MARCH-APRIL 2022

BCN Provider News

BCN Provider News User Guide

Blue Cross and BCN revise at-home COVID-19 testing policy

The federal government launched **COVIDtests.gov** on Jan. 19, a website where every home in the U.S. is eligible to order four at-home COVID-19 tests. The tests are free. The government says orders will usually ship in seven to 12 days and will be delivered by the U.S. Postal Service.

There is also a way for Blue Cross Blue Shield of Michigan members with Blue Cross or BCN pharmacy coverage to obtain free tests using some new options.

Blue Cross and BCN commercial plans have revised the at-home COVID-19 testing policy to comply with **Affordable Care Act FAQs** issued January 10, 2022. The new policy is in effect through the public health emergency.

Commercial members with pharmacy coverage through Blue Cross or BCN have coverage for up to eight FDA authorized over-the-counter, at-home rapid diagnostic COVID-19 tests per month. The at-home COVID-19 tests can be obtained in two ways:

- Through our preferred COVID-19 at-home testing pharmacy network at no cost to the member
- Through non-preferred pharmacies by requesting reimbursement of $12 or the cost of the at-home COVID-19 test, whichever is lower.

Commercial members that do not have pharmacy coverage through Blue Cross or BCN should contact their employer for details about how to obtain qualified at-home tests.

To view pharmacies in the network and the reimbursement process for COVID-19 at-home tests, visit our **COVID-19 webpage for individuals and families**.

These new at-home COVID-19 testing guidelines do not apply to Medicare Advantage plans.

Reminder about in-person COVID-19 testing: Our commercial plans continue to pay for other types of COVID-19 testing, other than rapid at-home testing, if they meet these criteria:

- The test has received or is waiting to receive approval for use (including emergency use) by the Food and Drug Administration or falls within one of the other categories of tests required to be covered by the Families First or CARES Acts.
- The test is administered or ordered by a qualified health professional who determines testing is appropriate using judgment in accordance with accepted standards of medical practice through an individualized clinical assessment.

Blue Cross and BCN don't cover testing performed only for occupational indications.

For more information, please refer to the **COVID-19 patient testing recommendations for physicians** document which has been updated to reflect this new at-home testing policy. This document can be found on our public website at **bcbsm.com/coronavirus** or within Provider Secured Services by clicking on *Coronavirus (COVID-19)*

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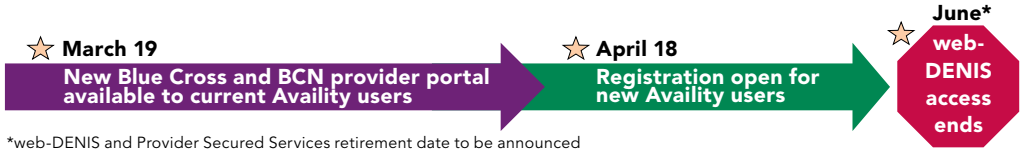

*web-DENIS and Provider Secured Services retirement date to be announced

Watch for special edition newsletter about our move to Availity

You'll soon receive an email from Blue Cross Blue Shield of Michigan with a special edition newsletter focused on Blue Cross and Blue Care Network's transition to our new provider portal. The special edition will help you learn about our new portal, including information on registration and training.

The Availity portal is now called Availity Essentials

You may have started seeing the word "Essentials" associated with Availity®. Don't worry. Availity still operates the multi-payer provider portal we've been telling you about. The new name of the Availity portal is now Availity Essentials. The new name recognizes the importance of the provider tools within Availity. In the coming weeks, as you begin using Blue Cross and BCN's new provider portal, we believe you'll enjoy the simple, fresh look and updated search features that Availity Essentials offers, along with continued access to many of the applications you're used to using for your Blue Cross and BCN patients.

Questions?

If you have questions about the move to Availity Essentials, 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.

Previous articles about Availity

We're providing a series of articles focusing on our move to Availity Essentials 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**)
- Alerts and provider resources within Availity (January-February 2022 **issue**)

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Provider web update includes enhancements

The public provider website, **bcbsm.com/providers**, debuted a new look in January. The project went beyond appearance, however. It provides a more flexible format that providers can access from a variety of devices, and the content has been reorganized to help you find what you need.

The change to this website is part of a larger project to update all **bcbsm.com** webpages to the same look, feel and access standards.

"We took the past year to really study the website in light of what our providers tell us they expect," said Jennifer Bussone, director of Provider Experience. "We've made incremental updates to the website over the years, but this gave us the chance to do a more complete assessment and revision."

The design team relied on research that pinpointed most frequently referenced content and built the layout with that in mind.

Users are interested in being able to scan quickly for the information they're seeking, which this new design supports.

From a content perspective, the project focused on reducing redundancy and validating accuracy and relevance.

Resources on bcbsm.com/providers

Here's where you can find some of the most-often consulted content:

- **Contact us** for frequently needed phone numbers and addresses
- **Drug lists** for commercial and Medicare Advantage plans
- **Forms and documents** for the most used materials
- **Help center** to find information on a wide variety of topics
- **Newsletters**, including the option to subscribe
- **Medical policy search tool** to find the latest Blue Cross Blue Shield of Michigan and Blue Care Network policies
- **Router for medical policy, precertification and prior authorization** to access important information for patients with coverage from any Blue Cross plan

HEDIS medical record reviews began in February

Each year from February through May, Blue Cross Blue Shield of Michigan and Blue Care Network conduct Healthcare Effectiveness Data and Information Set, or HEDIS®, medical record reviews for members who live in Michigan. This year, Blue Cross HEDIS clinical consultants will conduct reviews for members with Blue Cross PPO and HMO plans (including commercial, Medicare Advantage and individual products) who had services in 2021.

To support HEDIS and government-required programs, the Blue Cross and Blue Shield Association mandates who can retrieve medical records for patients living in Michigan but enrolled in another state's Blue Cross plan. Blue Cross is authorized to retrieve medical records for patients enrolled in a Blue Medicare Advantage PPO plan in another state.

Inovalon, an independent data and analytics firm, is authorized to retrieve medical records for patients enrolled in commercial Blue Cross PPO and HMO plans, as well as Blue Cross Medicare Advantage private fee for service and HMO plans.

For the HEDIS reviews, Blue Cross looks for details that may not have been captured in claims data, such as blood pressure readings, HbA1c lab results and colorectal cancer screenings. This information helps us improve health care quality reporting for our members.

Blue Cross HEDIS clinical consultants will contact you to schedule an appointment for a HEDIS review or request that you fax the necessary records. The HEDIS review also requires proof of service documentation for data collected from a medical record.

If you have questions or concerns, contact Ellen Kraft at **ekraft@bcbsm.com**.

HEDIS® (Healthcare Data and Information Set) is a registered trademark of the National Committee for Quality Assurance

Network Operations

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.

We recently added the following new learning opportunities:

- HEDIS® measures overview and scenarios — This eLearning lesson gives an overview of 10 HEDIS® measures. Each scenario covers the steps you should take to help close gaps in the measure.
- Provider training guide for genetic counselors — Offers training and resource information to support genetic counselors that join our network.
- 2021 lunch and learn webinar recordings — Two new topics have been added to this series:
  - Coding scenarios for primary care and specialty — This webinar shares best practices and a detailed scenario review for common coding errors.
  - Evaluation and management coding tips — This webinar focuses on best practices and coding tips for 2021 evaluation and management changes.

Action item

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

We also added an updated online course:

Risk adjustment: Best practices for documentation and coding — This recorded presentation reviews the risk adjustment process along with best practices for documentation and coding which applies to Medicare Advantage, individual and small group plans.

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 **log in**.

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

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 how to contact 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 will provide 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 1-866-373-9468. (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.

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.

How to request a member transfer

In some circumstances, a primary care physician 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 physician 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*.

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.

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.

Network Operations

Our self-service tools can help you find answers to your questions

We encourage our provider community to use our self-service tools to avoid long wait times to reach a representative.

Blue Cross Blue Shield of Michigan is committed to helping you become more knowledgeable about such topics as claims, benefits, authorizations, referrals and medical policy.

When you contact Provider Inquiry, you have an opportunity to interact with our automated system before speaking with a service representative. We urge you to take advantage of that useful option.

Additional self-service tools include web-DENIS, Provider Secured Services, online provider manuals and **ereferrals.bcbsm.com**.

Here's our main **Contact Us** page.

Have a question about authorizations and referrals?

Visit **ereferrals.bcbsm.com** before contacting Provider Inquiry. Select the Blue Cross or Blue Cross tab. You're likely to find your questions answered at this comprehensive site.

Have a medical policy question?

Check out our online provider manuals in one of two ways:

- After logging in as a provider at **bcbsm.com**, click on *Provider Manuals* in the lower right section of the page.
- From the homepage of *Provider Secured Services*, click on *Provider Manuals* on the left.

Other resources

- Click on *BCBSM Provider Publications and Resources* and then *Newsletters & Resources* while in web-DENIS or *BCN Provider Publications and Resources* for a wealth of information.
- **Blue Cross and BCN Provider Systems and Web Resources flyer**

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 22**.

Virtual provider symposiums to focus on patient experience and HEDIS

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 by clicking on the registration links, and you may register for more than one topic.

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	Session Date	Time	Sign-up link
We are Stars — HEDIS® /Star Measure Details and Exclusions	Wednesday, May 4	8 to 10 a.m.	**Register here**
We are Stars — HEDIS® /Star Measure Details and Exclusions	Tuesday, May 10	Noon to 2 p.m.	**Register here**
We are Stars — HEDIS® /Star Measure Details and Exclusions	Thursday, May 19	2 to 4 p.m.	**Register here**
We are Stars — HEDIS® /Star Measure Details and Exclusions	Wednesday, May 25	2 to 4 p.m.	**Register here**
We are Stars — HEDIS® /Star Measure Details and Exclusions	Tuesday, May 31	Noon to 1:30 p.m.	**Register here**
We are Stars — HEDIS® /Star Measure Details and Exclusions	Thursday, June 9	8 to 10 a.m.	**Register here**
Patient Experience — Providing great service 2.0	Wednesday, May 11	9 to 10:30 a.m.	**Register here**
Patient Experience — Providing great service 2.0	Tuesday, May 17	9 to 10:30 a.m.	**Register here**
Patient Experience — Providing great service 2.0	Tuesday, May 24	Noon to 1:30 p.m.	**Register here**
Patient Experience — Providing great service 2.0	Tuesday, June 7	Noon to 1:30 p.m.	**Register here**
Patient Experience — Providing great service 2.0	Tuesday, June 14	9 to 10:30 a.m.	**Register here**

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

If you have any questions about the sessions, email Ellen Kraft at **ekraft@bcbsm.com**. If you have questions about registration, email Patricia Scarlett at **pscarlett@bcbsm.com**.

Testing codes added to in-office billable list for BCN, BCN Advantage and Medicare Plus Blue

Blue Care Network, BCN Advantage℠ and Medicare Plus Blue℠ have added *87811 and *87428 to the list of tests that can be performed in the physician's office. We're making these codes payable retroactive to Jan. 1, 2021, to make it easier for our physicians to treat members. The codes were previously payable only for Blue Cross Blue Shield of Michigan commercial members.

If you received a previous rejection for performing this test in the physician's office for BCN commercial, BCN Advantage or Medicare Plus Blue members, you don't need to do anything. We'll reprocess the claims.

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).

Changes coming to preferred products for infliximab for Medicare Advantage members

For dates of service on or after April 1, 2022, we're making the following changes to the medications designated as preferred and nonpreferred infliximab products (reference product Remicade®):

Preferred products:

- Inflectra® (infliximab-dyyb), HCPCS code Q5103
- Avsola® (Infliximab-axxq), HCPCS code Q5121

Nonpreferred products:

- Remicade® (infliximab), HCPCS code J1745
- Renflexis® (infliximab-abda), HCPCS code Q5104

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

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

- **For members who start treatment on or after April 1:** Prescribe preferred products when possible. These products don't require prior authorization.

See **Changes coming to preferred products**, *continued on Page 10*

BCN Advantage

Changes coming to preferred products, *continued from Page 9*

- **For members who receive nonpreferred products for courses of treatment that start before April 1:** Please transition to a preferred product by April 1.

All nonpreferred products, including Renflexis, require prior authorization for dates of service on or after April 1, 2022.

Submitting requests for prior authorization

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

- **Preferred products:** Preferred products don't require prior authorization. Don't submit a request.
- **Nonpreferred products, for members who must take them:** 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.

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'll update the list to reflect this change prior to the effective date.

Changes to the prior authorization list for medical benefit drugs for Medicare Advantage members

We've made changes to prior authorization requirements for Medicare Plus Blue℠ and BCN Advantage℠ members.

Additional drugs that require prior authorization

The following drugs require prior authorization through the NovoLogix® online tool.

- For dates of service on or after Dec. 27, 2021, Susvimo™ (ranibizumab injection, for ocular implant), HCPCS code J3590
- For dates of service on or after Jan. 17, 2022, Ryplazim® (plasminogen, human-tvmh), HCPCS code J3590

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 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.

We require prior authorization for this drug when it's administered in any site of care other than inpatient hospital (place of service code 21) and is 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

Drug that no longer require prior authorization

For dates of service on or after Dec. 1, 2021, Tegsedi® (inotersen), HCPCS code J3490, no longer requires prior authorization.

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**.

Tezspir ,Vyvgar and Leqvio to require prior authorization for Medicare Advantage members

Providers must submit prior authorization requests through the NovoLogix® online tool for the following drugs covered under the medical benefit:

- **For dates of service on or after Feb. 21, 2022:** Tezspire™ (tezepelumab-ekko), HCPCS code J3490
- **For dates of service on or after March 1, 2022:**
  - Vyvgart™ (efgartigimod alfa-fcab), HCPCS code J3490
  - Leqvio® (inclisiran), HCPCS code J3490

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

When prior authorization is required

We require prior authorization when this drug is administered in any site of care other than inpatient hospital (place of service code 21) and is 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

Submitting prior authorization requests

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.

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**.

BCN Advantage

Documents in naviHealth's nH Access portal are only available for 30 days

Documents for Medicare Plus Blue℠ PPO and BCN Advantage℠ members are available within naviHealth's nH Access™ portal for only 30 days from the day they were posted. This was effective Feb. 11, 2022.

If you need access to a document after it's been removed from nH Access, contact your naviHealth care coordinator.

If you have questions about this change, contact your local naviHealth provider relations manager. If you aren't sure who your naviHealth provider relations manager is, send an email to umproviderconcerns@bcbsm.com.

naviHealth is committed to improving the post-acute care experience for our Medicare Advantage members. As part of this commitment, naviHealth provides access to patient information and documentation during the prior authorization process by making documents available through nH Access.

As a reminder, naviHealth:

- Authorizes patient-driven payment model levels during the patient's skilled nursing facility stay (from preservice through discharge)
- Authorizes PDPM levels based on medical necessity review and their proprietary naviHealth Predict functional assessment
- Works with SNFs to ensure billers submit proper PDPM levels for reimbursement

For more information, see **Post-acute care services: Frequently asked questions for providers**.

naviHealth Inc. is an independent company that manages authorizations for post-acute care services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.

Medicare sequestration suspension extended through March 31, 2022

As you may recall, Blue Cross Blue Shield of Michigan and Blue Care Network aligned with the Centers for Medicare & Medicaid Services' guidance when Congress and the Biden administration suspended the mandatory Medicare 2% sequestration reduction through the end of 2021.

Congress passed legislation on Dec. 9, 2021, that suspends the 2% sequestration reduction through March 31, 2022, and then reduces the sequestration cuts to 1% from April through June 2022. We'll update you before July 2022 on the status of sequestration after June 30, 2022.

Reminder: The 2% reimbursement adjustment is applied after determining any applicable member deductible, copayment or other required member out-of-pocket costs. The change won't affect reimbursement to providers who haven't been affected by sequestration previously, such as providers of durable medical equipment, lab services providers and providers treating patients with end-stage renal disease.

BCN Advantage

Gain insights from CAHPS research on improving the patient experience

The Centers for Medicare & Medicaid Services can help health care providers better understand their Medicare patients' needs and expectations by understanding 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: 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.

CAHPS® is a registered trademark of the Agency for Healthcare Quality and Research, or AHQR.

CAHPS survey tip sheet

Advanced illness and frailty exclusions allowed for HEDIS star measures

The National Committee for Quality Assurance allows patients to be excluded from select HEDIS® star quality measures due to advanced illness and frailty. They acknowledge that measured services most likely would not benefit patients who are in declining health.

You can 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.

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

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

Advanced Illness and Frailty Exclusions for HEDIS Star Measures guide

Encourage eligible Medicare Advantage patients to get screened for colorectal cancer

Colorectal cancer is the second leading cause of cancer death for both men and women combined in the United States, according to the American Cancer Society. However, more than half of all cases and deaths are attributable to modifiable risk factors, such as smoking, an unhealthy diet, high alcohol consumption, physical inactivity and excess body weight, and thus potentially preventable.[1] Colorectal cancer morbidity and mortality can also be mitigated through appropriate screening and surveillance.[2]

The Colorectal Cancer Screening (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.

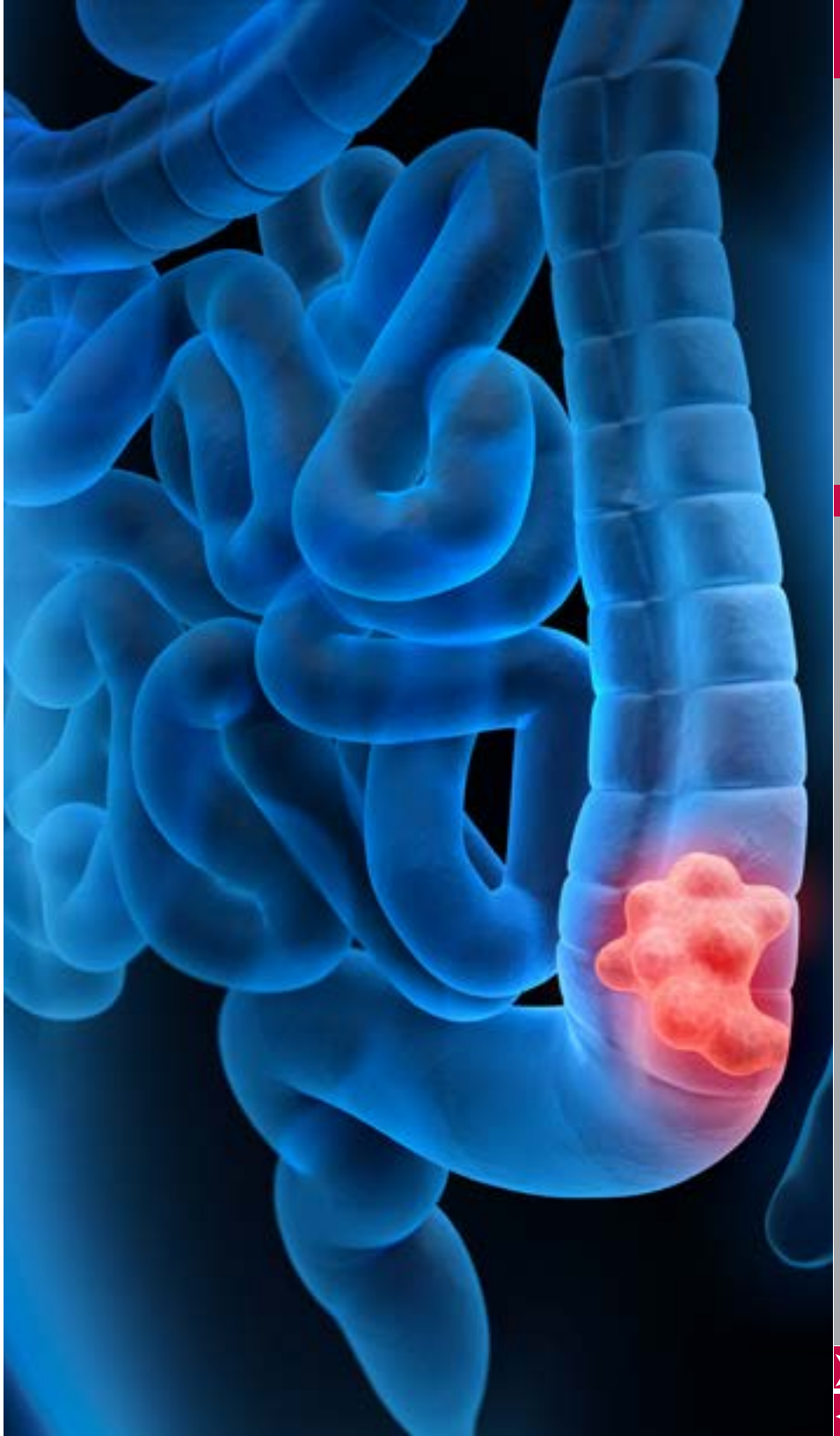
Read the *Colorectal Cancer Screening tip sheet* to learn about this measure including what information to include in medical records, codes for patient claims and tips for talking with patients.

Source: Colorectal cancer statistics, 2020 - Siegel - 2020 - CA: A Cancer Journal for Clinicians - Wiley Online Library

1. Islami F, Goding Sauer A, Miller KD, et al. Proportion and number of cancer cases and deaths attributable to potentially modifiable risk factors in the United States. CA Cancer J Clin. 2018;68:31-54.

2. Winawer SJ, Zauber AG. The advanced adenoma as the primary target of screening. Gastrointest Endosc Clin N Am. 2002;12:1-9, v.

Colorectal Cancer Screening tip sheet



2022 HEDIS quality measure changes

In October 2021, the National Committee for Quality Assurance released value set changes for some HEDIS® Healthcare Effectiveness Data and Information Set quality measures.

Here are new and returning measures that are expected to be included in the Medicare star ratings:

- **Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)**
  - Patients ages 18 and older who have multiple high-risk chronic conditions and who had a follow-up visit within seven days of an emergency department visit
- **Plan All-Cause Readmissions (PCR)**
  - The number of acute inpatient and observation stays for patients ages 18 and older who were followed by an unplanned acute readmission for any diagnosis within 30 days
- **Transitions of Care (TRC)**
  - Patients who had an acute or non-acute inpatient discharge during the measurement year and who had each of the following:
    - Notification of inpatient admission
    - Receipt of discharge information
    - Patient engagement after inpatient discharge
    - Medication reconciliation post-discharge
- The Comprehensive Diabetes Care measures have been separated as follows:
  - **Eye Exam for Patients with Diabetes (EED)**
    - Patients ages 18 to 75 with a diagnosis of diabetes (Type 1 or Type 2) who received screening or monitoring for diabetic retinal disease
  - **Hemoglobin A1c Control for Patients with Diabetes (HBD)**
    - Patients ages 18 to 75 with a diagnosis of diabetes (Type 1 or Type 2) whose HbA1c was adequately controlled (≤9%) as of Dec. 31 of the measurement year
  - **Kidney Health Evaluation for Patients with Diabetes (KED)**
    - Patients ages 18 to 85 with a diagnosis of diabetes (Type 1 or Type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate, or eGFR, and a urine albumin-creatinine ratio, or uACR, during the measurement year

We're updating our HEDIS and star tip sheets for 2022. We'll let you know when they've been posted in Provider Secured Services.

BCN Advantage

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 don't 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

What you need to know

- We've updated a document to help you navigate our care management and utilization management programs.
- You can bookmark the overview document so you can find it easily. See the link in the article.

Reminder: Get easy access to information about our care management and utilization management programs

In November 2021, we published the ***Care management and utilization management programs: Overview for providers*** document to help you navigate our care management and utilization programs more easily.

Since then, we've updated the document — and the documents it links to — to reflect changes that went into effect on Jan. 1, 2022. We'll continue to update these documents as information changes.

We recommend that you bookmark the **overview document** in your internet browser to make it easier to access the most up-to-date information.

This easy-to-use, one-page document tells you what you need to know about these two categories of programs:

- **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

The programs vary based on member coverage and may be administered by Blue Cross Blue Shield of Michigan or Blue Care Network staff or by contracted vendors.

In addition to being able to access the document from the links in this article, you can find it at **ereferrals.bcbsm.com**. Follow these steps:

1. Click on the *Quick Guides* link in the left-hand column (under *Additional Resources*).
2. Click on the *Care management and utilization management programs: Overview for providers* link.

For more details, see the **article** in the January-February 2022 *BCN Provider News* (Page 11).

We're providing more information on 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 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 a critical care setting, you can submit the request prior to completion of the two-day period, with all clinical documentation supporting the critical level of care.

What you need to know

- As part of our ongoing communications on what we're doing to align local rules for acute inpatient medical admissions of members with certain conditions who are admitted on or after March 1, we recently published a new document titled **Submitting acute inpatient authorization requests: Frequently asked questions for providers**.
- We've also made some modifications to previous articles on this topic. You'll want to use the information in this article as your reference on this topic going forward.

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

Effective date for this change

This update to local rules will go into effect for all members admitted on or after March 1, 2022. This includes Blue Cross Blue Shield of Michigan and Blue Care Network commercial members, as well as Medicare Plus Blue℠ PPO and BCN Advantage℠ members.

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

How determinations will be made

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.

See **Aligning local rules for acute inpatient medical admissions**, *continued on Page 19*

Aligning local rules for acute inpatient medical admissions, continued from Page 18

- 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 a 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 not approved, Blue Cross and BCN will reimburse as observation. The hospital will need to submit a claim for observation reimbursement.

Reason for change

We expect that this change will:

- Reduce the number of communications that typically accompany these types of authorization requests.
- Decrease nonapprovals 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.**

You may also want to reference the document **Submitting acute inpatient authorization requests: Frequently asked questions for providers**. In the document's table of contents, click on *What are the local rules that apply to members with certain conditions?*

Keep in mind that facilities can appeal nonapproval decisions as usual. Refer to the pertinent provider manual for information on how to submit an appeal.

Note: These local rules provide instructions only on when to submit the authorization request. They do not direct providers on how to write admission orders for observation or inpatient care or on how to determine the level of care for the member.

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

- Assisted reproductive techniques (title changed from "Reproductive techniques")
- Genetic testing — Preimplantation
- Infertility diagnosis
- Magnetic resonance-guided focused ultrasound
- Magnetic resonance imaging for detection and diagnosis of breast cancer
- Magnetic resonance imaging to monitor integrity of silicone-gel-filled breast implants
- Temporomandibular Joint Disorder
- Transcatheter aortic valve implantation for aortic stenosis
- Charged particle (proton or helium ion) radiotherapy for neoplastic conditions
- Genetic testing for BRCA1 or BRCA2 for hereditary breast/ovarian cancer syndrome and other high-risk cancers
- Genetic testing — noninvasive prenatal screening for fetal aneuploidies, microdeletions, and twin zygosity using cell-free fetal DNA
- Positron emission tomography (PET) for oncologic conditions
- Proprietary laboratory analyses (PLA) codes

Noncovered services

- Miscellaneous genetic and molecular diagnostic tests
- Subchondroplasty

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 BCN and BCN Advantage℠ services, practitioners or providers, and member rights and responsibilities
- Be treated with respect and recognition of their dignity and their right to privacy
- Participate with practitioners in making decisions about their health care
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- To voice complaints or appeals about BCN and BCN Advantage, or the care provided
- To make recommendations regarding BCN and BCN Advantage member rights and responsibilities policy

Members have a responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need to provide care
- Follow 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, to the degree possible

A complete list of these rights and responsibilities is available on our **website**.

Patient Care/ Quality

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 are available to all Blue Care Network primary care physicians, primary care groups and specialists.

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.

Behavioral Health

We've expanded existing quantity limit to include new prescriptions for long-acting opioids and tramadol

Blue Cross Blue Shield of Michigan and Blue Care Network have expanded our existing quantity limits on opioid medications to include long-acting opioids and tramadol in support of the Food and Drug Administration's efforts to balance the serious risk of opioids with the drugs' pain management benefits.

Long-acting opioids and tramadol have a five-day, **first fill** limit, effective Jan. 1, 2022.

This change applies to commercial members with a **new** long-acting opioid or tramadol prescription only.

This change doesn't apply to members currently taking a long-acting opioid or tramadol, or who are on Medicare.

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, from 8 a.m. to 5 p.m., Monday through Friday, to schedule a peer-to-peer review. To discuss a behavioral health case after normal business hours with one of our clinicians, call 1-800-482-5982.

How to obtain a copy of behavioral health criteria

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

Behavioral Health

Depression toolkit available for providers

As part of our efforts to improve the quality of care that members receive for depression and help our provider network meet the behavioral health needs of their patients, Blue Care Network has updated our depression toolkit.

The toolkit contains information to help diagnose and treat depression using evidence-based approaches to assessment and medication therapy. It also contains materials to help members understand the process of evaluating the effectiveness of prescribed medications to alleviate their symptoms.

You can find the toolkit on BCN's Behavioral Health page under Other Resources on **ereferralsbcbsm.com**.

The kit includes:

Tip Sheet: Major Depressive Disorder

Depression Office Flyer for Members

Depression Brochure for Members (can be sent electronically or printed for patients at discharge)

Antidepressant Medication Management (AMM) HEDIS tip sheet

You can also find depression screening tools at **ereferrals.bcbsm.com**. Click on the ***Behavioral Health Screening tools*** link under Other Resources on BCN's Behavioral Health page. Read the disclaimer information, then click the *I Accept* button to access a variety of screening tools, including the PHQ-9, a commonly used tool to screen for depression.

We've improved the commercial Blue Cross and BCN utilization management medical drug list

We've published updated documents with utilization management information about drugs covered under the medical benefit for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

Based on feedback we received from providers and others, we've made changes so the information will be clear and more accessible.

The redesigned ***Blue Cross and BCN utilization management medical drug list***:

- Offers a fuller explanation of our medical-drug utilization management programs for commercial members.
- Indicates more clearly where to submit prior authorizations requests — to AIM Specialty Health® or through the NovoLogix® online tool.
- Continues to indicate which drugs have prior authorization and site-of-care requirements that apply to Blue Cross or BCN commercial members.
- Continues to show the preferred and nonpreferred products for drugs for which we've designated preferred products.
- No longer contains medical policy information or information about documentation requirements, which makes the list shorter and easier to use.

The quantity limits information is in its own document, titled ***Blue Cross and BCN quantity limits for medical drugs***:

- This separate document provides easier access for providers who need only the quantity limits.
- This document continues to indicate whether the quantity limits apply to in-state or out-of-state providers or both.
- The *Blue Cross and BCN utilization management medical drug list* includes a link to the *Blue Cross and BCN quantity limits for medical drugs* document in the introductory text and in the table heading on each page.

We've published both lists on **bcbsm.com**, on the page titled ***Why do I need prior authorization for a prescription drug?*** Under the "How do I find out if my medication needs prior authorization?" heading, click Medical coverage drugs.

We'll also make these lists available at **ereferrals.bcbsm.com**:

- On the **Blue Cross Medical Benefit Drugs page**
- On the **BCN Medical Benefit Drugs page**

You'll also be able to find these lists behind the provider portal.

We appreciate the feedback we received from the provider community and encourage additional comments on the new documents. Blue Cross and BCN are committed to providing reliable, up-to-date, easy-to-use resources, to help navigate our medical-benefit drug utilization management programs.

Pharmacy News

Changes to the prior authorization list for medical benefit drugs for Medicare Advantage members

Providers must submit prior authorization requests through the NovoLogix® online tool for the following drugs covered under the medical benefit:

- **For dates of service on or after Feb. 21, 2022:** Tezspire™ (tezepelumab-ekko), HCPCS code J3490
- **For dates of service on or after March 1, 2022:**
  - Vyvgart™ (efgartigimod alfa-fcab), HCPCS code J3490
  - Leqvio® (inclisiran), HCPCS code J3490

For details, see the article on **Page 10**.

Changes coming to preferred products for pegfilgrastim (reference product Neulasta) for commercial and Medicare Advantage members

What you need to know

- We're making some changes to medications designated as preferred and nonpreferred pegfilgrastim products.
- The article outlines how to request prior authorization for preferred products and how to submit requests for nonpreferred products.

For dates of service on or after April 1, 2022, we're making the following changes to the medications designated as preferred and nonpreferred pegfilgrastim products (reference product: Neulasta®):

- Preferred products:
  - Neulasta®/Neulasta® Onpro® (pegfilgrastim), HCPCS code J2506
  - Fulphila® (pegfilgrastim-jmdb), HCPCS code Q5108
  - Ziextenzo® (pegfilgrastim-bmez), HCPCS code Q5120
- Nonpreferred products:
  - Udenyca® (pegfilgrastim-cbqv), HCPCS code Q5111
  - Nyvepria™ (pegfilgrastim-apgf), HCPCS code Q5122

This change affects select Blue Cross Blue Shield of Michigan commercial members, all Blue Care Network commercial members, all Medicare Plus Blue℠ PPO members and all BCN Advantage℠ members. (See

See **Changes coming to preferred products**, *continued on Page 26*

Changes coming to preferred products, continued from Page 25

the "Additional information for Blue Cross commercial members" section of this article for more information.)

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

- For commercial members: Members must transition to a preferred product by April 1, 2022.
- For Medicare Advantage members (Medicare Plus Blue PPO or BCN Advantage):
  - For members who start courses of treatment on or after April 1: Prescribe preferred products when possible. See "Submitting requests for prior authorization" below on 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 courses of treatment that start before April 1: These members can continue their courses of treatment using the nonpreferred product until their authorizations expire.

Submitting requests for prior authorization

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

- **Preferred products:** These products require prior authorization through AIM Specialty Health®. Submit the request through the **AIM provider portal** or call the AIM Contact Center at 1-844-377-1278.
- **Nonpreferred products — for members who must take them:** Submit the prior authorization request through the NovoLogix® online tool. NovoLogix offers real-time status checks and immediate approvals for certain medications. 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 Blue Cross commercial members

The requirements outlined in this article apply as follows:

- These requirements apply only to Blue Cross commercial 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 UAW Retiree Medical Benefits Trust members with Blue Cross non-Medicare plans.
- For Blue Cross commercial self-funded groups other than UAW Retiree Medical Benefits Trust:
  - **For preferred products:** These groups don't participate in the AIM oncology management program. Because of this, 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 NovoLogix for members who have coverage through these groups.

List 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 commercial and BCN commercial**
  - Medical oncology drug program: **Medical oncology prior authorization list for Blue Cross and BCN commercial members**
- For Medicare Advantage members, see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue℠ and BCN Advantage℠ members**.

Changes coming to preferred products for infliximab for Medicare Advantage members

For dates of service on or after April 1, 2022, we're making the following changes to the medications designated as preferred and nonpreferred infliximab products (reference product Remicade®):

- Preferred products:
  - Inflectra® (infliximab-dyyb), HCPCS code Q5103
  - Avsola® (Infliximab-axxq), HCPCS code Q5121
- Nonpreferred products:
  - Remicade® (infliximab), HCPCS code J1745
  - Renflexis® (infliximab-abda), HCPCS code Q5104

See the article on **Page 9** for full details.

NovoLogix user interface update: Old version of authorization screen will be retired March 1

Starting March 1, 2022, the old version of the NovoLogix authorization screen will be retired and the new version of the screen will open automatically for all providers. This is part of an upgrade to the NovoLogix user interface.

The new authorization screen has been available since 2020 and most providers are already using it.

What you should do

Providers who are still using the old authorization screen should switch to the new screen before March 1. To do this, click the *New Screen* check box in the upper-right corner of the old screen.

Benefits of new authorization screen

The new authorization screen streamlines the process of creating authorization requests. The main features include:

- Single-screen authorization entry, to avoid having to switch screens
- Easily collapsible panels, to speed up information entry
- Summary sections and alerts, to facilitate reviewing information and checking the status of a request

Additional information

The NovoLogix online tool is used to submit prior authorization requests for some medical benefit drugs for Blue Cross Blue Shield of Michigan commercial members, Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠ members.

As a reminder, you can find information about medical benefit drugs that require prior authorization on these webpages at **ereferrals.bcbsm.com**:

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

Reminder: Our transition to OptumRx

Blue Cross Blue Shield of Michigan and Blue Care Network have transitioned to a new pharmacy benefit manager, moving from Express Scripts, Inc. to OptumRx. This change took place on **Jan. 1, 2022**, for commercial individual and group members, and will take place on Jan. 1, 2023, for Medicare Advantage individual and group members.

We anticipate the bulk of the transition will be seamless for our members and health care providers. However, members using our current home delivery pharmacy to fill a prescription for a controlled substance — or those with expired prescriptions or prescriptions without refills — should ask their doctor to write a new prescription so it can be filled by OptumRx home delivery pharmacy.

As part of the transition, we've mailed about 1.8 million new ID cards to members. Members must show their new cards at the pharmacy starting Jan. 1 to help ensure their prescriptions are covered correctly under their benefits.

We've also made some enhancements 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.

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

Need more information?

- For more information on ePA and CoverMyMeds, see our **ePA flyer**.
- For more information on the transition to OptumRx, see the September-October 2021 issue (Page 26) of ***BCN Provider News***.

Use place of service code 10 for telehealth services provided in a patient's home

The Centers for Medicare & Medicaid Services implemented a new place of service code, POS 10, to reflect telehealth services provided in a patient's home. Providers have been using POS 02 to reflect telehealth services provided anywhere, including a patient's home.

Blue Cross Blue Shield of Michigan and Blue Care Network updated their systems to accept the new POS 10 code beginning Feb. 1, 2022. This applies to claims for telehealth services provided in a patient's home for dates of service on or after Jan. 1, 2022.

What you need to know

The POS codes below apply to claims for telehealth services for Blue Cross commercial, Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ members.

- **POS 02: Telehealth provided other than in patient's home**
  Use POS 02 when a patient isn't located in his or her home* when receiving health services or health related services through telecommunication technology.
- **POS 10: Telehealth provided in patient's home**
  Use the new POS 10 code when a patient is located in his or her home when receiving health services or health related services through telecommunication technology.

We updated the telehealth guides for **medical** and **behavioral health** providers to reflect the POS code changes.

For more information, review **MLN Matters Number: MM12427**, *New/Modifications to the Place of Service (POS) Codes for Telehealth.*

*A patient's home is a location other than a hospital or other facility, where the patient receives care in a private residence.

Billing Bulletin

We're updating our recovery process to provide detailed explanations on remittance advices

We're updating our recovery process for Blue Care Network and BCN Advantage℠ claims to align with Blue Cross Blue Shield of Michigan commercial PPO and Medicare Plus Blue℠ PPO.

We'll no longer send notification letters with claim recovery details. Instead, we'll provide more detailed explanations on your remittance advice. We're creating a detailed list of explanation codes to provide the reason for the recovery.

This change will be effective around the middle of the first quarter 2022 to give us time to update our systems.

Federal No Surprises Act prohibits 'surprise billing'

Blue Cross Blue Shield of Michigan and Blue Care Network have made changes to align with the federal No Surprises Act, effective Jan. 1, 2022. The law, part of the Consolidated Appropriations Act, or CAA, prohibits surprise billing nationwide for emergency, some non-emergency and air ambulance services.

Surprise billing is when a member unknowingly receives care from a health care provider who doesn't participate with the member's health insurance plan. The member then receives an unexpected bill for the difference between the health plan's payment and what the health care provider charges.

Blue Cross and BCN already align with the state surprise billing law, which went into effect Oct. 22, 2020. The state law prohibits surprise billing by Michigan nonparticipating professional providers for emergency services and some non-emergency services.

As of Jan, 1, 2022, Blue Cross is handling claims according to the federal law for self-funded ERISA plans, grandfathered plans and federal health plans. We're also following the federal law for fully insured plans and self-funded state or local government plans. However, these plans will still follow the state law for professional provider payment rates and arbitration procedures.

Blue Cross maintains the broadest network of providers in Michigan, and helps ensure access to high-quality, in-network care across the country through our relationship with the Blue Cross Blue Shield Association.

What you need to know

Blue Cross and BCN align with the federal No Surprises Act, which prohibits nonparticipating professional providers from surprise billing for emergency services, some non-emergency services and air ambulance services.

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

- **Blue Cross Blue Shield of Michigan**
  - Michigan physicians and other professional providers of care: 1-800-344-8525
  - Providers outside of Michigan: 1-800-676-2583
  - Michigan hospital and facility providers: 1-800-249-5103
  - Hospital and facility providers outside of Michigan: 1-800-676-2583
- **Blue Care Network**
  - Professional providers: 1-800-344-8525
  - Ancillary and facility providers: 1-800-249-5103

Billing Bulletin

BCN Provider *News*

Feedback

Testing codes added to in-office billable list for BCN, BCN Advantage and Medicare Plus Blue

Blue Care Network, BCN Advantage℠ and Medicare Plus Blue℠ have added *87811 and *87428 to the list of tests that can be performed in the physician's office. We're making these codes payable retroactive to Jan. 1, 2021, to make it easier for our physicians to treat members. The codes were previously payable only for Blue Cross Blue Shield of Michigan commercial members.

See article on **Page 9** for details.

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

Beginning in April, we'll offer webinars that will provide updated information on documentation and coding of common challenging diagnoses. These live lunchtime educational sessions will include an opportunity to ask any questions.

Here's our current schedule and the tentative topics for the sessions. All sessions start at 12:15 p.m. Eastern time and last about 30 minutes.

Click on a *Register* here link below to sign up for a session

Session Date	Topic	Registration
April 19	Coding and Documentation for HCC Capture and Risk Adjustment	**Register here**
May 5	Coding for Cancer/Neoplasms	**Register here**
June 16	Coding for Heart Disease/Heart Arrythmias	**Register here**
July 19	Coding for Vascular Disease	**Register here**
Aug. 17	Coding History and Rheumatoid Arthritis	**Register here**
Sept. 22	Coding Heart Failure, COPD, CHF	**Register here**
Oct. 11	2023 Updates for ICD 10 CM	**Register here**
Nov.16	Coding Scenarios for Specialty Providers/PCP	**Register here**
Dec. 8	E/M Coding Review and Scenarios	**Register here**

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**.

Virtual provider symposiums to focus on 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 by clicking on the registration links, and you may register for more than one topic.

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

Topic	Session Date	Time	Sign-up link
Medical record documentation and coding	Tuesday, May 3	8 to 9 a.m.	**Register Here**
Medical record documentation and coding	Thursday, May 12	Noon to 1 p.m.	**Register Here**
Medical record documentation and coding	Wednesday, May 18	2 to 3 p.m.	**Register Here**
Medical record documentation and coding	Tuesday, May 24	8 to 9 a.m.	**Register Here**
Medical record documentation and coding	Thursday, June 2	2 to 3 p.m.	**Register Here**
Medical record documentation and coding	Wednesday, June 8	Noon to 1 p.m.	**Register Here**

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

If you have any questions about the sessions, contact Ellen Kraft email **ekraft@bcbsm.com**. If you have questions regarding registration, email Patricia Scarlett at **pscarlett@bcbsm.com**.

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:

- New cataract codes for 2022 — modifier 55
- Reporting for observation by a professional provider
- Implantable cardiac defibrillators
- When screening colonoscopies become diagnostic

Clinical editing billing tips

AIM Specialty Health to update clinical guidelines for prostate cancer imaging

Starting March 13, 2022, AIM Specialty Health® will publish updated oncologic imaging clinical guidelines for prostate cancer to include indications for 18FDCFPyL (piflufolastat injection or Pylarify®) PET/CT imaging (radiology procedure code *78815).

In the future, these scans will be available for you to select when you submit prior authorization requests to AIM.

Until you're able to select these scans, use the free text field in the prior authorization request and:

- Enter "PET w/ Pylarify, tumor stage and prior treatment (prostatectomy and/or radiation)."
- List the conventional imaging that has been completed (MRI prostate/pelvis, CT or bone scan) and the results of those procedures.

This applies to the following members:

- Blue Cross commercial
- Medicare Plus Blue℠
- Blue Care Network commercial
- BCN Advantage℠

Where to find AIM's clinical guidelines

You can find AIM's clinical guidelines for oncologic management at **aimspecialtyhealth.com/**. Open the **Radiology Guidelines** webpage and search for "Oncologic Imaging." Then scroll to find the Prostate Cancer guidelines.

Submitting prior authorization requests

Submit prior authorization requests to AIM. For information on how to submit requests and for other resources, visit these webpages on our ereferrals.bcbsm.com website:

- **Blue Cross AIM-Managed Procedures**
- **BCN AIM-Managed Procedures**

Starting March 1, radiology procedure code 71271 requires prior authorization for most members

Prior authorization is required by AIM Specialty Health® for radiology procedure code *71271 to ensure that claims are eligible for reimbursement.

This is effective for dates of service on or after March 1, 2022, and applies to the following members:

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

Services associated with this procedure code already require prior authorization for most Blue Cross commercial members.

Submitting prior authorization requests

Submit prior authorization requests to AIM. For information on how to submit requests and for other resources, visit these webpages on our **ereferrals.bcbsm.com** website:

- **Blue Cross AIM-Managed Procedures**
- **BCN AIM-Managed Procedures**

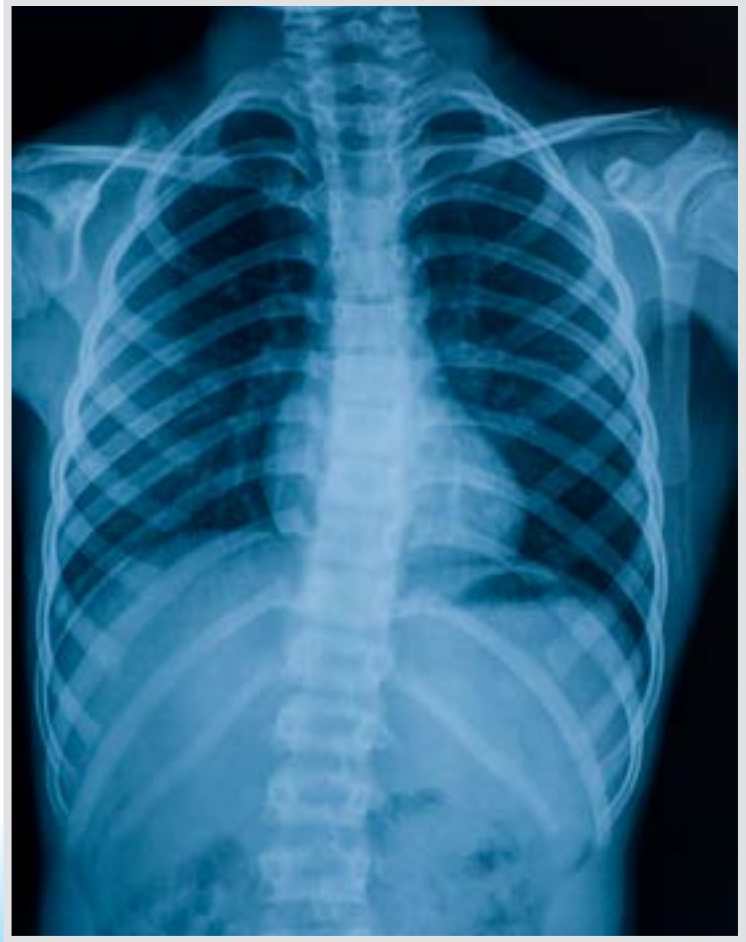
We've updated the list of **Procedures that require prior authorization by AIM Specialty Health** to reflect this requirement.

Additional information

As a reminder, AIM manages authorizations for various Blue Cross commercial, Medicare Plus Blue, BCN commercial and BCN Advantage members for these services:

- Select cardiology and radiology services
- Medical oncology and supportive care drugs
- High-tech radiology
- In-lab sleep management
- Radiation oncology

AIM Specialty Health is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage authorizations for select services.



Updated questionnaires open in the e-referral system

We updated the following questionnaires in the e-referral system in December:

- *Gastric stimulation* — For adult Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠ members. This questionnaire opens for the following additional procedure codes: *95980, *95981 and *95982.
- *Varicose vein treatment* — For adult BCN commercial and BCN Advantage members. This questionnaire opens for the following additional procedure codes: *36465 and *37700. It will no longer open for *36469.

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** to help 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 pages.

Changes to the musculoskeletal procedure codes that require authorization through TurningPoint

We updated the list of **Musculoskeletal procedure codes that require authorization by TurningPoint** to reflect the following changes.

Procedure codes that no longer require authorization

For dates of service on or after Jan. 1, 2022, the following procedure codes no longer require prior authorization: *63194, *63195, *63196, *63198 and *63199. The American Medical Association retired these codes.

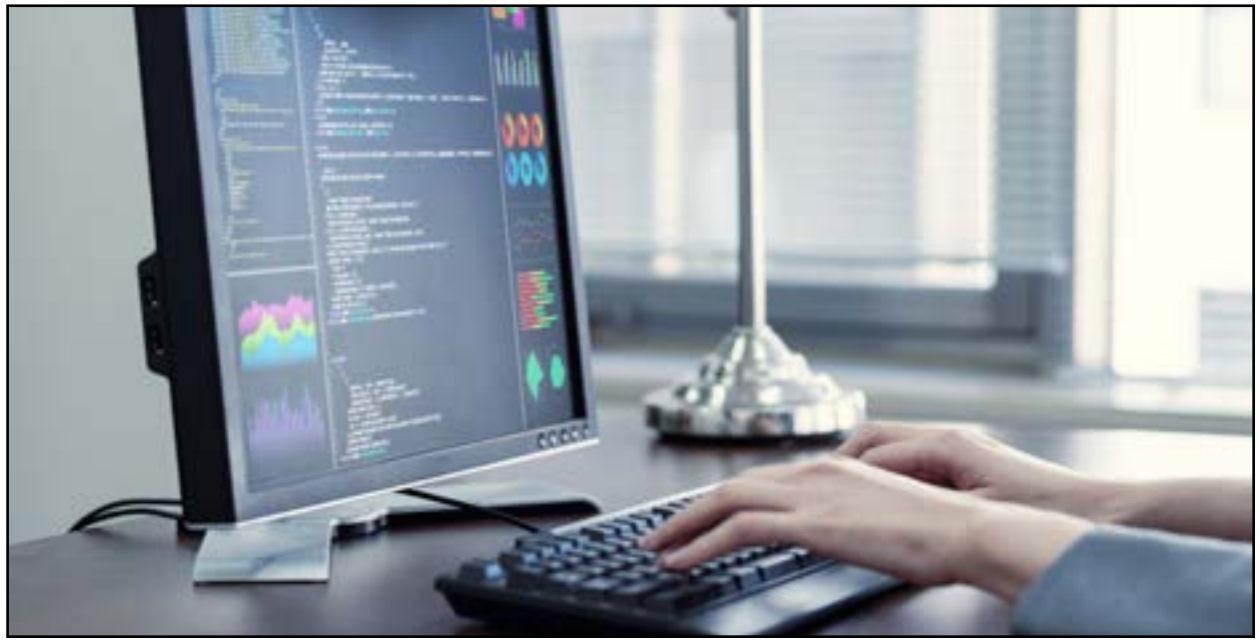
Additional procedures codes that will require prior authorization

For dates of service on or after March 27, 2022, the following procedure codes will require authorization through TurningPoint Healthcare Solutions LLC.

- **For Blue Cross commercial:** *63052 and *63053
- **For Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ members:** *0656T, *0657T, *0707T, *63052, *63053, *64628 and *64629

Additional information

TurningPoint Healthcare Solutions LLC is an independent company that manages authorizations for musculoskeletal surgical and other related procedures for Blue Cross Blue Shield of Michigan and Blue Care Network. For more information about TurningPoint, see the Musculoskeletal Services pages of our **ereferrals.bcbsm.com** website.



Referral Roundup

Updated *TurningPoint Documentation Guideline* for musculoskeletal procedures and related services

TurningPoint Healthcare Solutions LLC has updated the ***TurningPoint Documentation Guideline*** for musculoskeletal and related services.

TurningPoint made the following changes:

- Categorized the information within the document to make it easier to find what you need
- Clarified criteria related to body mass index and smoking cessation
- Clarified imaging requirements
- For joint replacement procedures due to arthritis, added the following grading scales and descriptive criteria:
  - Kellgren-Lawrence Radiographic Grading Scale of OA
  - Tonnis Grading Scale of Hip Osteoarthritis

The updated document is available on the following pages of our **ereferrals.bcbsm.com** website:

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

Documents in naviHealth's nH Access portal are only available for 30 days

Documents for Medicare Plus Blue℠ PPO and BCN Advantage℠ members are available within naviHealth's nH Access™ portal for only 30 days from the day they were posted. This was effective Feb. 11, 2022.

See the article on **Page 12** for details

Reminder: Get easy access to information about our care management and utilization management programs

In November 2021, we published the **Care management and utilization management programs: Overview for providers** document to help you navigate our care management and utilization programs more easily. Since then, we've updated the document — and the documents it links to — to reflect changes that went into effect on Jan. 1, 2022. See the article on **Page 22** for details.

Advantages of using the e-referral system for prior authorization requests

Using the e-referral system is the most efficient way to submit a prior authorization request for services managed by the Blue Cross Blue Shield of Michigan and Blue Care Network Utilization Management departments. It's also the easiest way to check the status of a request you've submitted.

Submitting a request

Here are some advantages to using the e-referral system to submit prior authorization requests:

- Requests that involve a questionnaire and that meet criteria can be automatically approved through e-referral, with no waiting.
- Utilization Management department phones are busy. Using e-referral is the best way to submit a prior authorization request quickly. No waiting on hold.
- The e-referral system is available anytime, day or night. While it's best to submit prior authorization requests before the service is performed, the request can be submitted anytime using e-referral.
- Required clinical documentation can be attached to authorization requests in the e referral. No need to fax it.
- Using e-referral instead of faxing speeds up these tasks:
  - Requesting extensions of approved authorization requests
  - Requesting continued stays
  - Submitting discharge dates

Checking the status of a request

You can use the e-referral system to check the status of a request you've submitted. The status of the request will be one of these:

- Pending decision
- Fully approved
- Partially approved
- Denied
- Voided

You can see the case status in the dashboard, in the Status column. The case status is also visible when the case is opened, at the upper left of the screen.

Additional information

For additional information on using e-referral, refer to the **e-referral User Guide**.

For information about registering for access to the e-referral system, refer to the **Sign up or Change a User** webpage.

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