.

We've updated the **Air ambulance flight information (non-emergency) form** to reflect the change. The fax number for Alacura is on the form as well; that number hasn't changed.

As a reminder, prior authorization by Alacura is required for non-emergency air transport of Blue Cross Blue Shield of Michigan commercial members and Blue Care Network commercial members. You'll find more details about the authorization requirements on the form (linked above).

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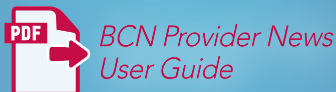

BCN Provider News User Guide

Home health care agencies can administer the COVID-19 vaccine in the home for eligible patients

The COVID-19 vaccine reimbursement has expanded to home health care agencies, allowing eligible patients to receive the vaccine at home. Home health care agencies have already begun administering vaccines to homebound patients.

Blue Cross Blue Shield of Michigan and Blue Care Network are following the Centers for Medicare & Medicaid Services' guidelines for determining which patients qualify for in-home COVID-19 vaccination. Patients qualify if they meet one of these requirements:

- The patient has difficulty leaving the home to get the vaccine, which includes:
  - Having a condition, due to an illness or injury, that restricts their ability to leave home without a supportive device or help from a paid or unpaid caregiver
  - Having a condition that makes them more susceptible to contracting a pandemic disease such as COVID-19
  - Being generally unable to leave the home, or doing so requires a considerable and taxing effort

What you need to know

- Home health care agencies receive reimbursement to administer COVID-19 vaccine to eligible patients within their home
- Provider guidelines for eligible Blue Cross Blue Shield of Michigan or Blue Care Network members with commercial coverage
- CMS guidelines for Medicare Plus Blue and BCN Advantage℠ members

Please see Home Health care continued on Page 2

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Home Health care, *continued from Page 1*

- The patient is hard to reach due to a disability or faces clinical, socioeconomic or geographic barriers to getting a COVID-19 vaccine in settings other than their home. This includes patients with transportation, communication or caregiving challenges.

The provider must document the patient's clinical status or barriers that justified the in-home vaccination in the patient's medical record. The additional payment described below and in the CMS links below applies if the only service provided during the home visit is administration of the COVID-19 vaccine.

This temporary expansion of COVID-19 vaccine coverage in the home for eligible patients is effective:

- June 8, 2021, for patients with Medicare coverage
- July 1, 2021, for patients with Blue Cross and Blue Care Network commercial coverage

This expansion is in place until further notice.

Here's what you need to know.

For eligible patients with commercial coverage:

Follow these guidelines for patients with Blue Cross or Blue Care Network commercial coverage.

- **Contact us to enroll** — Home health care agencies interested in administering the COVID-19 vaccine to eligible commercial members in their homes need to contact Provider Enrollment and Data Management at 1-800-822-2761 to enroll for this expanded service. You'll receive notification when you can begin providing this service.

Please see Home Health care continued on Page 3

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Home Health care, *continued from Page 2*

- **Submit professional claims using standard vaccine administration codes plus M0201** — Once you're approved to provide this service, home health care agencies need to submit professional claims using standard COVID-19 vaccine administration codes for dates of service July 1, 2021, and after. In addition, home health care agencies approved for this service should include HCPCS Level II code M0201 to receive additional payment in recognition of the cost agencies will incur for traveling to the patient's home.
- For M0201 to be payable, these requirements must be met:
  - The service is provided to a patient that meets the above requirements.
  - The provider documents justification for the service in the patient's record.
  - The only service provided was COVID-19 vaccine administration.
  - The service is administered in a home location (see **Medicare Payment for COVID-19 Vaccination Administration in the Home** for more information.)
  - The code is reported only once per individual home per date of service.

The COVID-19 vaccine administration codes are available on our COVID-19 webpages within our provider portal or on our public website at **bcbsm.com/coronavirus**. Refer to **COVID-19 vaccine information for providers** and **COVID-19 vaccine billing information at a glance**.

For eligible patients with Medicare primary or Medicare Advantage coverage:

Follow CMS guidelines for patients with Medicare Advantage coverage (Medicare Plus Blue℠ and BCN Advantage℠) and coverage with Medicare primary. More information is available at these links:

- **MLN Connects® special edition: Biden Administration Continues Efforts to Increase Vaccinations by Bolstering Payments for At-Home COVID-19 Vaccinations for Medicare Beneficiaries**
- **Medicare COVID-19 Vaccine Shot Payment webpage**
- **Medicare Billing for COVID-19 Vaccine Shot Administration**

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BCN names new chief medical officer

Scott Betzelos, M.D., has been named the new chief medical officer for Blue Care Network succeeding Marc Keshishian, M.D., who retired in January from Blue Cross Blue Shield of Michigan after many years of service.

Scott has more than 20 years of experience as a practicing emergency physician in Chicago while serving as chairman of Saints Mary and Elizabeth emergency department and president of the physician management group supporting four Chicago emergency departments and two hospitalist groups through 2010.

He also served as chairman of the board of EMPAC RRG, a medical malpractice insurance company for emergency medicine provider organizations. Most recently Scott served as chief quality officer at Presence Healthcare in Chicago, Ill., and chief clinical officer at ThedaCare in northern Wisconsin. While at Inova Health System in suburban Washington, D.C, he served as chief medical officer at Inova Fairfax, system chief patient safety officer and chief executive officer of Inova Medical Group.

"My vision as CMO for BCN will continue to build on the success of the past and focus on multiple areas within BCN while advancing convenience and affordability to our members and the population we serve," said Dr. Betzelos.

"My unique experience will afford me the opportunity to enhance and optimize the network through innovative ideas, and to advance the already strong relationships with our providers and members."

Dr. Betzelos says one of his goals is to create new experiences and relationships with our providers and to collaborate to develop mutually beneficial arrangements that will positively impact members, providers and the population we serve.

"I believe that value is achieved through optimizing quality, safety and ensuring members and providers are engaged, while reducing cost through payer-physician collaboration and focus groups. My aim is to achieve and outperform the industry in member experience, provider experience, innovative risk programs and digital engagement," he said.

No-cost COVID-19 treatment to end Sept. 30, 2021

As COVID-19 cases remain low throughout Michigan, we're ending our $0 cost share for COVID-19 treatment. The last date of service for the temporary waiver of member cost share for COVID-19 treatment is Sept. 30. We'll still pay for medically necessary treatment, but it will now be subject to member cost sharing. This change applies to Blue Cross, BCN, Medicare Plus Blue℠, BCN Advantage℠ and Medigap plans.

We initially published the extension of no-cost COVID-19 treatment through Sept. 30, 2021, in the **March-April BCN Provider News**. Effective Oct. 1, member cost share will apply for COVID-19 treatment.*

Throughout the pandemic, Blue Cross Blue Shield of Michigan and Blue Care Network have implemented many short-term changes to help our providers and our members during this difficult time. This included waiving authorization requirements and member cost sharing for COVID-19 testing and treatment. Many of our policies had ending dates that were revised throughout the health emergency. We are continuing to revise the end dates for temporary changes to our policies. For more information, refer to our **Temporary changes due to the COVID-19 pandemic document**.

We'll continue to cover physician-approved testing for the duration of the public health emergency, as required by federal guidelines.

*Note: Some commercial self-funded groups may conclude the temporary waiver of member cost share on a different date. For example, the Michigan Education Special Services Association, known as MESSA, is extending the waiver of member cost share through the end of 2021. Providers are encouraged to submit claims to Blue Cross and BCN and wait for the voucher before charging member cost share, if applicable.

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New rider for large groups in the Upper Peninsula will limit coverage outside Michigan

Effective Oct. 1, Blue Care Network large group plans will require a mandatory rider for group customers with locations in the Upper Peninsula. The rider will be added to all existing large groups upon renewal Oct. 1, 2021 and after and to new large group business upon their effective date.

The rider will limit coverage outside Michigan to urgent, emergency or accidental services. Non-urgent and non-emergency BlueCard® travel coverage outside of Michigan won't be covered.

We'll issue new member ID cards. The suitcase icon on the front of the card (which indicates coverage by BlueCard while traveling outside of Michigan) will be removed. Language on the back of the card will read, "Members do not have coverage outside the state of Michigan except for emergency, urgent or accidental services."

When you look up these members' benefits in web-DENIS and click on *Medical Benefits* to view the Benefits Description page, then Certificate/Rider, you will see one of the following riders listed:

- BCADD2 — for fully insured large groups
- BCNUSF — for self-funded large groups

Members will be able to see these updated riders by logging in to their member accounts at **bcbsm.com**.

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What you need to know

Some information in the following article has been updated since we ran it in the July-August issue. Use this one as your reference.

Refer our members only to network DME suppliers

When obtaining durable medical equipment, or DME, for our members, you must use suppliers who are part of the Blue Cross Blue Shield of Michigan or Blue Care Network supplier network. Your contract with us obligates you to do this. The only exceptions are for emergencies or for other situations described in the policies we publish.

Here are two guidelines to keep in mind:

- Don't refer to DME suppliers who are outside our network.
- You must determine whether a particular DME supplier participates with the member's plan before referring a member to the supplier.

Identifying a Blue Cross / BCN network DME supplier

For all members, you can find a Blue Cross or BCN network DME supplier by using the **Find a Doctor** tool on **bcbsm.com**.

Identifying a Northwood network DME supplier

For some members, you must use a supplier that's part of the Northwood, Inc., network, which is a subset of our general DME supplier network. This applies to:

- Fully insured Blue Cross commercial members
- Medicare Plus Blue℠ members
- BCN commercial members
- BCN Advantage℠ members

You can find a Northwood DME supplier by using the **Find a Doctor** tool on **bcbsm.com** and filtering by "Northwood Provider."

For additional help identifying a supplier in the Northwood network, call Northwood at 1-800-393-6432.

What happens when you use an out-of-network DME supplier

When you use out-of-network DME suppliers, members may be responsible for additional out-of-pocket costs. They may also be subject to balance billing by the suppliers because the suppliers aren't in the Blue Cross or BCN network or aren't following medical necessity requirements for replenishing supplies.

Our goal

Our goal is to partner with you to make sure our members have convenient access to appropriate high-quality, cost-effective DME supplies that meet their clinical needs and are covered by the plan they have.

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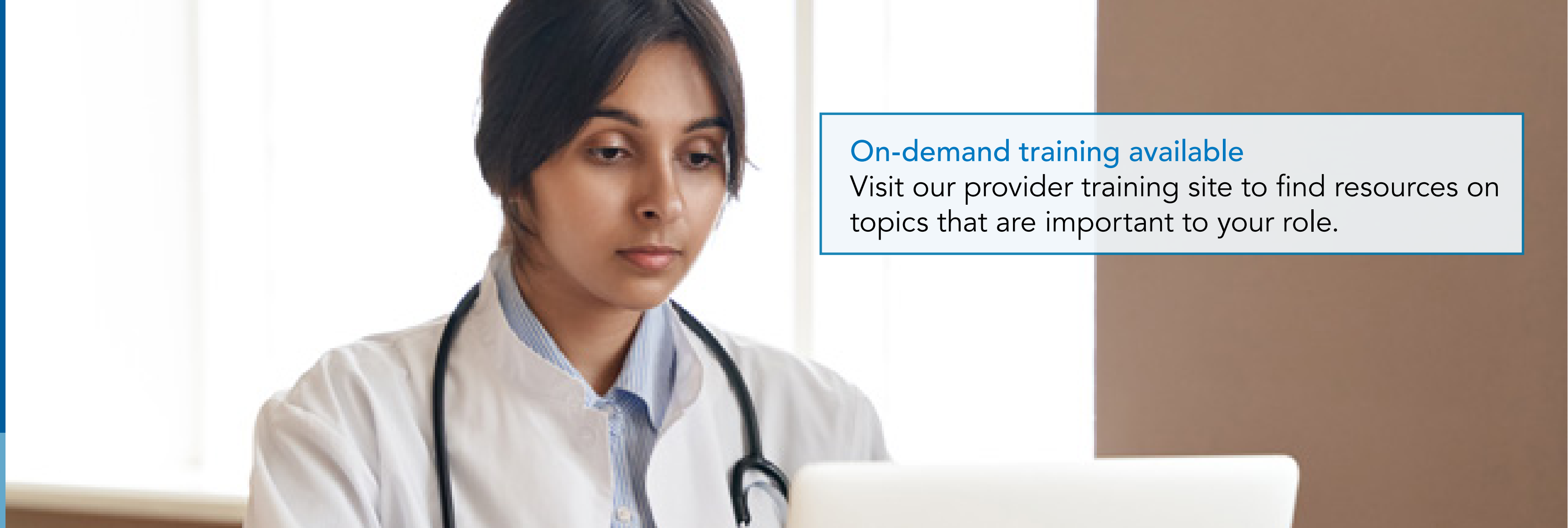

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We're offering training resources for health care providers and staff.

We've posted recordings of webinars previously delivered this year. Video and eLearning modules are also available on specific topics. The on-demand courses are designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

Here are the newest resources that are available:

- *Evaluation and management guidelines for 2020 and beyond:* This eLearning video reviews general coding and documentation requirements, evaluation and management guideline requirements and coding scenario examples.
- *HCPCS and revenue code combinations for facility claims:* This eLearning course teaches how to use the look-up tools that help providers match HCPCS/CPT codes with the correct revenue codes for facility claims.
- *Home Health Care Services Overview webinar:* This webinar recording reviews the CareCentrix® home health care authorization program and provider portal.
- *RBCE/MCG Self-Service user videos:* This series of videos demonstrate the steps for using the RCBE/MCG self-service tool to enroll new practitioners, modify status within your entity and make updates to practitioner affiliation.

Last month, we announced our new provider training site to enhance the training experience for health care providers and staff.

Active training courses and materials from 2019 to 2021 have moved from *BCBSM Provider Training* and *BCN Learning Opportunities* in Provider Secured Services to the new training site. To request access:

1. Open the **registration page**.
2. Complete the registration. We recommend using the same email you use to communicate with Blue Cross for provider-related needs. This will become your login ID.
3. Follow the **link** to login.

To learn more about the provider training site, watch this **video** that guides you through the experience. If you need assistance creating your login ID or navigating the site, contact **ProviderTraining@bcbsm.com**.

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Contact Provider Inquiry for claims issues

If you're experiencing claims or complex claims issues, contact Provider Inquiry. If you call your provider consultant, you'll first need a reference number from Provider Inquiry.

- Medical providers call 1-800-344-8525
- Facility provider call 1-800-249-5103
- Dental, hearing and vision providers call 1-800-482-4047
- Medicare Advantage providers call 1-866-309-1719

If your issue isn't satisfactorily resolved, ask the representative to escalate your inquiry to their leadership.

For enrollment questions, contact Provider Enrollment and Data Management at 1-800-822-2761 from 8 a.m. to 4 p.m. Monday through Friday.

Online tutorials about our e-referral system are available on the **Training Tools** page at **ereferrals.bcbsm.com**.

You'll also find job aids, FAQs, brochures, flyers and user guides on the *BCBSM Newsletters and Resources* and *BCN Provider Publications and Resources* pages on Provider Secured Services.

Build COVID-19 vaccine confidence with online resources from the Centers for Disease Control and Health and Human Services

We're getting closer to the State of Michigan's goal to vaccinate 70% or more of Michigan's population, but COVID-19 vaccine hesitancy remains one of the major roadblocks. Despite the massive amount of information provided by national public health messengers, some subgroups of our population are still on the fence about getting vaccinated or are refusing it altogether.

Reasons for the hesitancy could be lack of trust in the public figures or perceiving the information relayed by them as conflicting. The most trusted messengers of COVID-19 vaccine information are individual health care providers, according to the Kaiser Family Foundation's **COVID-19 Vaccine Monitor**, an ongoing research project launched in December 2020.

Please see Build Vaccine Confidence continued on Page 9

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Build Vaccine Confidence, *continued from Page 8*

Online toolkits and resources

To help providers increase acceptance of the vaccine, the Centers for Disease Control and Prevention and the U.S. Department of Health and Human Services provide helpful **online toolkits** for providers to address vaccine hesitancy not only among patients, but also among their health care provider staff.

Some of the resources in the CDC toolkits include:

- Strategies for building confidence in medical center and clinic immunization coordinators
- Materials for communicating with health care providers
- Digital and print communication resources
- Printable stickers
- Samples of social media messages and graphics

The **HHS COVID-19 Public Education Campaign** website includes resources and toolkits, a vaccine hesitancy map, campaign ads and information about joining the COVID-19 Community Corps, which emails weekly tips, news and resources to share with your community. One unique attribute of the HHS website allows you to target vaccine information using the filters below:

- Audience — by race or ethnicity, older adults, health care professionals, rural communities
- Format — social media, posters and flyers, video, informational content
- Language — Chinese, English, Filipino, Japanese, Korean, Spanish and Vietnamese
- Topic — building vaccine confidence, getting vaccinated, preventive measures, vaccine safety and efficacy

Please remind your patients that they will have zero out-of-pocket costs or network requirements to receive any of the COVID-19 vaccines. Blue Cross Blue Shield of Michigan and Blue Care Network thank you for your continued participation with our plans. We support and appreciate your ongoing efforts in caring for our members and improving the health of the citizens in our community.

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Evaluation and management guidelines are available through on demand eLearning videos on new Provider Training website

The evaluation and management guidelines and scenarios for 2020 and beyond is an eLearning lesson that helps you follow the new evaluation and management guidelines as you prepare claims for submission.

The course includes a video summary of the important points with links to supporting documents from Blue Cross Blue Shield of Michigan.

The lesson is available on our new provider training website. Access to the site will differ slightly for new and existing users.

- New users must **click here to register**.
- Existing users can follow this **link to log in**.

Once logged in, users can access the module two ways:

- Enter 'Evaluation' in the search box at the top of the screen.
- Look in the course catalog under Medical record documentation and coding.

If you need assistance creating your login ID or navigating the site, email **ProviderTraining@bcbsm.com**.

CareCentrix to manage network for independent home infusion therapy and ambulatory infusion suite providers, starting Jan. 1

Effective Jan. 1, 2022, Blue Cross Blue Shield of Michigan and Blue Care Network will delegate management of the in-state independent home infusion therapy and ambulatory infusion suite provider network to CareCentrix® for commercial members. (AISs are a subset of ambulatory infusion centers.)

This change won't affect hospital-owned HIT or AIS providers or members with Medicare Plus Blue℠ or BCN Advantage℠ plans.

See the article on **Page 35** for information about contracting and billing.

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Encourage eligible Medicare Advantage patients to get screened for colorectal cancer

Colorectal cancer is the third leading cause of cancer death for both men and women in the United States, according to the American Cancer Society. Screening, early detection and treatments are effective at reducing deaths from this cancer.

The Colorectal Cancer Screening, or COL, HEDIS® star measure assesses patients ages 50 to 75 who had appropriate screenings for colorectal cancer.

Colonoscopy is the gold standard for colorectal cancer screening. There are alternative options for patients who are hesitant to have one.

Read the *Colorectal Cancer Screening* tip sheet to learn about this measure, including what information to include in medical records, codes for patient claims and tips for talking with patients.

Healthcare Effectiveness Data Information Set; HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Colorectal Cancer Screening tip sheet

Help improve health of patients with diabetes while reducing medical record review requests

The Comprehensive Diabetes Care, or CDC, HEDIS® star measure is a composite measure that supports the consistent medical care and monitoring needed by patients with diabetes to reduce the risk of severe complications and improve outcomes.

Interventions to improve diabetes outcomes go beyond glycemic control. The CDC measure includes HbA1c control and blood pressure control, as well as screening for diabetic retinopathy and nephropathy.

View the Comprehensive Diabetes Care tip sheet to learn more about what is included in the measure, exclusions that include advanced illness and frailty, and ways you can close gaps in care for patients with diabetes.

The tip sheet also covers medical record documentation and claims coding that can reduce the need for medical record reviews.

Healthcare Effectiveness Data Information Set; HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Comprehensive Diabetes Care tip sheet

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Be sure to check out the tip sheets for the *Health Outcomes Survey* and the *Consumer Assessment of Healthcare Providers and Systems Survey* to learn how you can use the survey data to address care opportunities with patients.

Learn more about the HOS and CAHPS surveys

What are the Health Outcomes Survey and the CAHPS® survey?

The Health Outcomes Survey asks patients to report on their health outcomes, while the Consumer Assessment of Healthcare Providers and Systems Survey asks patients to report on their experiences with a wide range of health care services.

Why are these surveys important?

The goal of the Health Outcomes Survey is to gather clinically meaningful health status data from Medicare Advantage patients about health outcomes. The data gleaned from the survey is used to support quality improvement activities, monitor health plan performance and improve the health of this patient population.

The Consumer Assessment of Healthcare Providers and Systems Survey gathers data from members about a wide range of health care services. According to the **Agency for Healthcare Quality and Research**, a positive health care experience for patients is associated with positive clinical outcomes and better business outcomes, including improving patient loyalty, maximizing referrals and improving patient compliance.

To support discussions with your patients about their experiences, we began sending postcards to members in late July. The postcards remind patients to discuss their health care experiences and health-related concerns with their health care provider or office staff member at their next visit.

How can patients' experiences with health care services affect their health?

The health care team at a doctor's office not only includes physicians and medical assistants, but often includes nurses, customer service representatives, care managers and others. The entire team can affect the health of patients and how they assess their health care experience.

We encourage you to improve the experiences of your patients by addressing the following topics:

- Explain the benefits of getting COVID-19 and flu vaccinations.
- Discuss the importance of checking blood pressure regularly for patients with hypertension.
- Explain the importance of checking Hgb A1c for patients with diabetes.
- Tell patients how to find their results after testing. Let patients know the time frame in which they will receive their test results and when to call if they haven't received their results.
- Let them know to get a needed office appointment in a timely manner. Remind them that some appointments are routine or not urgent, so it's OK to have them scheduled at some point in the future. Help them understand what "urgent" means.
- Perform an assessment of your patient's physical activity and make recommendations on how to improve.
- For Medicare Advantage patients, perform an assessment of your patient's fall risk, and discuss measures to prevent falls.
- For your Medicare Advantage patients, ask if they have urinary incontinence or urine leakage, and review options for treatment.
- Perform an assessment of a patient's medication compliance and ability to pay for medications. Change prescriptions as appropriate. Let them know about avenues to explore if they need financial help.

We appreciate all you do to help keep your patients healthy and safe.

CAHPS survey

star-tips-medicare-health-outcomes-survey

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New eLearning training videos focus on Medicare star ratings

The Quality and Provider Education team continues to offer important training resources to health care providers and staff. New eLearning training videos, designed for physician office staff responsible for closing gaps related to Medicare star measures, are now available. The video series will discuss closing gaps and emphasize the importance of creating positive patient experiences.

Topics include:

- Clarifications on quality measure requirements
- Assistance with coding and documentation
- Tips for closing gaps
- Current information about HEDIS® quality measures (Note: Many HEDIS measures are also Medicare star ratings measures.)
- The Consumer Assessment of Healthcare Providers and Systems and Health Outcomes Survey

The video series will be available on our new provider training site. Access to the site will differ slightly for new and existing users:

- New users must register **here**.
- Existing users can log in **here**.

Log in to access the module in the course catalog under Quality management or by entering "Star" in the search box at the top of the screen.

Watch this **video** to learn more about the provider training site. If you need assistance creating your login ID or navigating the site, email **ProviderTraining@bcbsm.com**.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.

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Aduhelm, Empaveli and Arcalyst require prior authorization for Medicare Advantage members

The following medications require prior authorization through the NovoLogix® online tool:

- Aduhelm™, (aducanumab), HCPCS code J3590 — for dates of service on or after June 8, 2021
- Empaveli™, (pegcetacoplan), HCPCS codes J3490, J3590 — for dates of service on or after June 14, 2021
- Arcalyst® (rilonacept), HCPCS code J2793 — for dates of service on or after Sept. 13, 2021

This applies to Medicare Plus Blue℠ and BCN Advantage℠ members.

When prior authorization is required

For Medicare Advantage members, we require prior authorization for these drugs when they're administered by a health care professional in a provider office, at the member's home, in an off-campus or on-campus outpatient hospital or in an ambulatory surgical center (place of service codes 11, 12, 19, 22 and 24) and billed as follows:

- Electronically through an 837P transaction or on a professional CMS-1500 claim form
- Electronically through an 837I transaction or by using the UB04 claim form for a hospital outpatient type of bill 013x

Important reminder

Submit prior authorization requests for these drugs through NovoLogix. It offers real-time status checks and immediate approvals for certain medications.

If you have access to Provider Secured Services, you already have access to NovoLogix.

If you need to request access to Provider Secured Services, complete the **Provider Secured Access Application form** and fax it to the number on the form.

For a list of requirements related to drugs covered under the medical benefit, please see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**.

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What you need to know

- We clarify when you can substitute services provided by clinicians with lower-level credentials.
- We explain when you need to submit authorization request for additional disciplines that haven't been authorized by CareCentrix®.

Home health care: Helpful tips for adding disciplines and substituting services provided by clinicians with lower-level credentials

CareCentrix has managed authorizations for home health care services for Medicare Plus Blue℠ and BCN Advantage℠ members since June 1, 2021.

Here are some clarifications on this new program:

- For Medicare Plus Blue members who receive services in Michigan, you don't need to submit requests to add disciplines to existing 30-day episodic authorizations that have already been approved by CareCentrix.

Notes:

- For Medicare Plus Blue members receiving services outside of Michigan, follow the reimbursement guidelines for your local Blue Cross plan.
- For BCN Advantage members, home health care services use a fee-for-service payment methodology, so you need to submit authorization requests for additional disciplines that haven't been authorized by CareCentrix; see below for additional details.

- For BCN Advantage members, you don't need to update approved authorizations when services are provided by a clinician with a lower-level credential than the clinician who was authorized by CareCentrix. This substitution is allowed as long as the clinician with the lower-level credential is within the same discipline that CareCentrix authorized. For example:
  - A licensed practical nurse can provide services when CareCentrix authorized services to be provided by a registered nurse.
  - A physical therapy assistant can provide services when CareCentrix authorized services to be provided by a physical therapist.

Note: You also don't need to update authorizations for Medicare Plus Blue members when services are provided by clinicians with lower-level credentials.

See the following table to determine which HCPCS codes are associated to revenue codes by discipline:

Please see Home health care continued on Page 16

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Home health care, *continued from Page 15*

Service	HCPCS code	Associated revenue codes
Home health aide	• G0156: Home health aide	0570, 0571, 0572, 0579
Medical social services	• G0155: Medical social worker	0560, 0561, 0562
Occupational therapy	• G0152: Occupational therapist • G0158: Occupational therapist assistant • G0160: Occupational therapist, establish or deliver occupational therapy maintenance program	0430, 0431, 0432, 0434
Physical therapy	• G0151: Physical therapist • G0157: Physical therapist assistant • G0159: Physical therapist, establish or delivery physical therapy maintenance program	0420, 0421, 0422, 0424, 0429
Skilled nursing	• G0299: RN visit • G0300: Licensed vocational nurse/LPN visit • G0162: RN, for management and evaluation of the care plan • G0493: RN clinical assessment, initial • G0494: LPN, for the observation and assessment of patient condition • G0495: RN, training / education of a patient or family member • G0496: Practice nurse, training/ education of a patient or family member	0550, 0551, 0552
Speech therapy	• G0153: Speech therapist • G0161: Speech language pathologist, establish or deliver speech language pathology maintenance program	0440, 0441, 0442, 0444

We've updated the **Home health care: Frequently asked questions** for providers document to reflect these clarifications.

As a reminder, CareCentrix manages prior authorizations for home health care services for Medicare Plus Blue and BCN Advantage members as follows:

- For episodes of care that start on or after June 1, 2021
- For episodes of care that started prior to June 1, 2021, when one of the following occurs on or after June 1: recertification is needed, resumption of care is needed or there's a significant change in condition.

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Inflammation side effect of COVID-19 vaccine can cause inaccurate mammogram results

Before scheduling patients' screening mammograms, ask if they've received a COVID-19 vaccine in the last four to six weeks. The Centers for Disease Control and Prevention suggests scheduling any screening mammograms before getting a COVID-19 vaccination. Patients who already received the vaccine should schedule their screening mammogram four to six weeks **after** getting their complete vaccination dose, per the CDC's recommendation.

The COVID-19 vaccine, like some other vaccines including influenza and pneumococcus, can cause temporary swelling of lymph nodes in the underarm area, or axilla, near where a patient received the shot. The swelling may produce a false positive result on a mammogram performed too soon after the vaccine. These false positive results may lead to repeat studies and member anxiety.

Waiting will reduce unnecessary call-backs for more diagnostic screenings and radiation exposure.

If patients ask questions about the vaccination, reassure them that:

- The COVID-19 vaccine is not associated with breast cancer.
- The lymph node inflammation is normal and means the immune system is working.

Patients can find more information on the CDC's website here: **COVID-19 Vaccination and Other Medical Procedures**.

Another good source of information on this topic is from Johns Hopkins' website, hopkinsmedicine.org: **COVID-19 Vaccine: Can It Affect Your Mammogram Results?**

We've updated our *choices for care* and Blue Cross Online Visits toolkits

We've refreshed our *choices for care* and Blue Cross Online Visits[SM] employer toolkits to continue supporting member education about the care that's always there with their Blue Cross Blue Shield of Michigan and Blue Care Network health plans.

These employer toolkits, which contain print, digital and video resources, are part of our continuing efforts to make sure members know they have 24-hour access to care that's always there. You are welcome to use these materials in your office.

Choices for care

In the *choices for care* campaign, we remind members to check with their primary care providers first when they need care and that many primary care providers have the following options available:

- In-person care
- Virtual care
- Phone consultations
- Extended hours, including weekends

We also stress that members follow up with their primary care provider when they receive care elsewhere.

The other choices for care available to members when their primary care provider isn't available are:

- The 24-Hour Nurse Line
- Blue Cross Online Visits
- Walk-in clinics

Download materials from the ***choices for care* toolkit**.

Blue Cross Online Visits

We know that many primary care providers offer virtual care. If your office doesn't offer virtual care or your Blue Cross and BCN patients need virtual care after hours, you can let them know about Blue Cross Online Visits. Download materials from the **Blue Cross Online Visits toolkit**.

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Culturally competent health care can improve health outcomes and patient satisfaction

This is part of a series of articles we're running on health and health care disparities in Michigan. We're looking at the various aspects of disparities and what Blue Cross Blue Shield of Michigan, Blue Care Network and its participating health care providers are doing to improve them.

The increasing diversity of the country has underscored the importance for health care providers, health care systems and policy makers to create and deliver culturally competent services.

According to the National Institutes of Health, **4 out of 10 Americans** will belong to a racial or ethnic minority group by 2030. This is especially important to keep in mind since racial and ethnic minorities have higher rates of morbidity and mortality from chronic diseases.

Yet, despite the increase in diversity in this country overall, the medical field has been predominantly white. A recent survey by the Association of American Medical Colleges found 56.2% of active physicians identified as white, 17.1% identified as Asian, 5.8% identified as Hispanic and 5% identified as Black or African American.

This relative lack of diversity representation in the medical field can play a key role in contributing to health care disparities. Sometimes the assumptions and stereotypes on which we unconsciously rely — what we call unconscious bias — not only can influence the decisions and actions of health care providers but can affect the quality of care delivered.

Cultural competency defined

Cultural competency is the ability of providers and organizations to effectively deliver health care services that meet the social, cultural and linguistic needs of patients.

A culturally competent health care system can help improve health outcomes and quality of care, and contribute to the elimination of racial and ethnic health and health care disparities, according to **an article** published by Georgetown University's McCourt School of Public Policy.

The article stated that If providers, organizations and systems aren't working together to provide culturally competent care, patients are at higher risk of having negative health consequences, receiving poor quality care or being dissatisfied with their care. For example:

- African Americans and other ethnic communities report less partnership with physicians, less participation in medical decisions and lower levels of satisfaction with care.
- The quality of patient-physician interactions is lower among non-white patients, particularly Latinos and Asian Americans.
- Lower quality patient-physician interactions are associated with lower overall satisfaction with health care.

Additionally, **one in five Americans** say communication with physicians is a problem in receiving health care — a figure that increases to 27% among Asian Americans and 33% among Latinos. Research has shown that when there are language barriers between providers and patients, providers often compensate by ordering additional diagnostic tests. This can result in higher costs for the patient and health care system.

Please see Cultural Competency continued on Page 19

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Cultural Competency, *continued from Page 18*

A lack of cultural competency can also have the following effects on patients:

- Lower patient satisfaction with care
- Poor comprehension and adherence to treatment plans
- Lower quality of care
- More interactions with the health care system
- Negative health consequences
- Less partnership with physicians in medical decisions

How to improve cultural competency

Acknowledging the need to address cultural competency among health care providers is a good first step, according to a **blog** on MI Blues Perspectives. Here are some other strategies to consider:

- Consult with traditional, culturally appropriate leaders as needed.
- Coordinate your efforts with community health workers.
- Ensure that services and materials — including medical billing, appointment bookings, flyers and registration forms — are available in more than one language.
- Offer interpreter services.
- Expand hours of operation.
- Include family and community members in health care decision-making.
- Offer clinic locations in areas accessible for the population you're trying to reach.
- Provide staff training to increase cultural awareness, knowledge and skills. (See article in the **July-August issue** of *BCN Provider News* for information on available training modules.)
- Seek out a diverse staff that's representative of different cultures, communities and backgrounds.

The bottom line

A health care system that is culturally competent can help eliminate racial and ethnic health disparities and help improve health outcomes and quality of care for all.

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Medical policy updates

Blue Care Network's medical policy updates are posted on Provider Secured Services. Go to *BCN Provider Publications and Resources* and click *Medical Policy Manual*. Recent updates to the medical policies include:

Covered services

- Breast reduction for breast-related symptoms (title changed from Reduction mammaplasty for breast-related symptoms)
- Genetic testing for FMR1 and FMR2 variants (Including Fragile X and Fragile XE syndromes)
- Genetic testing — Preimplantation
- Analysis of human DNA in stool samples as a technique for colorectal cancer screening
- BMT— hematopoietic cell transplantation (HCT) for CNS tumors, embryonal tumors and ependymoma
- Laboratory tests for post-transplant (kidney and heart) and for heart failure
- Noninvasive techniques for the evaluation and monitoring of patients with chronic liver disease
- Orthognathic surgery
- Light and laser therapy for vitiligo and atopic dermatitis
- Myolysis of uterine fibroids using laparoscopic percutaneous or transcervical techniques
- Responsive neurostimulation for the treatment of refractory partial epilepsy
- Circulating tumor DNA for management of non-small-cell lung cancer (liquid biopsy)

Noncovered service

- Noncontact ultrasound treatment for wounds

MIU Men's Health Foundation hosts annual event in Detroit to promote preventive screenings

On average, men die five years earlier than women in America, and about seven years earlier worldwide. Preventive health screenings can catch early signs of cancer, heart disease and other serious health conditions. The MIU Men's Health Foundation is hosting its 11th annual Men's Health Event which offers no-hassle preventive screening.

Roughly 535,000 Michigan residents did not have health insurance in 2018 which help cover preventive and medical expenses. In addition, more than 111,000 residents in Wayne County, Michigan under the age of 65 did not have health insurance in 2018. MIU Men's Health foundation wants to ensure **men of any age over 18 will be seen regardless of insurance status** at their event.

The Men's Health Event is Oct. 9, 2021 at Ford Field, in Detroit, from 9 a.m. to 3 p.m.

The event offers vital screenings, in-depth bloodwork, flu vaccinations, HIV testing, skin cancer screening and more. By taking advantage of preventive screenings and other medical care, conditions such as cardiovascular disease can lower risk by up to 50%. Preventive health screenings and other medical services can help men sustain healthier and longer lives.

For event information, please visit the **Men's Health Foundation website**. For more information about the importance of preventive screening, please see ***Preventive care saves lives***.

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Requirement for CADC credential for facilities that treat substance abuse orders, effective July 1

For members with a diagnosis involving a substance use disorder, group counseling and didactic group sessions must be provided by a certified CADC professional, a registered nurse or someone with a higher credential. This was effective starting July 1, 2021.

This requirement applies to facilities that treat members who have coverage through these plans:

- Blue Cross Blue Shield of Michigan commercial
- Medicare Plus Blue℠
- Blue Care Network commercial
- BCN Advantage℠

This requirement applies to facilities that provide and bill for one or more of the following types of treatment for substance use disorders:

- Subacute detoxification
- Residential treatment
- Partial hospital program
- Intensive outpatient program
- Individual treatment

When employees don't have the CADC credential

Fully licensed mental health practitioners who are employed by these facilities but who do not have the CADC credential can provide group counseling and didactic group sessions, but they must do the following:

- Within 30 days of hire, document the submission of an application to obtain the CADC credential. The application must be submitted to the **Michigan Certification Board for Addiction Professionals**.

  Note: MCBAP allows the submission of an application within 30 days of hire as part of the normal process of obtaining the CADC credential.

  - Within the first 40 months of employment, obtain the CADC credential through MCBAP.

    Note: MCBAP indicates on its website that three years is generally provided or needed to obtain the credential, but we're allowing an additional four months to accommodate any interruption of the process for sickness or for other issues that may temporarily interfere with completion of the educational program within the intended time frame.

  Note: Group psychotherapy must be provided by a fully licensed mental health practitioner, for example, a licensed master's social worker, or LMSW.

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From the medical director: Consider these guidelines for documenting psychotherapy in 2021 and beyond

By William Beecroft, M.D.

We've all had training on the important role that documentation plays in everything we do. As changes occur within the health care industry, the documentation needs to evolve accordingly.

Over the past few years, there have been additional interventions behavioral health practitioners can provide to better address the needs of our patients — and these interventions need to be coded appropriately. Here are a few examples of some recent developments:

- During the COVID-19 pandemic, we witnessed a significant increase in the use of telemedicine services for patients.
- The use of extended service codes has expanded in concert with the expansion of such treatments as:
  - Evidence-based interventions, such as exposure response prevention therapy for obsessive compulsive disorder, anxiety and phobias.
  - Eye movement desensitization, or EMDR, for trauma and post-traumatic stress disorder.
  - Use of esketamine for the treatment of severe depression and suicidal thoughts. (This medication isn't part of psychotherapy. It's a new treatment that will require observation over time.)
- Crisis codes that have always been available are now easier to use — and documenting the interventions you perform becomes even more important.
- Telephone check-in visits and health assessments, including behavioral health assessments, have proliferated to provide more comprehensive care for patients.

As you know, the traditional 30- ,45- and 60-minute psychotherapy sessions have been a mainstay of the treatment process. Like any provider of a service to another individual, documenting the items that were addressed during the time you're billing for is essential. It's not only important for reimbursement purposes, but to retain as background in case a patient asks what you've done for them. In addition, regulatory agencies may ask to see your records to assess your treatment practices or courts may request documentation related to the consequences of an injury.

Please see From the medical director, continued on Page 23

William Beecroft, M.D. is medical director of Behavioral Health for Blue Cross Blue Shield of Michigan and Blue Care Network.

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From the medical director, *continued from Page 22*

The main tenet to keep in mind is this: If it's not written, you didn't do it.

Clinically, there's evidence that "treating to target" is the gold standard of care. For example, treating diabetes to a A1c less than 7 or treating depression to a PHQ-9 less than 5 is necessary to show the progress and eventual success of your intervention. Using this model proves your dedication to quality and adherence to scientific methods, along with the art of behavioral health interventions.

Blue Cross Blue Shield of Michigan and Blue Care Network want you to get reimbursed for the work you do but, at the same time, we want you to bill us appropriately for that work. Documenting what has transpired in the practice setting will support that.

Much like the architect designing a building will document the time and tasks represented in his or her bill, we expect you to document the components of the work you're doing and objectively justify that the interventions are for the member's best interest.

For many years, we've required the elements below in your documentation to support medical necessity:

- Date of the visit and the start and stop times
- Names of those present during the session. (If separate individuals are interviewed, include the duration each is present. Identify the service provided.)
- Updated medical history and current medications (changes) along with the name of the prescribing medical provider and evidence that coordination of care has occurred at least quarterly
- Clinical findings on reexamination
- Brief indication of the patient's reaction to therapeutic intervention (for example, "The patient is open to treatment suggestions" or "The patient is reluctant to make recommended changes.")
- Objectively stated treatment plan and rationale, if changed from the last visit
- Results of objective screening or monitoring tools to gauge improvement
- Instructions, recommendations and precautions given to the patient or other significant parties
- Signature and credentials of the treating provider and by the supervisor, as applicable

In my opinion, this would be a minimum needed for documentation that truly reflects your work. See the full **documentation requirements** for more details.

The American Psychological Association also has **guidelines** you may want to check out.

At Blue Cross, we appreciate all you do to take care of our members. We recognize this is a big responsibility and we value your partnership. We hope the information in this column will help you stay current on documentation and practice trends that are changing rapidly as the clinical science evolves.

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New method of obtaining emergency crisis assessment for psychiatric issues, treatment coming soon

Starting Oct. 1, 2021, Blue Cross Blue Shield of Michigan and Blue Care Network will begin covering mobile crisis and crisis stabilization services. Both urgent care and crisis residential services are already covered.

Note: Medicare Plus Blue℠ members won't be included in this new program at this time.

Mobile crisis services include:

- Professional mental health teams in the community who can evaluate the members wherever they are located
- Face-to-face or telephone evaluations to determine appropriate placement for the member
- The mobile crisis team may stay involved for two to four weeks after the initial encounter to ensure members are connected to the right level of care for mental health or substance use disorder treatment and to provide treatment, as necessary.

Crisis stabilization services (formerly psychiatric observation) include:

- Behavioral health evaluation to initiate appropriate treatment (similar to medical observation services)
- Physical site-based services that are necessary to support the mobile crisis team
  - Services include intake assessment, psychiatric evaluation, crisis intervention, psychotherapy, medication administration, therapeutic injection, observation and peer support
- Initiate linkages and "warm handoffs" to the appropriate level of care and community resources

Please see Emergency Crisis continued on Page 25

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Emergency Crisis, *continued from Page 24*

"The goal of such services is to make sure our members get treated at the right place at the right time," said Dr. William Beecroft, medical director of behavioral health.

Facilities to be used for physical site-based services would be open 24/7 and use the services of a multidisciplinary staff, including physicians, registered nurses, LMSWs, psychologists, clinical supervisors and additional support staff. Members may be referred to a facility from a mobile crisis team, law enforcement or other community-based services, or they may walk in on their own.

Blue Care Network recently conducted a pilot program with two providers in Southeast Michigan — **COPE Intervention Center** ** and **Common Ground Resource and Crisis Center**. As the State of Michigan further develops the certification process for crisis stabilization units in freestanding and hospital-affiliated locations across the state, Blue Cross and BCN will expand their efforts to include additional providers within the state.

Here's some additional information about the Common Ground and COPE centers:

Common Ground Resource and Crisis Center
Hours: Open 24 hours
Phone: 248-451-2600
Services: Mobile, walk-in, crisis stabilization (observation), residential

COPE Intervention Center
Hours: Open 24 hours
Phone: 734-721-0200
Services: Mobile, walk-in, crisis stabilization (observation), residential

BCN has had two years of experience working with these two centers, with positive results. Some of the benefits for members receiving treatment at one of these two locations include:

- A speedy assessment of their immediate needs. Members can be seen by a behavioral health specialist promptly.
- A multidisciplinary evaluation, which leads to a plan of care and placement in the appropriate level of care.
- A positive, less stigmatizing experience than with some other systems of care.
- Rapid access to behavioral interventions, including medication, nursing care, psychotherapy and psychoeducation.
- Alleviation of a sense of crisis, encouraging feelings of hope.

As part of the evaluation and treatment process at these centers, some members may still need psychiatric hospitalization.

Dr. Beecroft pointed out that the Substance Abuse and Mental Health Services Administration, or SAMHSA, published a paper suggesting that a significant number of individuals presenting for crisis services don't require hospital admission and can be treated in another, more appropriate care setting. "Centers that offer mobile crisis and crisis stabilization services make it more likely that people will get treated quickly and at the right level of care," he said.

We'll be publishing additional details about our coverage of crisis services as they become available, and let you know of additional providers that join us in this transformative program of care. We'll also be including program criteria in our provider manuals. Watch for further updates in web-DENIS, *The Record* and *BCN Provider News* for information on how you can become involved.

**COPE, which stands for Community Outreach for Psychiatric Emergencies, is a program created by Hegira

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We're transitioning to a new pharmacy benefit manager

Blue Cross Blue Shield of Michigan and Blue Care Network's transition to a new pharmacy benefit manager, which we reported in a March-April *BCN Provider News* **article**, will result in certain changes we want to alert you to.

As you may have read, we're moving from Express Scripts, Inc. to OptumRx on Jan. 1, 2022, for commercial and individual group members, and Jan. 1, 2023, for Medicare Advantage individual and group members. The change is expected to improve the pharmacy experience for members and customers, better manage drug costs and drive better health outcomes.

While we anticipate that the bulk of the transition will be seamless for our members and health care providers, members who use home delivery pharmacy services may be affected. Most of these members' current prescriptions with Express Scripts will automatically transfer to OptumRx if they have refills remaining, but prescriptions for controlled substances won't transfer automatically.

Members with a prescription for a controlled substance will need to see their doctor to request a new prescription for our new home delivery pharmacy. Examples include medications for ADHD and seizures, as well as opioid pain medications like oxycodone, methadone and other drugs that put a person at high risk for developing substance use disorder.

We're sending letters to members in mid-September to explain what they need to do. A second letter from OptumRx will follow in November.

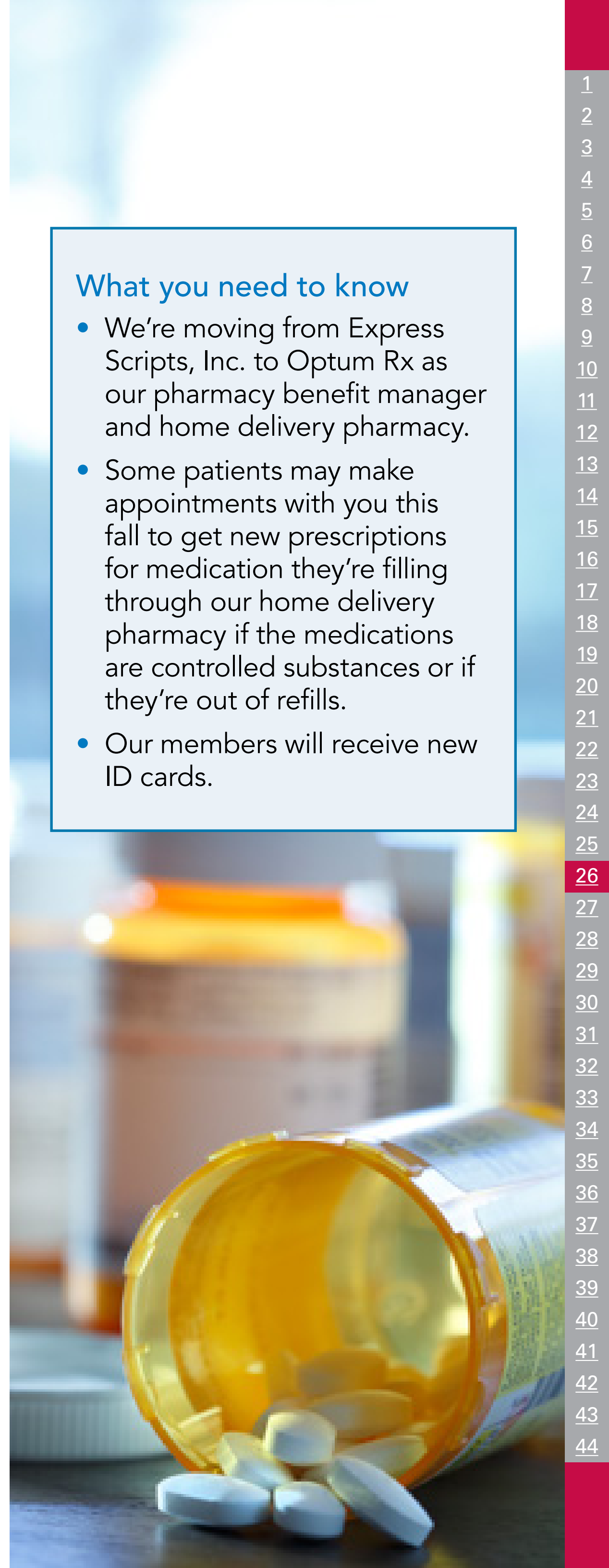
After receiving these letters, some members may schedule appointments with their health care providers, including primary care doctors and specialists, to request new prescriptions for medications they want delivered to their homes.

New ID cards

Due to the transition to OptumRx, we'll mail about 1.8 million new ID cards to members this fall, beginning Oct. 3. Members must show their new cards at the pharmacy starting Jan. 1 in order for their prescriptions to be covered correctly under their benefits.

Electronic tools for providers

We'll provide more information later this year about electronic tools for prior authorization requests and member benefits information related to this transition.



What you need to know

- We're moving from Express Scripts, Inc. to Optum Rx as our pharmacy benefit manager and home delivery pharmacy.
- Some patients may make appointments with you this fall to get new prescriptions for medication they're filling through our home delivery pharmacy if the medications are controlled substances or if they're out of refills.
- Our members will receive new ID cards.

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Quarterly update:

Requirements changed for some commercial medical benefit drugs

During April, May and June 2021, Blue Cross Blue Shield of Michigan and Blue Care Network made changes to prior authorization requirements, site-of-care requirements, or both for the following medical benefit drugs:

HCPCS code	Brand name	Generic name
J9999*	Abecma®	idecabtagene vicleucel
J3590*	Empaveli®	pegcetacoplan
Q5112	Ontruzant®	trastuzumab-dttb
Q5114	Ogivri®	trastuzumab-dkst
Q5113	Herzuma®	trastuzumab-pkrb
J9355	Herceptin®	trastuzumab
Q5108	Fulphila®	pegfilgrastim-jmdb
Q5111	Udenyca®	pegfilgrastim-cbqv
Q5120	Ziextenzo®	pegfilgrastim-bmez
J9312	Rituxan®	rituximab
Q5115	Truxima®	rituximab-abbs
J9035	Avastin®	bevacizumab
J3590*	Evkeeza™	evinacumab-dgnb
J3590*	Nulibry™	fosdenopterin

*Will become a unique code

For a detailed list of requirements, see the **Blue Cross and BCN utilization management medical drug list**. This list is available on the following pages of the **ereferrals.bcbsm.com** website:

- **Blue Cross Medical Benefit Drugs**
- **BCN Medical Benefit Drugs**

As a reminder, an authorization approval isn't a guarantee of payment. Health care providers need to verify eligibility and benefits for members.

Opioid medications will be limited to a 30-day supply, starting Sept. 1

Blue Cross Blue Shield of Michigan and Blue Care Network are changing the way we cover opioid medications in support of the Food and Drug Administration's efforts to educate patients and providers about balancing the serious risk of opioids with the drugs' pain management benefits.

Starting Sept. 1, 2021, we'll limit all supplies of opioids to a 30-day fill. This includes new prescriptions and any refills members have left on a current prescription.

We're making exceptions for members who have prescription opioids. Prescription opioids are powerful pain-reducing medications that include prescription oxycodone, Vicodin and Tylenol No. 3, among others. Members will still have access to their medication, but depending on the type of opioid prescription, they may need a new prescription.

We've sent letters to members about this change. We're also recommending they talk to their doctors about their treatment options or any concerns they may have.

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We're changing how we pay for some prostate cancer drugs that must be administered by a health care provider

Starting Oct. 1, 2021, Blue Cross Blue Shield of Michigan and Blue Care Network will no longer pay for the drugs in the chart below with the patients' drug benefits.

These drugs should only be administered by a health care provider; therefore, we'll pay for them when billed under the patients' medical benefits. Our drug plans only pay for drugs that can be self-administered by the patient, per FDA-approved prescription labeling.

If a member fills a prescription for one of these drugs at a pharmacy on or after Oct. 1, 2021, he or she will be responsible for the full cost.

Drugs that will be paid for only by medical benefits starting October 1, 2021	HCPCS Code	Common use
Eligard®	J9217	Prostate cancer
Lupron Depot® 7.5mg, 22.5mg, 30mg, and 45mg	J9217	
Trelstar®	J3315	
Zoladex®	J9202	Prostate cancer, endometriosis, endometrial thinning, breast cancer

We're notifying affected members of these changes and advising them to talk with their providers about continuing to receive treatment. Providers should bill these drugs under the patient's medical benefits.

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We're covering additional vaccines, effective June 14

Blue Cross Blue Shield of Michigan and Blue Care Network have added the following vaccines to our list of vaccines covered under the pharmacy benefit.

Our goal is to increase access to vaccines and decrease the risk of vaccine-preventable disease outbreaks.

Vaccine	Common name	Age requirement	Date added
MenQuadfi™	Meningococcal A, C, W and Y	None	June 14
Daptacel®	Tdap (Tetanus, diphtheria and whooping cough, also known as pertussis)	None	June 14
Infanrix®	Tdap (Tetanus, diphtheria and whooping cough, also known as pertussis)	None	June 14

The following lists all the vaccines that are covered under eligible members' prescription drug plans. Most Blue Cross and BCN commercial (non-Medicare) members with prescription drug coverage are eligible. If a member meets the coverage criteria, the vaccine is covered with no cost sharing.

Vaccine	Common name	Age requirement
Influenza virus	Flu	Under 9: Two vaccines per 180 days 9 and older: One vaccine per 180 days
ActHIB®	Haemophilus influenzae type B	None
Hiberix®	Haemophilus influenzae type B	None
PedvaxHIB®	Haemophilus influenzae type B	None
Havrix®	Hepatitis A	None
Vaqta®	Hepatitis A	None
Energix-B®	Hepatitis B	None
Heplisav-B®	Hepatitis B	None
Recombivax HB®	Hepatitis B	None
Twinrix®	Hepatitis A and B	None
Gardasil®9	HPV (Human papillomavirus)	None
M-M-R® II	Measles, mumps, rubella	None
ProQuad®	Measles, mumps, rubella and varicella	None
Menveo®	Meningitis	None
Menactra®	Meningitis	None
Menomune®	Meningitis	None
Trumenba®	Meningococcal B	None
Bexsero®	Meningococcal B	None
MenQuadfi™	Meningococcal A, C, W and Y	None
Ipol®	Polio	None
Pneumovax 23	Pneumonia	None

Please see Additional Vaccines, continued on Page 30

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Additional Vaccines, *continued from Page 29*

Vaccine	Common name	Age requirement
Prevnar 13®	Pneumonia	None
Rotarix®	Rotavirus	None
RotaTeq®	Rotavirus	None
Shingrix®	Shingle (Zoster)	None
Boostrix®	Tdap (Tetanus, diphtheria and whooping cough, also known as pertussis)	None
Daptacel®	Tdap (Tetanus, diphtheria and whooping cough, also known as pertussis)	None
Infanrix®	Tdap (Tetanus, diphtheria and whooping cough, also known as pertussis)	None
Adacel®	Tdap	None
Vaxelis™	Tdap, inactivated poliovirus, haemophilus B, hepatitis B	None
Pediarix®	Tdap, hepatitis B, polio	None
Kinrix®	Tdap, polio	None
Quadracel® Tdap-IPV	Tdap, polio	None
Pentacel®	Tdap, polio, haemophilus influenzae type B	None
Diphtheria and tetanus toxoids	Tetanus, diphtheria	None
Tenivac®	Tetanus, diphtheria	None
TDVax®	Tetanus, diphtheria	None
Varivax®	Varicella (chickenpox)	None

If a member doesn't meet the age requirement for a vaccine, we won't cover the vaccine under the prescription drug plan, and the claim will reject.

Vaccines must be administered by certified, trained and qualified registered pharmacists.

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Rybrevant requires prior authorization for dates of service on or after Sept. 27 for most members

For dates of service on or after Sept. 27, 2021, Rybrevant™ (amivantamab-vmjw), HCPCS codes J9999, J3490, J3590 and C9399, will require prior authorization through AIM Specialty Health®. This drug is covered under the medical benefit.

Prior authorization requirements apply when this drug is administered in outpatient settings for:

- Blue Cross and Blue Shield of Michigan commercial members who have coverage through fully insured groups and who have individual coverage

Exceptions: This requirement doesn't apply to Michigan Education Special Services Association members or members who have coverage through the Michigan Blue Cross and Blue Shield Federal Employee Program®. This requirement also doesn't apply to UAW Retiree Medical Benefits Trust PPO non-Medicare members and other members with coverage through self-funded groups.

- Medicare Plus Blue℠ members
- Blue Care Network commercial members
- BCN Advantage℠ members

How to submit authorization requests

Submit authorization requests to AIM using one of the following methods:

- Through the **AIM ProviderPortal**
- By calling the AIM Contact Center at 1-844-377-1278

More about the authorization requirements

Authorization isn't a guarantee of payment. As always, health care practitioners need to verify eligibility and benefits for members.

For additional information on requirements related to drugs covered under the medical benefit, see:

- **Blue Cross commercial and BCN commercial: Medical oncology prior authorization list for Blue Cross commercial fully insured and BCN commercial members**
- **Medicare Advantage: Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**

We'll update the appropriate drug lists to reflect the information in this message prior to the effective date.

Aduhelm, Empaveli and Arcalyst require prior authorization for Medicare Advantage members

The following medications require prior authorization through the NovoLogix® online tool:

- Aduhelm™, (aducanumab), HCPCS code J3590 — for dates of service on or after June 8, 2021
- Empaveli™, (pegcetacoplan), HCPCS codes J3490, J3590 — for dates of service on or after June 14, 2021
- Arcalyst® (rilonacept), HCPCS code J2793 — for dates of service on or after Sept. 13, 2021

This applies to Medicare Plus Blue℠ and BCN Advantage℠ members.

See full article on **Page 14** for details.

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We're updating our policy for non-chemotherapy drug administration coding

Beginning later this year, Blue Care Network will update our policy for non-chemotherapy drug administration. We're adopting the Centers for Medicare & Medicaid Services LCD A58544 for our commercial and Medicare Advantage lines of business. Non-chemotherapy drugs should be reported with the administration CPT code *96372, not chemotherapy administration CPT code *96401.

- *96401: Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
- *96372: Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

If the following drugs are billed with a chemotherapy administration code, the administration code will be denied.

Generic name	Trade name	HCPCS code
benralizumab	Fasenra™	J0517
canakinumab	Ilaris®	J0638
certolizumab pegol	Cimzia®	J0717
denosumab	Prolia/Xygeva®	J0897
filgrastim (g-csf) excludes biosimilars	Neupogen®	J1442
tbo-filgrastim	Granix®	J1447
filgrastim-sndz biosimilar	Zarxio®	Q5101
filgrastim-aafi	Nivestym®	Q5110
luspatercept-aamt	Reblozyl®	J0896
mepolizumab	Nucala®	J2182
octreotide acetate depot	Sandotstatin LAR depot	J2353
omalizumab	Xolair®	J2357
pegfilgrastim	Neulasta®	J2505
pegfilgfrastim-jmdb, biosimilar	Fulphila®	Q5108
pegfilgrastim-cbqv	Udenyca®	Q5111
pegfilgrastim-bmez	Ziextenzo®	Q5120
pegfilgrastim-apgf, biosimilar	Nyvepri™	Q5122
rilonacept	Arcalyst®	J2793
tildrakizumab-asmn	Ilumya™	J3245

To check that you are using the correct administration code when billing non-chemotherapy drugs, see examples of correct coding provided in this CMS LCD A58544 (Complex Drug Administration Coding) billing and coding **article**:

We'll provide updates on this policy in future communications.

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Sign up for webinars on risk adjustment and coding

Action item

Sign up now for live, monthly, lunchtime webinars.

We're continuing to offer lunchtime webinars that provide updated information on risk adjustment documentation and coding of common challenging diagnoses.

Sessions start at 12:15 p.m. Eastern time and run for 15 to 30 minutes. They also provide physicians and coders with an opportunity to ask questions.

Click on a link below to sign up for a webinar.

Session date	Topic	Led by	Sign-up link
Thursday, Sept. 23	Malignant neoplasm	Physician	Register here
Tuesday, Oct. 12	Updates for ICD-10-CM	Coder	Register here
Wednesday, Nov. 17	Coding scenarios for primary care and specialty	Coder	Register here
Thursday, Dec. 9	E/M coding tips	Coder	Register here

You can watch previously hosted sessions on our new provider training site.

Past topics include:

- Acute conditions reported in the outpatient setting
- Morbid (severe) obesity
- Major depression
- Diabetes with complication

Access to the site will differ slightly for new and existing users.

- New users must click **here to register**.
- Existing users can follow this **link to log in**.

Once logged in, users can access the module two ways:

- Look in the course catalog under *Quality management*
- Enter 'Lunch and Learn' in the search box at the top of the screen

If you need assistance creating your login ID or navigating the site, email **ProviderTraining@bcbsm.com**.

If you have any questions about the sessions, contact April Boyce at **aboyce@bcbsm.com**.
If you have questions about registration, email Patricia Scarlett at **pscarlett@bcbsm.com**.

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Reminder: Use the correct diagnosis codes for COVID-19 testing

Here's a reminder and clarification on which diagnosis codes to use for COVID-19 testing for commercial members:

Blue Cross Blue Shield of Michigan and Blue Care Network continue to cover COVID-19 testing that is considered medically necessary by an attending health care provider.

For commercial members, when an attending health care provider administers or refers a patient for COVID-19 testing, Blue Cross and BCN assume the health care provider has determined the test to be medically necessary, unless it's coded with a noncovered diagnosis code (see below). Medical necessity is possible regardless of whether the patient is experiencing symptoms or has been exposed to COVID-19.

- For medically necessary testing (includes symptomatic testing and testing due to contact with and [suspected] exposure to COVID-19): Use Z20.822 as the primary diagnosis for dates of service on or after Jan. 1, 2021. (Use Z20.828 for dates of service on or before Dec. 31, 2020.)
- For pre-operative COVID-19 testing: Use Z01.810, Z01.811, Z01.812 or Z01.818

Blue Cross and BCN don't cover COVID-19 administrative tests that aren't medically necessary. Examples include tests that are required by an employer, school or sports team or that occur as part of a research study. Use Z11.52 or Z11.59 for coding these tests.

These diagnosis codes aren't payable for commercial members. For our Medicare Advantage plans (Medicare Plus Blue℠ and BCN Advantage℠), continue to follow Centers for Medicare & Medicaid Services guidelines.

For more information, see the **COVID-19 patient testing recommendations for physicians document** on our public website at **bcbsm.com/coronavirus** or within Provider Secured Services by clicking on *Coronavirus (COVID-19)*.

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eviCore to use its clinical editing software with BCN radiation oncology claims starting fourth quarter 2021

Starting sometime in the fourth quarter of 2021, eviCore healthcare® will use its Claims Studio℠ clinical editing software for radiation oncology claims for BCN commercial and BCN Advantage℠ members.

Claims Studio is eviCore's proprietary claims editing program. The claims are reviewed before payment and correct-coding edits are applied using guidelines from the American Society for Radiation Oncology, or ASTRO, and the Centers for Medicare & Medicaid Services.

You may already be familiar with eviCore's clinical editing program. It's been used with radiation oncology claims for Blue Cross Blue Shield of Michigan commercial fully insured members and Medicare Plus Blue℠ members for the last few years.

What you need to know

- BCN commercial and BCN Advantage radiation oncology claims will be subject to clinical editing through eviCore's Claims Studio program. Currently, they're subject to clinical editing carried out by Blue Care Network.
- To increase the chances that your radiation oncology claims will be payable after the Claims Studio clinical editing, we encourage you to review the eviCore documents linked in the article.

What will change

Here's what will change starting later this year:

- BCN commercial and BCN Advantage radiation oncology claims will be subject to clinical editing through eviCore's Claims Studio program. Currently, they're subject to clinical editing carried out by Blue Care Network.
- We'll update the *BCN Provider Manual* to reflect this change.
- We'll update the list of radiation oncology procedure codes for which eviCore manages authorizations. You can access that list on BCN's **eviCore-Managed Procedures** page on our **ereferrals.bcbsm.com** website. Scroll down and click ***Procedures that require authorization by eviCore healthcare***.

What won't change

You'll still submit your radiation oncology claims to BCN.

Review eviCore documents

To increase the chances that your radiation oncology claims will be payable after the Claims Studio clinical editing, we encourage you to review these eviCore documents:

- **Coding guidelines for radiation oncology**
- **Clinical guidelines for radiation oncology**

For more information about the radiation oncology and other services managed by eviCore for BCN, refer to BCN's **eviCore-Managed Procedures** page on our **ereferrals.bcbsm.com** website.

On that page, you'll find a link to the document ***Requesting authorizations from eviCore: Frequently asked questions for providers***.

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CareCentrix to manage network for independent home infusion therapy and ambulatory infusion suite providers, starting Jan. 1

Effective Jan. 1, 2022, Blue Cross Blue Shield of Michigan and Blue Care Network will delegate management of the in-state independent home infusion therapy and ambulatory infusion suite provider network to CareCentrix® for commercial members. (AISs are a subset of ambulatory infusion centers.)

This change won't affect hospital-owned HIT or AIS providers or members with Medicare Plus Blue℠ or BCN Advantage℠ plans.

CareCentrix is a leader in managing infusion therapy services through a national network of more than 800 HIT and AIS providers. We expect the transition to CareCentrix to improve member care through better management of HIT and AIS services.

Here's what you need to do

1. **If you aren't already contracted with CareCentrix, contract with them as soon as possible and prior to Jan. 1, 2022.** This will allow you to continue to provide in-network services to Blue Cross commercial and BCN commercial members. You'll receive a letter from CareCentrix that outlines the steps you'll need to take.

   If you're already contracted with CareCentrix, you don't need to do anything. Your CareCentrix contract manager will reach out to you to discuss this change.

2. **For services provided in Michigan to Blue Cross commercial and BCN commercial members on or after Jan. 1, 2022, independent HIT and AIS providers who are contracted with CareCentrix must bill CareCentrix.** Don't bill Blue Cross or BCN for HIT or AIS services; Blue Cross and BCN will reject these claims with a message to bill CareCentrix.

What you need to know

- You need to contract with CareCentrix before Jan. 1, 2022, to continue providing HIT or AIS services to commercial Blue Cross and BCN members.
- To learn more, see the document titled *Home infusion therapy and ambulatory infusion suite provider network management: Frequently asked questions*. There's a link to this document at the bottom of this article

Note: Independent HIT and AIS providers can continue to bill Blue Cross and BCN for services provided to Medicare Advantage members and for other services, such as providing durable medical equipment and supplies. These services aren't affected by this change.

We'll end-date all Blue Cross and BCN independent HIT and AIS contracts for commercial coverage, effective Dec. 31, 2021.

Who is affected by this change

This change applies to independent HIT and AIS providers who:

- Participate with Blue Cross and BCN
- Aren't owned by a hospital system
- Provide home infusion services to Blue Cross and BCN commercial members in Michigan

This change doesn't apply to hospital-owned HIT and AIS providers.

We'll notify all non-hospital-owned HIT and AIS providers of this change by mail. We'll also send letters to members who may be affected by this change, and we'll work with CareCentrix to ensure that there are no gaps in care.

Questions?

To learn more, see the document titled ***Home infusion therapy and ambulatory infusion suite provider network management: Frequently asked questions***.

If you have questions about provider contracting, email CareCentrix at **homeinfusion@carecentrix.com**.

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Providers may only bill members for applicable deductibles and copayments

We want to reminder providers that you must bill Blue Cross Blue Shield of Michigan and Blue Care Network for all covered services and may only bill members for applicable deductibles and copayments. In keeping with provider contracts, you may not collect deposits or bill members upfront for unpaid balances of covered services.

The following guidance comes from the Member Eligibility chapter of the *BCN Provider Manual*,

- *For office and outpatient or ancillary services:* When the member's benefit includes a copayment, providers should collect the copayment from the member at the time of service.
- *For all services:* When the member's benefit includes a deductible, coinsurance or out-of-pocket maximum dollar limit, providers may collect amounts that members owe at the time medical care is provided.

Providers also have the option to wait until they receive the Remittance Advice before they collect from the member. The Remittance Advice shows the provider what the member owes; it also shows whether the member has satisfied the out-of-pocket maximum for that plan year and is not currently responsible for a deductible, copayment or coinsurance. Waiting for the Remittance Advice can help avoid situations in which providers are later required to reimburse members.

We encourage you to use web-DENIS to check the member's remaining deductible, coinsurance maximum or out-of-pocket maximum amounts. The amounts on web-DENIS may vary from the amount shown on the Remittance Advice if additional claims are processed before the provider's claim shown on the Remittance Advice.

As a reminder, contracted providers may not bill members for unpaid balances of a covered service beyond the member's deductible, copayment or coinsurance.

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Facility charges for daily respiratory therapy services will be prorated

Blue Cross Blue Shield of Michigan and Blue Care Network are prorating daily respiratory therapy services by hours used, not to exceed 24 hours in a single day. We communicated this in a January 2021 ***Record* article** titled, "Facilities required to prorate respiratory therapy services."

Providers have told us that they're unable to bill respiratory therapy on an hourly basis. Therefore, we will manually prorate the service and won't reimburse the full charge.

This reimbursement policy is effective Jan. 1, 2021, for Blue Cross commercial, Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ members. It applies to an inpatient setting only.

The following is a list of general respiratory therapy services applicable to this billing policy:

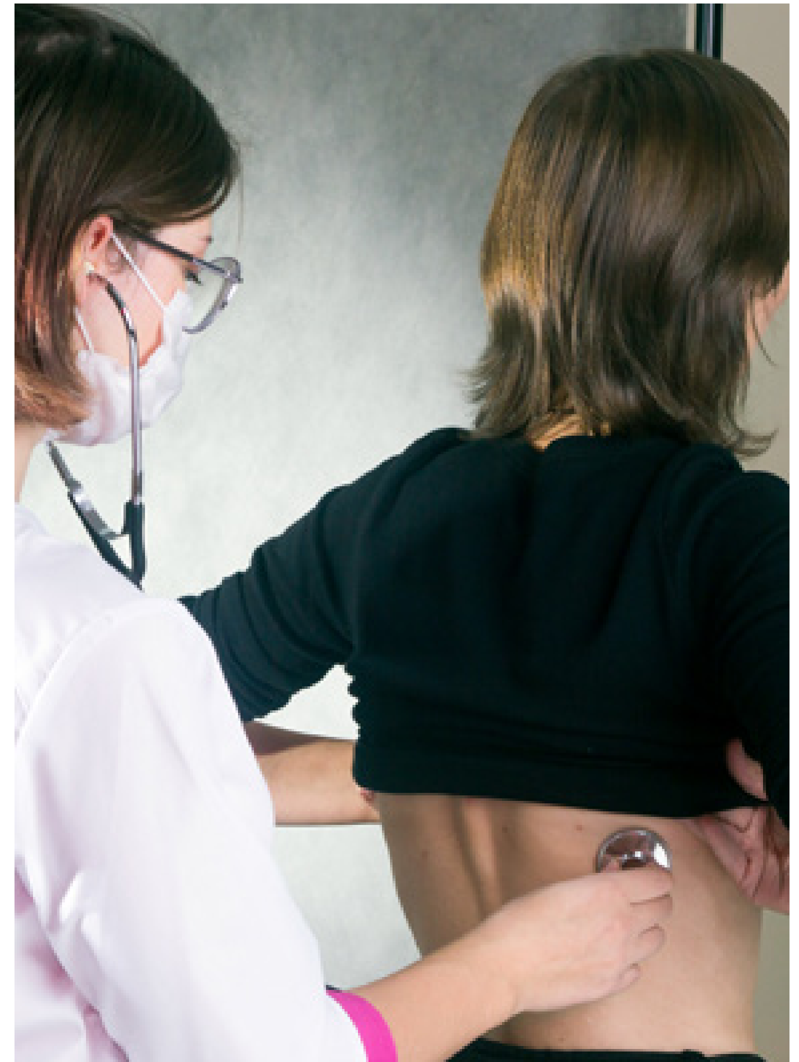
- All types of ventilators
- Continuous Positive Airway Pressure, or CPAP
- Bilevel Positive Airway Pressure, or BIPAP
- All types of oxygen

Billing guidance

If, on a single day of service, a patient is on the ventilator for five hours and then weaned to CPAP for the remaining 19 hours of the day, Blue Cross and BCN will only provide reimbursement for those hours used for each modality. Currently, services are billed at a daily rate, regardless of hours used.

Background

Respiratory therapy services are services prescribed by a physician or a non-physician practitioner for the assessment and diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function. This reimbursement policy isn't intended to affect physician decision-making; providers are expected to apply medical judgement when caring for all members.



Clinical editing billing tips

In most issues, we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and the performed procedure is correctly reported to us.

This issue's tip:

- Clinical editing resources

Clinical editing billing tips

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We've updated questionnaires in the e-referral system

On June 27, 2021, we updated the following questionnaires in the e-referral system:

- *Artificial heart, total questionnaire* — For adult and pediatric Blue Care Network commercial members. This questionnaire will no longer open for procedure code *33929. It now opens for procedure code *33995 and continues to open for other codes listed in the **Artificial heart**, total preview questionnaire.
- *Hammertoe correction surgery* — For adult Medicare Plus Blue[SM], BCN commercial and BCN Advantage[SM] members. This questionnaire will no longer open for procedure code *28160. It will continue to open for the other procedure codes listed in the **Hammertoe correction surgery** preview questionnaire.
- *Pediatric feeding* — For BCN commercial members ages 18 and younger.

We also updated the corresponding preview questionnaires and authorization criteria on the **ereferrals.bcbsm.com** website.

As a reminder, we use our authorization criteria, our medical policies and your answers to the questionnaires in the e-referral system when making utilization management determinations on your authorization requests.

Preview questionnaires

You can access preview questionnaires at **ereferrals.bcbsm.com**. They show the questions you'll need to answer to help you prepare your answers ahead of time.

To find the preview questionnaires:

- **For BCN**: Click BCN and then click **Authorization Requirements & Criteria**. Scroll down and look under the "Authorization criteria and preview questionnaires" heading.
- **For Medicare Plus Blue**: Click Blue Cross and then click **Authorization Requirements & Criteria**. In the "Medicare Plus Blue members" section, look under the "Authorization criteria and preview questionnaires — Medicare Plus Blue" heading.

Authorization criteria and medical policies

The pertinent authorization criteria and medical policies are also available on the Authorization Requirements & Criteria page.

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We've updated pain management questionnaires and *Postservice change request form* for TurningPoint

Blue Cross Blue Shield of Michigan, Blue Care Network and TurningPoint Health Care Solutions LLC continue to identify ways to enhance your experience with the TurningPoint surgical quality and safety management program.

We've added the following enhancements in July:

- **For pain management procedures:** We've updated the questionnaires you complete when you request authorizations.
- **For all orthopedic, pain management and spinal procedures:** We've updated the *Postservice change request form*.

The updated forms are available on the **ereferrals.bcbsm.com** website.

Pain management questionnaires

To simplify the process for submitting prior authorization requests, we've updated most questions on the following questionnaires to require a "yes" or "no" response:

- Epidural steroid injections
- Facet joint injections
- Neuroablation procedures
- Sacroiliac joint injections

These questions appear on the questionnaires in the TurningPoint provider portal and in the fax forms for submitting prior authorization requests.

Postservice change request form

We've updated the *Postservice change request* fax form as follows:

- Added information about procedure code substitutions to help you identify situations where you can substitute a different procedure code for the procedure code TurningPoint authorized
- Added the following questions:
  - "Have you submitted a claim to Blue Cross or BCN?"
  - "Have you submitted an appeal to Blue Cross or BCN?"

Your answers to these questions will streamline the steps required to process postservice change requests.

Where to find fax forms for the TurningPoint program

You can find all fax forms for the TurningPoint program on the following pages of the **ereferrals.bcbsm.com** website, along with other resources:

- **Blue Cross Musculoskeletal Services**
- **BCN Musculoskeletal Services**

Please see Pain Management Questionaires continued on Page 41

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Pain Management Questionaires, *continued from Page 40*

Information about previous enhancements to this program

To view other enhancements to the TurningPoint program, see:

- The article titled **We're enhancing TurningPoint surgical quality and safety management program to improve your experience** in the July-Aug 2021 issue of *BCN Provider News*.

We also published this information in the July 2021 issue of *The Record*.

- The Provider Alert titled **Additional enhancements to the TurningPoint musculoskeletal surgical quality and safety management program**

Additional information

As a reminder, TurningPoint manages authorizations for orthopedic, pain management and spinal procedures for the following:

- Blue Cross commercial* — All fully insured groups, select self-funded groups and all members with individual coverage
- Medicare Plus Blue℠ members
- BCN commercial members
- BCN Advantage℠ members

*To determine whether you need to submit prior authorization requests for Blue Cross commercial members, see the document titled **Determining whether Blue Cross commercial members require prior authorization for musculoskeletal surgeries and related procedures**.

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Changes to TurningPoint medical policies for some pain management procedures

As of May 25, 2021, TurningPoint updated pain management medical policies to align more closely with Centers for Medicare & Medicaid Services guidelines. Pain management medical policies have been updated as follows.

Note: TurningPoint applies CMS local and national coverage determination guidelines for Medicare Plus Blue℠ and BCN Advantage℠ members. For more information about the criteria TurningPoint uses to make determinations on authorization requests for pain management procedures for all members, see this news item on the ereferrals.bcbsm.com website.

Frequency of sessions allowed for Zepidural steroid injections

Previous policy	Updated policy
Allowed a total of 3 ESI injection sessions in a 6-month period **regardless of region** (cervical / thoracic or lumbar)	Allows 3 injection sessions in a 6-month period **per episode of pain per region** (cervical / thoracic or lumbar)

Number of levels allowed per session for epidural steroid injections

Previous policy	Updated policy
Allowed one ESI level regardless of type	Number of levels allowed depends on type: • One level is allowed for caudal, interlaminar or bilateral transforaminal • Two levels are allowed for unilateral transforaminal

Time frame requirements for conservative treatments

Previous policy	Updated policy
Required 6 weeks of conservative treatment for epidural steroid injections, facet joint injections and sacroiliac joint injections	Requires only 4 weeks of conservative treatment for epidural steroid injections, facet joint injections and sacroiliac joint injections

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We're removing prior authorization requirements for select procedures

For dates of service on or after July 1, 2021, we won't require prior authorization for the following procedure codes for refilling and recharging pain pumps: *62367, *62368, *62369 and *62370.

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Home health care: Helpful tips for adding disciplines and substituting services provided by clinicians with lower-level credentials

CareCentrix has managed authorizations for home health care services for Medicare Plus Blue℠ and BCN Advantage℠ members since June 1, 2021.

See the full article on **Page 15** to learn when you can substitute services provided by clinicians with lower-level credentials and when you need authorization request for additional disciplines that haven't been authorized by CareCentrix®

Clarification: We started pending some authorization requests, starting July 25

We ran an article in the May-June 2021 issue of *BCN Provider News*, titled *"Starting in June, we'll use clinical information to validate providers' answers to some questionnaires in the e-referral system."*

The effective date has changed to July 25. On that date, we started pending some authorization requests that would usually be auto-approved based on your answers to the questionnaires in the e-referral system. This allows us to validate the answers you provided on the questionnaire

Review the original **article** for details.

eviCore to use its clinical editing software with BCN radiation oncology claims starting fourth quarter 2021

Starting sometime in the fourth quarter of 2021, eviCore healthcare® will use its Claims Studio℠ clinical editing software for radiation oncology claims for BCN commercial and BCN Advantage℠ members.

Claims Studio is eviCore's proprietary claims editing program. The claims are reviewed before payment and correct-coding edits are applied using guidelines from the American Society for Radiation Oncology, or ASTRO, and the Centers for Medicare & Medicaid Services.

For details, see the full article on **Page 35**.

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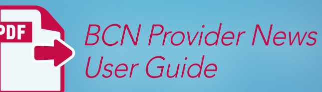
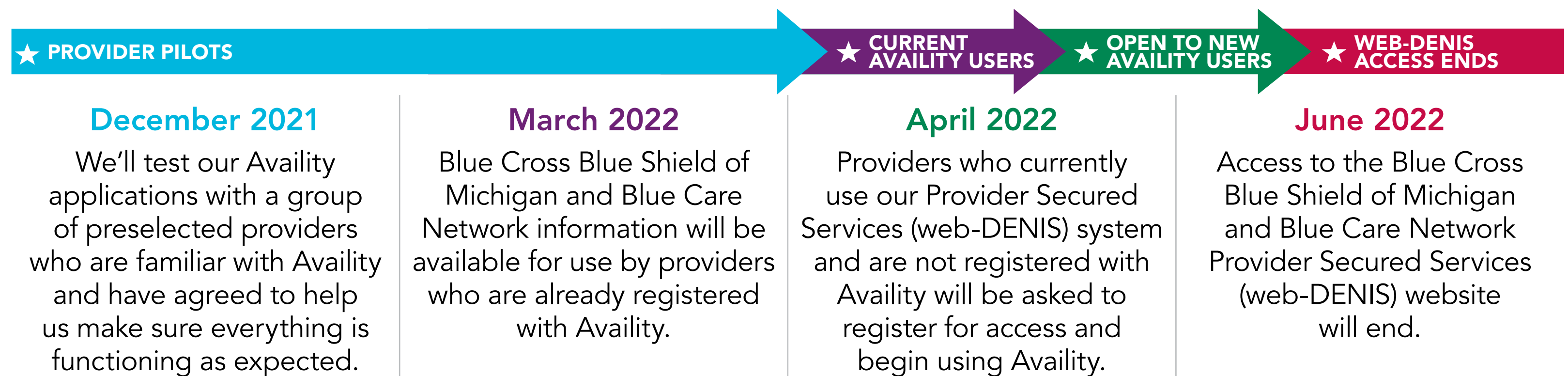


BCN Provider News User Guide

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:



December 2021	March 2022	April 2022	June 2022
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.	Blue Cross Blue Shield of Michigan and Blue Care Network information will be available for use by providers who are already registered with Availity.	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.	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.

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Feedback | Subscribe

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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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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.

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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**.

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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**.

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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.

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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*.

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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[SM] for its PPO members and BCN Advantage[SM], 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

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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[SM] 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[SM] HMO-POS Prime Value and BCN Advantage[SM] 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[SM] HMO-POS Elements

BCN Advantage[SM] HMO-POS Classic

BCN Advantage[SM] HMO-POS Prestige

BCN Advantage[SM] HMO ConnectedCare

BCN Advantage[SM] HMO-POS Prime Value

BCN Advantage[SM] HMO-POS Community Value

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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.

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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*

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Remind your eligible patients to get regular mammograms

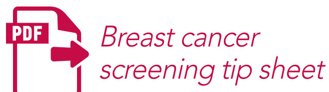
One in eight women in the United States will be diagnosed with invasive breast cancer in her lifetime, according to the American Cancer Society. You play an integral role in early detection by recommending regular screenings to your patients. Early detection through regular screening is key to a better 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.



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.

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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.

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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**.

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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.

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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.

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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)

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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

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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.

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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**.

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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.

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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.

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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.

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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

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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.

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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

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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.

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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®

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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®

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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®

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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.

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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.

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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.

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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

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(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.)

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Bariatric surgery won't require prior authorization for BCN members starting Jan. 1

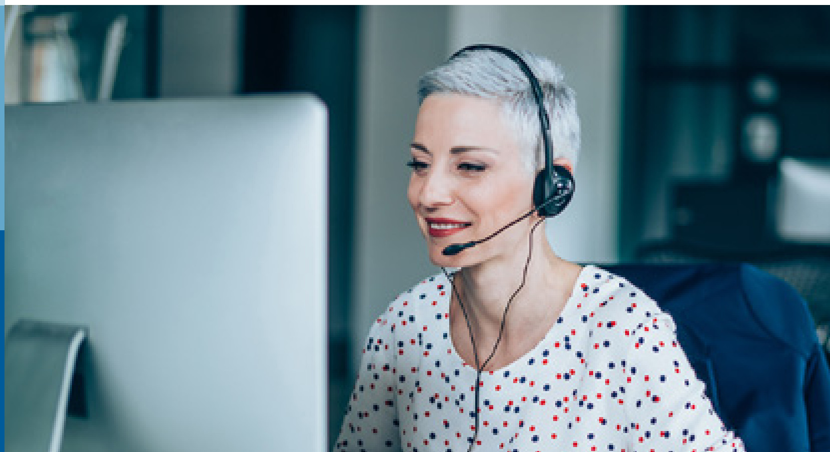
For dates of service on or after Jan. 1, 2022, bariatric surgery won't require prior authorization for BCN commercial and BCN Advantage℠ members.

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**.

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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.

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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.

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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***.

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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**

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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.

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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

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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.

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