JANUARY-FEBRUARY 2022

BCN Provider News

BCN Provider News User Guide

Alerts and provider resources within Availity

After we transition to the Availity® provider portal, you'll still be able to access important alerts, resources and publications for Blue Cross Blue Shield of Michigan and Blue Care Network. However, how you find this information will change. You'll also see a new and improved look.

Currently, you read broadcast messages when you click on web-DENIS. They're listed in the center of the screen under *Welcome to web-DENIS*. In the left navigation of web-DENIS, you can click on one of the following to find the information you need to do business with us:

- *BCBSM Provider Publications and Resources*
- *BCN Provider Publications and Resources*
- *Provider Manuals*

New way to find alerts and provider resources

After the transition to Availity, what you see now as web-DENIS broadcast messages will simply be called "alerts." You'll find them, along with provider publications, resources and manuals, within the Blue Cross and BCN Payer Space.

Alerts and provider resources, *continued on Page 2*

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**)
- We're moving to Availity in 2022 (November-December 2021 **issue**)

Inside this issue…

Alerts and provider resources, *continued from Page 1*

After logging into Availity, you'll click on *Payer Spaces* on the top navigation bar, then click on *BCBSM and BCN*.

This will bring you to our payer space, which will include information for both Blue Cross Blue Shield of Michigan and Blue Care Network. You'll see three tabs:

- **Applications** — Our payer space will always open on the *Applications* tab. This is where you'll find applications specific to Blue Cross Blue Shield of Michigan and Blue Care Network. Examples include e-referral, Benefit Explainer, Health e-Blue℠ and Provider Enrollment and Change Self-Service.
- **Resources** — Clicking the *Resources* tab will bring you links to our websites and provider manuals where you can find the information you need.
- **News and Announcements** — This tab will connect you with our provider alerts so you can find breaking or critical news you need to know.

Improvements

We're working to make it easier for you to find what you need. For example, our new Provider Resources website, which you'll reach through the payer space *Resources* tab, will have information for both Blue Cross and BCN within a single site and will include a new search feature. Also, within the payer space *Applications* and *Resources* tabs, you'll be able to select specific items that you use frequently as "favorites" so they're accessible from your Availity top navigation bar no matter where you are in the portal.

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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Network Operations

Availity training opportunities

You'll have plenty of opportunities to participate in training so you can get the most out of the Availity® provider portal. Whether you're brand new to Availity or you currently use Availity for another Michigan health plan, the trainings offered will provide the basics and details about how Blue Cross Blue Shield of Michigan and Blue Care Network's information will be displayed.

Training specific for Blue Cross and BCN providers

We'll soon share with you a special webpage that will provide guidance through the registration process. We'll also share a dedicated training page where you can sign up for live webinars explaining the different Availity features you'll need to do your job. Watch for a special edition email with this information in March.

Training available within Availity

Once you have access to Availity, you'll be able to access training within the portal. In the top right navigation, you'll see "Help & Training". The Help & Training section offers two options:

- **Find help** — This is a searchable directory of help topics. If you want more information about eligibility, for example, you can type in that search word. If your question is specific to Blue Cross and BCN, you can type in the search word "BCBSM". You'll find tips and explanations, often with screenshots, to help you use Availity more effectively.

- **Get trained** — Clicking here takes you to the Availity Learning Center where you can sign up to attend live webinar offerings by clicking *Sessions*. You can also use the *Search catalog* field to view previously recorded trainings that are available on demand.

We encourage you to take advantage of the learning opportunities that work best for you, whether that's a live webinar, a recorded training or online help tips with screenshots.

Blue Cross updates continuity of care to align with law

In 2020, the president signed the Consolidated Appropriations Act of 2021, or CAA, into law. That legislation had several health care-related provisions. Part of the legislation addresses continuity of care requirements.

Blue Cross Blue Shield of Michigan and Blue Care Network already allow for continuity of care for our members in Michigan as required by state law and the Affordable Care Act, and we are updating our policies to align with the requirements of the CAA.

What is continuity of care?

Sometimes, a contract between a health care provider and a health plan is modified (for example through departicipation or termination) and results in a loss or reduction of benefits for an individual. Through continuity of care, the individual is still able to see their health care provider under certain circumstances because their health situation requires it. In addition, the care would be provided as if there were no change to the contract.

What does the CAA say about continuity of care?

According to the legislation, effective Jan. 1, 2022, if a health care provider changes network status, patients with complex care needs have the option of up to 90 days of continued coverage at in-network cost sharing to allow for a transition of care to an in-network health care provider.

Complex care circumstances where you can continue treatment

The circumstances below are similar to our existing continuity of care situations with some changes outlined in the CAA legislation. You can still see your patient if he or she is:

- Undergoing a course of treatment for a "serious and complex condition," defined as:
    - An acute illness — A condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
    - A chronic illness or condition — A condition that is:
        - Life-threatening, degenerative, potentially disabling or congenital; and
        - Requires specialized medical care over a prolonged period of time
- Getting inpatient care
- Scheduled to undergo nonelective surgery, including receipt of postoperative care for that surgery
- Pregnant and undergoing a course of treatment for the pregnancy
- Determined to be terminally ill (defined as "a medical prognosis that the individual's life expectancy is six months or less") and is receiving treatment for their illness

Requirements to provide services under continuity of care

If you choose to treat your patient for a continuity of care period of time, you're required to:

- Accept payment from Blue Cross as payment in full (less any required copays or deductibles)
- Adhere to Blue Cross' standards for maintaining quality health care and provide Blue Cross with necessary medical information related to your patient's care
- Adhere to Blue Cross' policies and procedures, including, but not limited to, those concerning utilization review, referrals, pre-authorizations and treatment plans

For more information about continuity of care, see our online provider manuals on Provider Secured Services.

Network Operations

Blue Cross 2022 individual plans include an HMO value plan

Blue Cross Blue Shield of Michigan and Blue Care Network offer 30 individual (non-group) ACA compliant plans in 2022, including a new Blue Cross® Preferred HMO Value plan in 63 rural counties where the HMO doesn't currently offer a Value plan.

The Value plan is for adults under 30, or those who have a financial hardship who aren't eligible for a cost-sharing or advanced premium subsidy on the exchange.

The Value plan offers the following benefits before a deductible needs to be met: primary care provider visits, OB/GYN visits, behavioral health visits, telehealth visits from a PCP, retail health visits, urgent care visits.

The Value plan covers the following benefits at 100%:

- Laboratory tests
- Blue Cross Online Visits (medical)
- Diabetes management program
- MyStrength behavioral health app by Livongo
- Preventive services and immunizations

2022 offerings include:

- 20 plans in three Southeast Michigan counties
- 14 plans in 17 urban counties
- Eight plans in 48 rural lower peninsula counties
- Five plans in 15 Upper Peninsula counties

Ask to see the latest member ID card

January is the time when many patients change health care plans. You should always ask to see the latest member ID card and make sure it matches the coverage listed on web-DENIS.

Direct reimbursement available to acupuncturists, effective March 1, 2022

Acupuncturists have the opportunity to participate in Blue Cross Blue Shield of Michigan's Traditional and TRUST PPO networks, Medicare Plus Blue℠ PPO, BCN commercial and BCN Advantage℠, effective March 1, 2022.

Participating acupuncturists can bill their professional services using codes *97810, *97811, *97813 and *97814 Acupuncturists can also bill using codes *20560 and *20561 for Medicare Advantage members only. 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 March. 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 acupuncture 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 physician must submit a referral for a specialist office visit. Referrals are not required for other members.

Enrollment forms

Acupuncturists 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.

Network Operations

2022 member ID cards to display deductible, out-of-pocket maximum

Member ID cards issued to Blue Cross Blue Shield of Michigan and Blue Care Network commercial members will display their deductible and out-of-pocket maximum, effective Jan. 1, 2022. This changes applies to both the physical and electronic ID cards. The Consolidated Appropriations Act of 2021 requires us to provide this information on the cards issued to participants, beneficiaries or members.

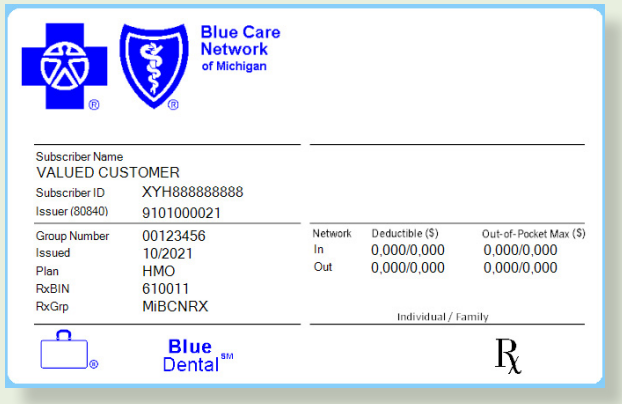
The new CAA mandate requires that issued ID cards contain the following:

- In-network and out-of-network individual and family deductibles
- Out-of-pocket maximums

See the sample card image. Providers should continue to use web-DENIS for benefit information.

In some cases where member deductibles or out-of-pocket maximums aren't available, the card will show "See Benefits." Members will be directed to access their benefits at **bcbsm.com** or the BCBSM mobile app.

In addition, for commercial members with prescription drug coverage, their cards will also show a new RxBIN to reflect the pharmacy benefit manager change from Express Scripts, Inc. to OptumRx. This was announced in an **article** in the September-October 2021 *BCN Provider News*, Page 26.



Enrollment flyers help new providers joining our networks

We've updated some of our enrollment flyers to help providers joining Blue Cross Blue Shield of Michigan or Blue Care Network. The *Enrollment helpful hints* flyers walk new providers through each section of their enrollment application. Depending on the classification type, new providers may see different form fields on their application.

- The ***Enrollment documents helpful hints*** flyer now includes tips for all provider types. Previously, this document was specific to behavioral health providers. This flyer can be found on the ***Provider enrollment page*** of **bcbsm.com/providers**.
- The Outpatient psychiatric center information that was included in the original Enrollment helpful hints flyer has been separated into its own ***Enrollment helpful hints – New Outpatient Psychiatric Center flyer***. OPCs can locate this flyer on their provider enrollment webpage after choosing Outpatient psychiatric care facilities from the *Facilities* type list.
- An ***Enrollment documents helpful hints – New Ancillary Providers Located Outside of Michigan flyer*** was also created for those providers looking to enroll. This flyer can be found on the *Provider enrollment* page of **bcbsm.com/providers**.

New on-demand training available

Provider Experience continues to offer training resources for health care providers and staff.

On-demand courses are designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

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

- Medicare Advantage risk adjustment program — We have expanded the course with additional modules on topics that review clinical criteria, medical documentation, coding guidelines and requirements. The five new modules include:
  - Chronic kidney disease
  - Atherosclerosis of aorta and peripheral vascular disease
  - Chronic obstructive pulmonary disease
  - Pulmonary artery hypertension
  - Hyperparathyroidism
- 2021 lunch and learn webinar recordings
  - *Cancer in risk adjustment* focuses on classification and risk adjustment for cancer and clinical scenarios.
  - *Updates for 2022 ICD-10 CM codes* reviews key changes for the ICD-10 CM codes and guidelines.

Action item

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

- Claims Attachment Process — This updated video guides through the process to identify services requiring documentation, locate the *Medical Record Routing Form* and use the form to correctly submit medical records or documentation.
- e-referral tutorials — Updates have been made to several modules within this series that reviews how to perform major tasks in the e-referral tool to manage referrals and authorizations. This series has moved from **ereferrals.bcbsm.com** to our new provider training site.
- Blue Care Network PCP orientation — This narrated video presentation prepares primary care physicians and their staff to work with BCN as they care for patients. The presentation reviews provider roles, responsibilities and processes that are part of the collaborative process

Our provider training site is available to enhance the training experience for health care providers and staff.

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.

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

Blue Cross and BCN receive high Medicare star ratings from CMS

The Centers for Medicare & Medicaid Services recently announced its 2022 Medicare star ratings — and Blue Cross Blue Shield of Michigan performed very well.

- Our BCN Advantage℠ HMO plan now has a 5-star rating — the highest rating possible and the first 5-star rating Blue Cross Blue Shield of Michigan has ever achieved.
- Our Medicare Plus Blue℠ PPO plan now has a 4.5-star rating, an increase of one star over last year.

These were the only two Medicare Advantage plans in Michigan that improved by one full star over the previous year.

CMS publishes star ratings each year to measure the quality of health services received by beneficiaries enrolled in Medicare Advantage plans. They're designed to evaluate how well plans that contract with Medicare perform, and help consumers select a Medicare Advantage plan that works best for them.

"Ensuring our senior members receive the quality health care and services they need is essential to delivering the exceptional Medicare Advantage plans members expect from Blue Cross Blue Shield of Michigan," said Daniel J. Loepp, Blue Cross president and CEO. "These high ratings from CMS are a testament to the work we put in every day to maintain the highest quality networks and access to care, in addition to taking care of our members' complete health needs."

Medicare considers five categories when assigning a star rating:

- How the plan emphasizes staying healthy, including such benefits as screenings, tests and vaccines
- How the plan manages chronic conditions
- How responsive the plan is, as well as the quality of care that people with the plan receive
- Member complaint reports, which include problems in getting services and decisions on appeals
- How many members leave the plan each year

Blue Cross Blue Shield of Michigan's high ratings for 2022 reflect improvements made in several key areas, including HEDIS® measures* and CAHPS® surveys. The Consumer Assessment of Healthcare Providers and Systems surveys, developed by the Agency for Healthcare Research and Quality, evaluate a member's experience with their plan, quality of care received and access to care.

The role of health care providers

In a letter to physician organization administrators and medical directors, Dr. James Grant, senior vice president and chief medical officer for Blue Cross, acknowledged the important role health care providers played in achieving the ratings. "We couldn't have achieved this strong performance without your partnership and the efforts of the entire care team — the physicians, the nurses, the physician assistants, the medical assistants and all those who touch our patients either face to face or behind the scenes," he wrote. "Strong HEDIS results are directly associated with quality care. Members also indicated a favorable perception of their health care experience through this year's CAHPS scores."

Going forward, Blue Cross and BCN will continue to work with health care providers to focus on quality, pursue operational excellence and provide a best-in-class experience to our members.

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

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a registered trademark of the Agency for Healthcare Quality and Research.

Get ready for 2022 Medicare wellness visits

The new year will bring new and existing Medicare Plus Blue℠ PPO and BCN Advantage℠ members to your medical practice for their annual wellness visits, which is at no cost to them. These visits play an important role in helping your patients maintain or improve their health.

Welcome to Medicare visit

New Medicare Advantage members should be scheduling their Welcome to Medicare preventive visit, also known as the initial preventive physical 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, immunization records, family medical history and other preventive care services. For more information on the components of a Welcome to **Medicare visit, see the Medicare Learning Network Educational Tool**.

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

Annual wellness visit

Existing Medicare Advantage members should be scheduling their annual wellness visits. Medicare will cover an annual wellness visit every 12 months for patients who've been enrolled in Medicare for longer than 12 months.

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 part of the annual wellness visit. It includes self-reported information from your patient to be completed before or during the visit. For more information on the components of an annual wellness visit, see **the Medicare Learning Network Educational Tool**.

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)

You can also offer to conduct visits by telehealth depending on your office's capabilities.

BCN Advantage

Bill Medicare Advantage plans for administration of COVID-19 vaccines beginning Jan. 1, 2022

Beginning Jan. 1, 2022, the Centers for Medicare & Medicaid services will require Medicare Advantage plans to cover the cost to administer COVID-19 vaccines (including approved booster doses) and monoclonal antibody products to treat COVID-19, with no out-of-pocket costs for members.

For dates of service on or after Jan. 1, 2022, submit claims for the administration of vaccines and monoclonal antibody treatments to Blue Cross Blue Shield of Michigan or Blue Care Network for members with Medicare Plus Blue℠ or BCN Advantage℠ plans.

Note: If your patient scheduled an office visit on or after Jan. 1, 2022, for any other reason than getting the vaccine or monoclonal antibody treatments, bill the usual office visit charge.

More information

For more information on the COVID-19 vaccine, refer to **CMS' COVID-19 toolkit** for health care providers.

For more information on monoclonal antibody treatment, see the **Monoclonal Antibody COVID-19 Infusion webpage** of CMS' COVID-19 toolkit for health care providers.

Reminder

For dates of service on or after Oct. 1, 2021, cost share applies for any treatment related to COVID-19, other than monoclonal antibody treatment, for Medicare Plus Blue and BCN Advantage members.

None of the information in this article is intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with all applicable state and federal laws and regulations.

Action item

Watch a video that introduces this new star measure and register for one of our February webinars that goes into more detail about the measure.

Attend one of our webinars about Transitions of Care, a new Medicare star measure

The four components of the HEDIS® Transitions of Care will be added to the list of Medicare star measures starting in 2022. Watch this short **video** about training efforts to help you avoid gaps in the measure.

Attend our webinar to learn more about Transitions of Care, including requirements and coding tips. Click the registration link for the session that best suits your schedule

Session date	Time	Sign-up link
Tuesday, February 1	10 to 11 a.m.	Register here
Thursday, February 3	12 to 1 p.m.	Register here
Wednesday, February 9	12 to 1 p.m.	Register here
Thursday, February 10	2 to 3 p.m.	Register here

Overview of care management and utilization management programs now available

Blue Cross Blue Shield of Michigan and Blue Care Network have implemented many care management programs for members and utilization management programs for providers.

- Care management programs provide patient support by identifying patients with health risks and working with them to improve or maintain their health.
- Utilization management programs focus on ensuring that patients get the right care at the right time in the right location through the authorization process.

These programs vary based on member coverage and may be administered by Blue Cross or BCN staff or by contracted vendors.

What you need to know

- We recently published the *Care management and utilization management programs: Overview for providers* document to help you navigate our care management and utilization management programs.
- The document is available on **ereferrals.bcbcm.com**.

We recently published the **Care management and utilization management programs: Overview for providers** document to help you navigate these programs. This information may help you to identify services that could be useful to your patients or to learn more about programs in which your patients participate.

In the overview document, we've:

- Categorized the programs and the services for which we have care management and utilization management programs
- Listed, for each category, who provides services within that category (Blue Cross or BCN staff, contracted vendors or both)
- Indicated whether services are available to Blue Cross commercial, Medicare Plus Blue℠, BCN commercial or BCN Advantage℠ members.

To see more detail about the programs, click a category heading. A document will open that provides:

- A summary of available services
- The groups and individual members to which services are available
- Resources for finding more information

You can access the overview document at **ereferrals.bcbsm.com**. Click the *Quick Guides* link (under Additional Resources) and then click the *Care management and utilization management programs: Overview for providers* link

Quality Corner: MQIC Clinical Practice Guidelines

The Michigan Quality Improvement Consortium publishes clinical practice guidelines for various medical and behavioral health disorders. Guidelines 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 that may be comorbid with behavioral health disorders, including diabetes.

New this year are guidelines for screening, diagnosis and referring members with substance use disorders for treatment.

The MQIC guidelines are intended not only for behavioral health practitioners but also for primary care professionals to help deliver the most effective, evidence-based care for behavioral health and related disorders.

Below is 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:

Substance Use

Screening, diagnosis, and referral for substance use disorders guideline

To join the MQIC mailing list to be notified of any updates, click on the ***Join Now*** link on the site. The MQIC app can also be downloaded from the Google Play Store or Apple App Store.

HEDIS 2021 results

The Healthcare Effectiveness Data and Information Set, or HEDIS®, is the most widely used set of performance measures in the managed care industry and is used by the National Committee for Quality Assurance for accreditation.

HEDIS is 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 Centers for Medicare & Medicaid Services for their star ratings.

Despite continued challenges related to COVID-19 and the Delta variant, HEDIS performance remains strong. Blue Care Network noted several areas of improvement in 2021 (measurement year 2020) across all lines of business.

The areas of improvement are noted below. You can click on the PDF icon to get detailed information on each measure.

Commercial

- Weight assessment and counseling for nutrition and physical activity for children/ adolescents — BMI percentile
- Antidepressant medication management — Effective acute and continuation phase treatment
- Asthma medication ratio
- Avoidance of antibiotic treatment for acute bronchitis/ bronchiolitis
- Childhood immunizations — Combo 10
- Follow-up after emergency department visit for mental illness — 7 day
- Follow-up after hospitalization for mental illness — 7 day
- Follow-up after emergency department visit for alcohol and other drug abuse or dependence — 7 day
- Follow-up care for children prescribed ADHD medication — Continuation and maintenance phase
- Pharmacotherapy management of COPD exacerbation — Bronchodilators
- Prenatal and postpartum care — Timeliness of prenatal care
- Use of first-line psychosocial care for children and adolescents on antipsychotics
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Initiation and Engagement in Alcohol and Other Drug Dependence Treatment – Engagement
- Statin therapy for patients with cardiovascular disease — Therapy and adherence
- Statin therapy for patients with diabetes — Therapy and adherence

2021 HEDIS® results BCN commercial

2021 HEDIS® results Marketplace/QHP

2021 HEDIS® results for BCN Advantage — Medicare

- Use of imaging studies for low back pain
- Emergency department utilization

Medicare

- Antidepressant medication management — Effective continuation phase
- Controlling high blood pressure
- Emergency department utilization
- Follow-up after emergency department visit for alcohol and other drug abuse or dependence — 7 day
- Follow-up after emergency department visit for mental illness — 7 day
- Follow-up after hospitalization for mental illness — 7
- Follow-up after emergency department visit for people with multiple high-risk chronic conditions

HEDIS 2021 results, *continued on Page 14*

Please see HEDIS 2021 results continued from Page 13

- Pharmacotherapy management of COPD exacerbation — Bronchodilators and corticosteroid
- Hospitalization for potentially preventable complications
- Non-recommended PSA-based screening in older men
- Potentially harmful drug-disease interactions in older adults
- Plan all-cause readmissions
- Risk of continued opioid use – 15 day
- Statin therapy for patients with cardiovascular disease — Therapy and adherence
- Statin therapy for patients with diabetes — Therapy and adherence
- Transitions of care — Notification of inpatient admission and patient engagement
- Use of opioids at high dosage
- Use of opioids from multiple providers — Multiple prescribers and pharmacies

Marketplace

- Antidepressant medication management — Effective acute and continuation phase treatment
- Appropriate treatment for upper respiratory infection
- Cervical cancer screening
- Childhood immunizations — Combo 3
- Controlling high blood pressure
- Follow-up after hospitalization for mental illness — 7 day
- Initiation and engagement in alcohol and other drug dependence treatment — Engagement
- Plan all-cause readmissions

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.

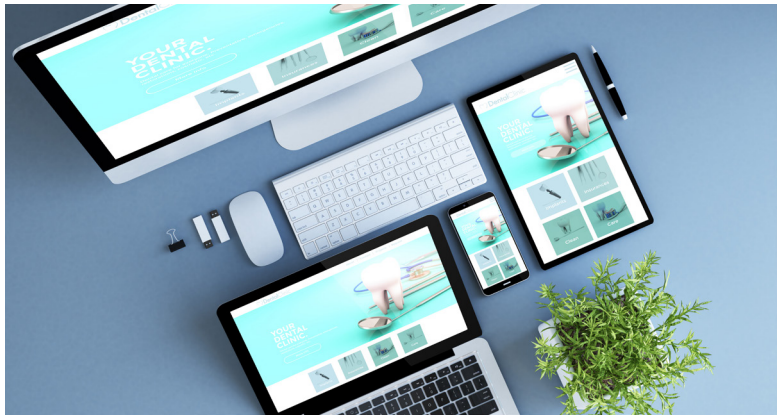
Primary care practitioners can still find opportunities to provide aggressive intervention in the management and care of our members with diabetes and high blood pressure, and in ordering procedures for breast, cervical and colorectal cancer screening.

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

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 the Clinical Data Operations at 1-855-228-8543.



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

- Genetic testing for Li-Fraumeni syndrome
- Kidney transplantation
- KRAS, NRAS and BRAF variant analysis in metastatic colorectal cancer (including liquid biopsy)
- SPECT/CT fusion imaging
- Intermittent (72 hours or greater) or continuous invasive glucose monitoring
- Contraception and voluntary sterilization
- Magnetic resonance imaging — low field
- Reproductive techniques
- Treatment of hyperhidrosis, excluding botulinum
- Genetic testing — gene expression profiling for uveal melanoma
- Retinal care for diabetic retinopathy
- Amniotic membrane and amniotic fluid
- Genetic testing for hereditary hearing loss

Medical Policy Updates

Intensive outpatient program and partial hospital program services now payable by telemedicine

We've updated our *Telemedicine Services medical policy* to allow behavioral health intensive outpatient program and partial hospitalization program services to be payable through synchronous (real time) telemedicine when delivered by providers at contracted facilities. This was effective Nov. 1, 2021.

We're doing this to make it easier for members to receive these services beyond the COVID-19 pandemic. Previously, we allowed these services to be payable temporarily through telemedicine during the pandemic.

For more information, including information about billing for these services, see the *Telehealth for behavioral health providers* document.

Reminders

- Facilities can provide behavioral health IOP and PHP services to BCN commercial and BCN Advantage℠ members only when their contracts specifically include IOP and PHP services.
- For Blue Cross commercial members, most plans don't cover IOP services for mental health or PHP services for substance use disorders. IOP services for substance use disorders must be delivered by a substance abuse treatment facility. Be sure to check member eligibility and benefits through web-DENIS or Provider Inquiry before performing services.
- For Medicare Plus Blue℠ PPO members, follow Centers for Medicare & Medicaid Services guidance.

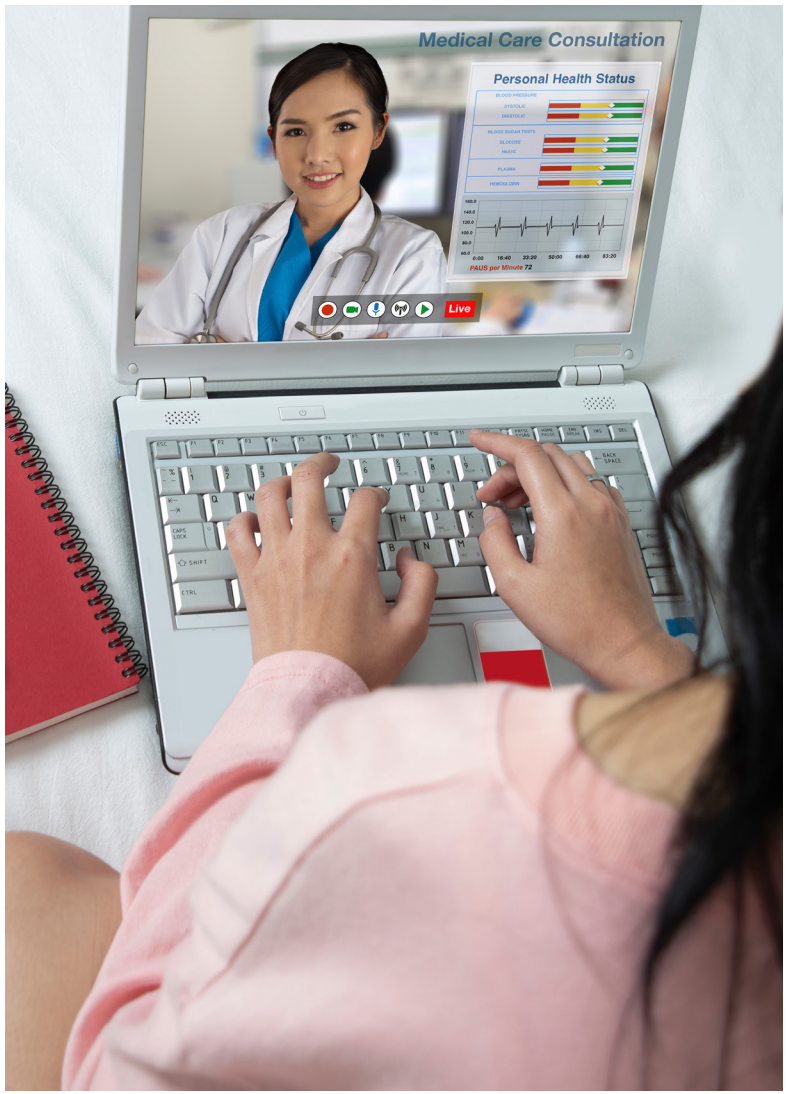
Updated documents

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

- *Telehealth for behavioral health providers*
- *Temporary changes due to the COVID-19 pandemic*

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

You can view the updated *Telemedicine Services medical policy* through our **Medical Policy & Pre-Cert/Pre-Auth Router** on **bcbsm.com**.



Behavioral health services can be delivered by synchronous telemedicine, with some exceptions

Updates to the following medical policies allow additional behavioral health and autism spectrum disorder, or ASD, services to be payable when delivered by telemedicine. The updates were effective Nov. 1.

- *Telemedicine services*
- *Autism spectrum disorder services*

Behavioral health and ASD services must be delivered synchronously (in real time), with the exception of *96130 and *96156, which can be delivered asynchronously.

Telemedicine asynchronous (store and forward) care is generally not payable for behavioral health services.

This applies to Blue Cross commercial, Medicare Plus Blue℠ PPO, BCN commercial and BCN Advantage℠ members.

For more information about providing behavioral health and ASD services by telemedicine, see the *Telehealth for behavioral health providers* document, which is available on our public website at **bcbsm.com/coronavirus** or within Provider Secured Services.

You can view the updated medical policies through our **Medical Policy & Pre-Cert/Pre-Auth Router** on **bcbsm.com**.

Additional autism interventions now payable by telemedicine and restrictions are removed from protocol modification

Effective Nov. 1, 2021, we've updated our Autism Spectrum Disorder Services medical policy to allow additional services for autism spectrum disorder to be payable when delivered by telemedicine. The updated removed restrictions on protocol modification (*97155).

As previously communicated, Blue Cross Blue Shield of Michigan and Blue Care Network began temporarily allowing additional services for autism spectrum disorder to be payable when delivered by telemedicine. This was a temporary measure during the COVID-19 pandemic.

These changes apply to members whose coverage includes an autism benefit.

Note: To determine which procedures can be performed by telehealth for Medicare Plus Blue℠ PPO members who have an autism benefit, see the **Medicare-covered telehealth services for the COVID-19 PHE** document.

Services that are now payable by telemedicine

In line with the updated medical policy, we'll now allow the following autism services to be delivered through synchronous (real-time) telemedicine:

- Assessment, *97151
- Applied behavior analysis, or ABA, *97153

  Note: This service is allowed by telehealth for children who meet appropriateness criteria. The **Guidelines for autism interventions delivered via telemedicine** document offers guidance in determining which members can benefit from direct-line ABA interventions delivered by telemedicine.
- Skills training, *97154
- Intensive skills training, *97158

Restrictions lifted on protocol modification

Per the updated medical policy, protocol modification, *97155, will be allowed by real-time telemedicine visits 100% of the time. (Previously, this service was allowed to be delivered by telemedicine only 50% of the time.)

Note: During the COVID-19 pandemic for dates of service from April 14, 2020, through Oct. 31, 2021, we allowed licensed behavior analysts, or LBAs, to troubleshoot treatment protocols directly with the parent or caregiver functioning as the behavioral technician. With the Nov. 1, 2021, update to the Autism Spectrum Disorder medical policy, this temporary measure is no longer payable.

Reminder

The following services continue to be payable when delivered through real-time telemedicine: caregiver training (*97156), multi-family caregiver training (*97157), supervision (S5108) and caregiver training (S5111).

Note: S5108 and S5111 are payable only to Michigan providers who deliver services to out-of-state members and cannot use the American Medical Association category 1 codes.

What you need to know

- A temporary measure to allow certain services for autism spectrum disorder to be delivered by telemedicine has been made permanent, effective Nov. 1.
- We've lifted restrictions on protocol modification.

Updated documents

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

- *Telehealth for behavioral health providers*
- *Temporary changes due to the COVID-19 pandemic*

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

You can view the updated *Telemedicine Services medical policy* through our **Medical Policy & Pre-Cert/Pre-Auth Router** on **bcbsm.com**.

Update: We're reversing an earlier decision to require CADC and CAADC credentials for facilities that treat substance use disorders

Staff who work at facilities contracted with Blue Cross Blue Shield of Michigan and Blue Care Network for the treatment of substance use disorders are not required to have a Certified Alcohol and Drug Counselor or Certified Advanced Alcohol and Drug Counselor credential.

This reverses our earlier communications on this topic, including an article in the August 2021 issue of *The Record*, an article in the September-October 2021 issue of *BCN Provider News*, a web-DENIS message posted July 1, 2021, and a news item posted in July on our **ereferrals.bcbsm.com** website.

Reason for the change

After we published the earlier communications, we had additional discussions with our contracted facilities and determined that requiring the CADC or CAADC credential creates hardships for facilities trying to recruit staff during the pandemic.

As a result, Blue Cross and BCN are dropping the requirement and will defer to the agencies that accredit our contracted facilities (the Commission on Accreditation of Rehabilitation Facilities, The Joint Commission and similar agencies) to ensure that standards related to the education and credentialing of facility staff are met.

It's our hope that this will provide some relief as the pandemic continues and our contracted facilities continue to face challenges in recruiting clinical staff.

Which providers this applies to

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

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

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

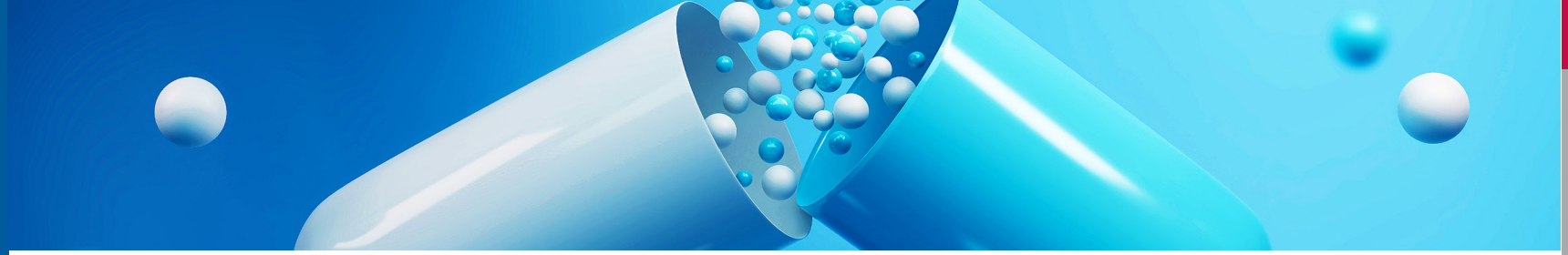
- Subacute detoxification
- Residential treatment
- Partial hospital program
- Intensive outpatient program
- Individual treatment

MQIC clinical practice guidelines

The Michigan Quality Improvement Consortium has published new guidelines for screening, diagnosis and referring members with substance use disorders for treatment.

The MQIC guidelines are intended not only for behavioral health practitioners but also for primary care professionals to help deliver the most effective, evidence-based care for behavioral health and related disorders.

See the article on **Page 12** for more information about guidelines related to ADHD, depression and substance abuse.



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 Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members.

During July, August and September 2021, we made changes to prior authorization requirements, site-of-care requirements for both for Blue Cross and BCN commercial members for the following medical benefit drugs:

HCPCS code	Brand name	Generic name
J3490	Ryplazim®	plasminogen, humantvmh
J3490	Nexviazyme™	avalglucosidase alfangpt
J3490	Saphnelo™	anifrolumab-fnia
J3590	Aduhelm™	aducanumab-avwa

Note: The code shown above will become unique codes.

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.

Additional information

For Blue Cross commercial groups, this authorization requirement applies only to groups that currently participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit. To determine whether a group participates in the prior authorization 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.

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.

Pharmacy News

BCN Provider *News*

Feedback

Ivermectin prescriptions require prior authorization for Blue Cross and BCN commercial members effective Oct. 1, 2021

Effective Oct. 1, 2021, until further notice, Blue Cross Blue Shield of Michigan and Blue Care Network are requiring prior authorization for prescriptions for Stromectol®, or ivermectin, for members with commercial coverage.

Prior authorization will be granted for indications approved by the U.S. Food and Drug Administration.

In addition, the quantity of ivermectin tablets dispensed will be limited to 20 tablets per year for commercial members with plans that include quantity limits. The quantity limit is applied over 365 days, not a calendar year.

Blue Cross and BCN are adding these requirements to discourage unauthorized use of this medication, such as for treatment of COVID-19. For more information, view the **CDC Health Advisory**.

Prescriptions for members with Medicare Advantage coverage aren't affected.

Reminder: Starting Jan. 1, 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 members receive safe, high-quality care that meets their needs.

See the article on **Page 24** of the November-December issue for details

Billing Bulletin

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:

- Counseling for smoking and tobacco use cessation
- Performing a transesophageal echocardiography during surgery
- Clinical editing appeal submission reminders

Clinical editing billing tips

Recorded webinars for physicians and coders focus on risk adjustment, coding

We recently offered a series of webinars for physicians and coders focusing on risk adjustment documentation and coding for common challenging diagnoses.

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

Topics include:

- Renal disease
- Coding scenarios for primary care and specialty
- Evaluation and management coding tips
- Acute conditions reported in the outpatient setting
- Morbid (severe) obesity
- Major depression
- Diabetes with complication
- Malignant neoplasm
- Updates for ICD-10 CM

Access to the training site differs slightly for new and existing users:

- New users must c**lick 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.

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

Specialists will see new message in e-referral system when global referral is missing

Starting in late January 2022, when a specialist submits a prior authorization request before the member's primary care provider has submitted a global referral, the e-referral system won't accept the request and the specialist will see the following message:

"You are not able to submit this request. A global referral is required. Contact the member's primary care provider and request a global referral. Then submit the request."

When you see this message, contact the member's primary care provider to have them submit the global referral. Don't contact the BCN Utilization Management department.

This change will allow the specialist to know immediately that the global referral is missing.

Before this change, it might have taken several days for Utilization Management to review and deny the request, then notify the provider that a global referral is not on file.

We'll update the **e-referral User Guide** and our computer-based training modules with this information.

As a reminder, global referrals must be issued for a minimum of 90 days. In addition:

- BCN's referral requirements vary based on the region assigned to the medical care group for the member's primary care provider.
- A global referral is required for BCN commercial members whose primary care provider is part of a medical care group based in the East or Southeast region.

You can find a summary of these and other requirements related to global referrals in the **BCN referral and authorization requirements for Michigan providers**. Look in "Section 2: Referral requirements."

What you need to know

- This article updates information published in earlier communications.
- We're clarifying that authorization requests for inpatient admissions for certain acute medical conditions should be submitted only after the member has spent two days in the hospital. (We previously indicated that the member had to be in the hospital 48 hours or had to be in an observation setting.)
- We're also revising the effective date for this change for BCN commercial members from Jan. 3, to Feb. 1, 2022.

Update: We're aligning local rules for acute inpatient medical admissions

For certain conditions, authorization requests for acute medical admissions should be submitted only after the member has spent two days in the hospital. Once the two days has elapsed, the facility can submit the request to authorize an inpatient admission on the third day. You must provide clinical documentation that demonstrates that the InterQual® criteria have been met at the time you submit the request.

Exception: When a member is receiving intensive care services that require an ICU critical care setting, you can submit the request before completion of the two-day period, along with all clinical documentation supporting the critical level of care.

We're aligning our local rules for all lines of business to reflect this change.

Effective dates for this change

This update to local rules will go into effect as follows:

- For Medicare Plus Blue℠ and BCN Advantage℠ members: This change is effective for members admitted on or after Jan. 3, 2022.
- For Blue Care Network commercial members: This change is effective for members admitted on or after Feb. 1, 2022.
- For Blue Cross Blue Shield of Michigan commercial members: This change is effective for members admitted on or after March 1, 2022.

Conditions this applies to

This applies to members with the following conditions:

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

Please see Aligning local rules, continued on Page 25

Aligning local rules, *continued from Page 24*

How determinations will be made

When the request has been received, Blue Cross and BCN will conduct a medical necessity review based on the clinical documentation you submitted. InterQual criteria will be applied based on the member's condition at the time the clinical documentation is received:

- If InterQual criteria are met, the authorization request will be approved.
- If InterQual criteria aren't met, the authorization request will be sent to the plan medical director for review.
- If the member hasn't been in the hospital for two days and isn't in an ICU critical care setting, Blue Cross and BCN will request that the facility wait until the member has been in the hospital for two days to send additional information about the member's condition. We'll make the request through the Case Communication field in the e-referral system, by calling the facility, or both.

  After receiving the request from the hospital on the third day, Blue Cross and BCN will do the following:

  - If the facility sent additional clinical information and it meets criteria, we'll approve the request.
  - If the facility hasn't sent additional clinical information or has sent additional clinical information but it doesn't meet criteria, we'll refer the request to the medical director for review.

For requests that are nonapproved, Blue Cross and BCN will reimburse as observation. The hospital will need to submit a claim for observation reimbursement.

Reason for the change

We expect that this change will:

- Reduce the number of communications that typically accompany these types of authorization requests
- Decrease denials for lack of clinical information, because all clinical documentation in support of the admission would be received after two days of hospital care
- Ensure appropriate reimbursement (inpatient versus observation level of care)

Additional information

For most members, facilities can request peer-to-peer reviews, if desired. Refer to the document **How to request a peer-to-peer review with a Blue Cross or BCN medical director.**

In addition, facilities can appeal denial decisions, as usual. Refer to the pertinent provider manual for information about how to submit an appeal.

Updated questionnaire opens in the e-referral system

We've updated the *Endoscopy, upper gastrointestinal, for Gastroesophageal Reflux Disease (GERD)* and *Bone-anchored Hearing Aid (BAHA)* questionnaires for BCN commercial and BCN Advantage℠ members in the e-referral system.

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** 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

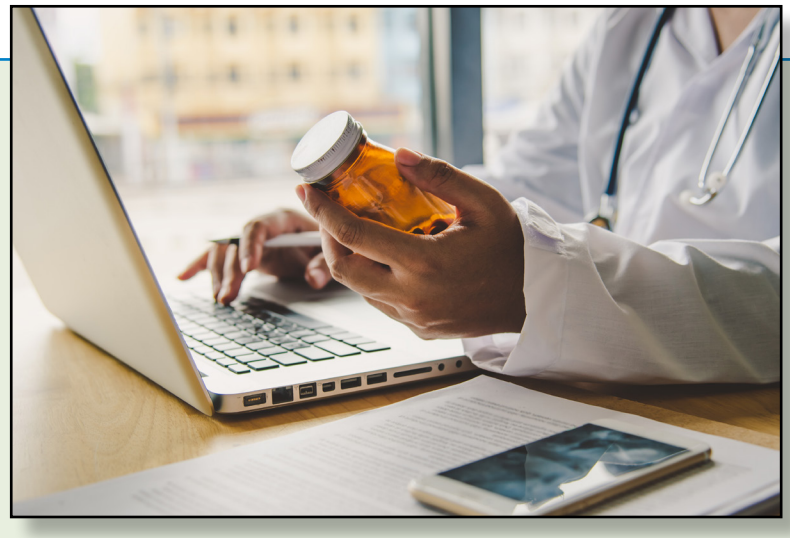
The pertinent authorization criteria and medical policies are also available on the Authorization Requirements & Criteria page.

Overview of care management and utilization management programs now available

We recently published the *Care management and utilization management programs: Overview for providers* document to help you navigate our care management and utilization management programs.

The document is available on **ereferrals.bcbcm.com**.

See the article on **Page 11** for more information.



Referral Roundup

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 certain procedure codes, 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.

For details, see the article in the Nov-Dec ***BCN Provider News***, Page 34.

Quarterly update: Requirements changed for some commercial medical benefit drugs

We recently made changes to prior authorization requirements, site-of-care requirements or both for Blue Cross and BCN commercial members for some medical benefit drugs.

See the full article on **Page 27** for details.

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

TurningPoint Healthcare Solutions LLC will review the site of care for total hip and knee surgeries as part of each authorization determination for dates of service on or after Jan. 3, 2022. 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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