MAY-JUNE 2022

BCN Provider News

BCN Provider News User Guide

Notice: Last day for Provider Secured Services and web-DENIS is June 21

It's official. Blue Cross Blue Shield of Michigan and Blue Care Network's Provider Secured Services and web-DENIS will have their last day of operation on June 21. Beginning June 22, these tools will no longer be available.

Don't worry. Making the move to Availity Essentials is easy. Here are our recommended steps. We encourage you to take these steps now.

1. **Register** — If you're not already registered with Availity, do so now. Here's how:
   a. **Select an Availity administrator** — This individual must register your organization on Availity. Resources include:
      i. ***Register and Get Started with Availity Essentials*** — This webpage offers registration training and job aids to help your office administrator with the registration process.
      ii. ***Register for access*** — This is where your office administrator registers for Availity access.
   b. **Set up users** — Once registered, your Availity administrator can add your users and set up their user roles.
   c. **Set up e-referral and Health e-Blue℠** — The Availity administrator must also set up access to the e-referral and the Health e-Blue tools. See *Availity administrators: Ensure access to e-referral and Health e-Blue tools within Availity*, **Page 5**.

Please see Provider Secured Services and web-DENIS continued on Page 2

Need help?

Here's where you can find it:

- Call Availity Client Services at **1-800-AVAILITY** (282-4548) Monday through Friday, 8 a.m. to 8 p.m. Eastern time (excluding holidays).
- Within Availity, click on *Help & Training* and then click on *Availity Support*.
- ***Welcome to Availity special edition newsletter***
- ***Welcome to Availity webpage***
- ***Transitioning to the Availity provider portal frequently asked questions for providers***

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Network Operations

Provider Secured Services and web-DENIS, *continued from Page 1*

2. **Train** — Whether you're already familiar with Availity or you're a new user, take advantage of the webinars and recordings available to help you find the Blue Cross and BCN information you need quickly within Availity. Use the ***Get up to Speed with Training website*** to find the trainings you need.
3. **Enjoy** — Once you've been trained, we're sure you'll find it fast and easy to find the information you need when you need it.

Providers score Blue Cross high on our commitment to health and providing support for patient care

Blue Cross Blue Shield of Michigan and Blue Care Network received high marks from providers and office staff on many elements of their experiences with us, including the value of provider network participation, our commitment to improving health care in Michigan and the support we offer to help deliver patient care.

But they want us to do more to enhance their understanding of which procedures need authorization. Physicians also want to have input into new programs and policies that affect patient care.

What you need to know

- We surveyed providers and office staff to understand the key elements of their experiences with us.
- Blue Cross outperforms other insurers on all experience measures; BCN is on par.
- Providers were satisfied with our efforts to improve health care in Michigan.
- Providers and office staff identified operational areas where we can do better.

Blue Cross outperforms other insurers on all experience measures, and Blue Care Network is on par with competitors, according to our recent provider and office staff surveys. At least seven in 10 providers are satisfied with the metrics below.

For providers, the highest ratings were for the overall relationship with Blue Cross and Blue Cross' demonstrated commitment to improve health and health care in Michigan and the value of participating in the provider network.

- Seventy-six percent of providers said they were somewhat or very satisfied (score of 6 through 10 on a 0 to 10 scale) with the value of participating in the provider network.
- Seventy-three percent of providers were very satisfied with our dedicated commitment to improve health and health care in Michigan.

Please see Providers score Blue Cross high continued on Page 3

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Network Operations

Providers score Blue Cross high, *continued from Page 2*

- Seventy-four percent of providers were very satisfied in their overall relationship with Blue Cross.
- Seventy-three percent of providers were very satisfied with the ease of doing business with Blue Cross.
- Seventy-one percent of providers were somewhat or very satisfied with the overall support Blue Cross provides to help deliver patient care.
- Sixty-five percent of providers were somewhat or very satisfied with the support and resources during the pandemic.
- Seventy-one percent of providers said they were somewhat or very satisfied with the direction Blue Cross is headed for the future.

By comparison, other health plans in Michigan scored in the range of 50% to 60% satisfaction on the above statements.

Physicians want a partnership

Physicians want to have a say in the strategic decisions Blue Cross is considering when it will affect patient care and they want fair compensation. Gathering feedback from research efforts is one way that we're listening to providers.

- Fifty-four percent of providers agreed or strongly agreed that Blue Cross trusts their expertise as a medical doctor.
- Forty-nine percent of providers somewhat or strongly agree that Blue Cross is a partner to their practice by providing tools and support to provide quality care to their patients.
- Fifty-five percent of providers somewhat or strongly agree that Blue Cross provides fair compensation.

Provider Inquiry can be improved

Long wait times for provider inquiry help are a primary concern for office staff.

Only 25% of office staff respondents agree that Provider Inquiry has gotten somewhat or much better in the last 12 months. However, 80% of office staff were somewhat or very satisfied that Provider Inquiry information is accurate regarding patient eligibility and benefits.

In addition:

- Sixty-nine percent of office staff said they were somewhat or very satisfied with the ease of finding accurate patient eligibility and benefits information.
- Sixty-three percent of office staff said they were somewhat or very satisfied with representatives' ability to resolve issues and concerns.

Prior authorizations

Understanding when prior authorizations are required is an ongoing pain point for physicians and office staff.

Fifty percent of Blue Cross providers and office staff somewhat or strongly agree that they know when prior authorization is required; the percentage was 45% for BCN.

Nearly half (47%) of physicians and office said they understand Blue Cross prior authorization and medical criteria. The rate was somewhat lower (43%) for BCN. And approximately one-third (31%) of office staff respondents said it was easy to determine which medical services require authorization.

Our move to Availity

Providing extra support and education around the benefits of Availity may ease hesitancy about the switch from web-DENIS.

Among those who have experience with Availity, six in 10 are satisfied, while others are hesitant to switch from web-DENIS to Availity.

Please see Providers score Blue Cross high continued on Page 4

Network Operations

Providers score Blue Cross high,

continued from Page 3

To help with the transition to Availity, we've provided communications in our newsletters for the past year and have recently posted a **special edition newsletter** on March 16 all about Availity, how to register and how to access training.

Survey methodology

Here's how we conducted the survey

We conducted 10-minute surveys among Blue Cross physicians and office staff, administered by an independent firm.

- Physicians completed the survey online and were sent invitations by email and fax. Additional reminders were sent by fax as well.
- Invitations for office staff were sent by mail, offering the option to complete online or by mail. Postcard reminders were also sent.
- The physician survey was open from November 9 through December 22, 2021.
- The office staff survey was open from November 12, 2021, through January 3, 2022.

A total of 428 physicians and 283 office staff completed a survey.

Check out our new secure Provider Resources site

When you move to our new provider portal, you'll find that there's a new website for resources. Information you used to find on either the BCBSM Newsletters and Resources or the BCN Provider Publications and Resources sections of web-DENIS are now combined into a single location, the secure Provider Resources website. Here you'll find provider manuals, alerts, forms, fee schedules and other helpful information.

To reach the website:

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* on the Availity menu bar.
3. Click the BCBSM and BCN logo.
4. Click *Secure Provider Resources (Blue Cross and BCN)* on the *Resources* tab.

Make it a favorite

You can "favorite" the secure Provider Resources link on the Resources tab by clicking the heart icon next to the title. When you make an item a favorite on our provider portal, you can then reach it from anywhere within the portal by clicking *My Favorites* at the top of the page. Any items you've marked as favorites throughout the portal will show up there for you to access with one click.

The secure Provider Resources site has been organized so that you can easily find the information you need. Tabs include:

- Alerts
- Authorizations
- Billing and Claims
- Fee Schedules
- Forms
- Member Care
- Products
- Publications

Filter by plan

Some pages, like those in the Forms and Alerts, have a filter at the top to make it easier for you to find what you're looking for. You can filter by:

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

You can now search

In the upper-right corner of the page, you'll find a search box, where you can search the site, including provider alerts. Enter your key words and click the magnifying glass. In the future, we plan to offer advanced search options.

We encourage you to explore the new site, designed to make the information you need easy to find.

Network Operations

Availity administrators: Ensure access to e-referral and Health e-Blue tools within Availity

Your Availity® administrator needs to take action to set up access to e-referral and (if appropriate) Health e Blue℠. This will ensure users can access these tools through Availity Essentials.

- The e-referral tool is used to submit requests for referrals and authorizations.
- The Health e-Blue tools provide patient health reporting on conditions, treatment opportunities, pharmacy claims, diagnosis gaps and more.

Each organization (office, practice or facility) must have at least one Availity administrator. Administrators handle access for other Availity users; users can't set up their own access. The provider alerts linked below describe how to identify the Availity administrator for your organization.

Be sure your Availity administrator sets up access to these tools for all users who need to obtain information for patients who have coverage through Blue Cross Blue Shield of Michigan and Blue Care Network.

If your Availity administrator doesn't take action, users of these tools won't be able to access them through Availity and they may receive error messages when they try.

To view step-by-step setup instructions for Availity administrators, see the following provider alerts:

- **Availity® administrators: Set up the e-referral tool within Availity**
- **Availity® administrators: Set up Health e Blue℠ tools within Availity**

The provider alerts contain the same information we published in the ***Welcome to Availity*** special edition newsletter, which was published in mid-March. See that newsletter for additional information about Availity.

The following videos also show the setup steps:

- ***Getting Started with e-referral on Availity Essentials***
- ***Getting Started with Health e-Blue on Availity Essentials***

Network Operations

Providers in the east, mid and southeast regions have a new email box to reach provider consultants

Blue Cross Blue Shield of Michigan and Blue Care Network want to make it easier and simpler for you to reach a provider consultant when you need to escalate a provider inquiry. To this end, providers in the east, mid and southeast regions now have a new email box to use: petcontactus@bcbsm.com.

The mailbox acronym stands for Provider Engagement & Transformation, or PET, and signifies how consultants want to engage with you and help ease, or transform, the way you do business with us.

When you send an email to this new mailbox, please include the following information:

- Your name
- Phone number
- NPI
- Provider or facility type (PCP, cardiologist, skilled nursing facility, physical therapist)
- Reference number from call with Provider Inquiry
- A detailed description of your issue or question

Your issue will be assigned to the appropriate provider consultant, and you'll receive status updates as your issue is resolved.

Please note that the first step continues to be contacting Provider Inquiry for any claim or benefit question. The new email box is for use when your issue is not resolved through Provider Inquiry.

Providers in the west and Upper Peninsula regions should continue to contact their assigned consultant directly if Provider Inquiry can't solve their claim or benefit issue. Have the Provider Inquiry reference number available when contacting a west or U.P. provider consultant.

1. Go to **bcbsm.com/providers**.
2. Click on *Help*.
3. Click on *Contact us*.
4. Use the "select a plan type" dropdown to select the line of business (*Blue Cross Blue Shield of Michigan, Blue Care Network, Vision provider or Dental provider*).
5. Use the "select a topic" dropdown to select *Provider consultants*.

Providers must comply with access and availability guidelines

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

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

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

To find the manual:

- Go to **Availity**.
- Click on *Blue Cross/BCN*.
- Go to Payer Spaces and click on *Resources*.
- Scroll down to Provider manuals.

Network Operations

Action item

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

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:

- Provider training and resources guide for acupuncture providers — This quick guide reviews available training and resources for acupuncturists who treat Blue Cross Blue Shield of Blue Cross commercial, Medicare Plus Blue℠ PPO, Blue Care Network commercial and BCN Advantage℠ members.
- Transitions of Care recorded webinar — View our recent session about the Transitions of Care HEDIS® measure. The lesson focuses on measure requirements, medical record documentation and billing codes.

We would also like to remind you of a new course that launched last month:

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.

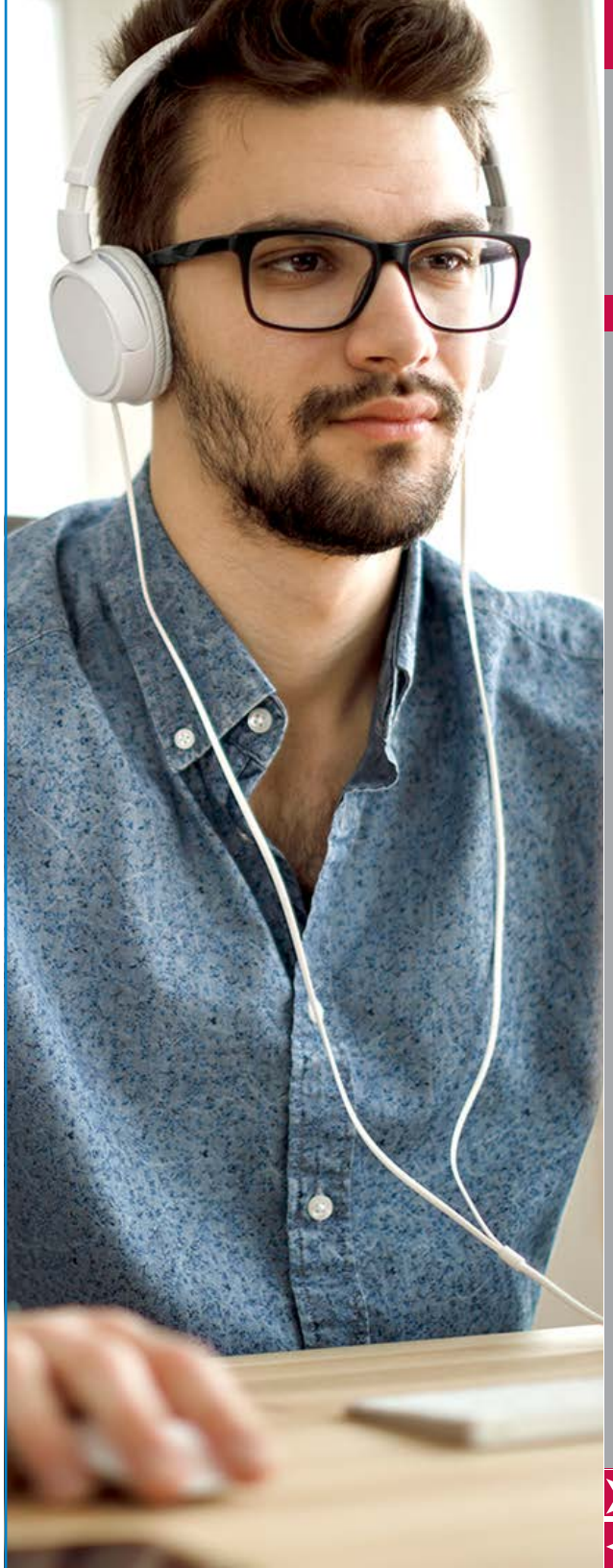
Our provider training site is available to enhance the training experience for health care providers and staff.

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, contact ProviderTraining@bcbsm.com.

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



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**
	Tuesday, May 10	Noon to 2 p.m.	**Register here**
	Thursday, May 19	2 to 4 p.m.	**Register here**
	Wednesday, May 25	2 to 4 p.m.	**Register here**
	Tuesday, May 31	Noon to 2 p.m.	**Register here**
	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**
	Tuesday, May 17	9 to 10:30 a.m.	**Register here**
	Tuesday, May 24	Noon to 1:30 p.m.	**Register here**
	Tuesday, June 7	Noon to 1:30 p.m.	**Register here**
	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.

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Five questions with Vanita Pindolia: What you can do to boost Medicare star ratings

In a November-December **article**, *Physician & Hospital Update reported about our 2022 Medicare star ratings performance. We wanted to get some additional information for our physicians and their staff, so we talked with Vanita Pindolia, our Medicare star ratings vice president.*

1. Can you give us a brief refresher of what star ratings are and how they're developed?

The Centers for Medicare & Medicaid Services developed the Medicare star ratings program to help consumers compare Medicare Advantage health plans based on quality and performance. CMS rates the quality of service delivered by health plans — and the care delivered by health care providers — using a 5-star rating scale, with 5 stars indicating the highest score. As you may recall, our 2022 star ratings performance was impressive, but there's always room for improvement.

2. How does CMS determine the ratings of a particular health plan?

There are approximately 40 measures in the star ratings framework, spanning the five star categories listed below. Each measure is assigned a weight, ranging from 1 to 4. As CMS assigns new weights to metrics each year, the impact of each category on the overall star ratings changes. For example, several years ago, the HEDIS® Category was weighted at 25% of overall star performance, but in 2021, it only represented 12% of the total rating as CMS placed a greater emphasis on metrics related to patient experience.

The ratings include measures that assess the perception that our members — your patients — have of their clinical experience, as well as operational measures. To best capture a range of quality metrics, CMS uses various data sets for each star category, including the following:

- **Healthcare Effectiveness Data and Information Set, or HEDIS®** — HEDIS data reflects the care delivered by providers and staff, as well as clinical outcomes.
- **Prescription drug event data** — This information is collected by health plans to provide insight into how providers are performing on prescription drug-related measures.
- **Consumer Assessment of Healthcare Providers and Systems, or CAHPS®** — This is an annual survey sent to a random sample of members every spring to measure their experience with their health plan, prescription drug plan, health care provider and office staff. The experience members have with their physicians comprises 50% of the overall CAHPS score. The data gleaned from the survey provides insight into members' perception of whether they have access to high-quality health care.
- **Health Outcomes Survey, or HOS** — This survey is sent every summer to a random sample of members to measure self-reported health status and the quality of their health care. A follow-up survey is sent to these same members two years later to measure any changes in health perception.
- **Operations data from health plans** — This information is used to assess the quality of customer service and other services health plans are providing to their members.

Please see Five questions with Vanita Pindolia continued on Page 10

Five questions with Vanita Pindolia,
continued from Page 9

3. What role can health care providers play in boosting our Medicare star ratings?

By providing high-quality care to patients in a timely manner, providers play a crucial role in our star ratings performance. There are various opportunities for providers to engage with patients to help ensure high-quality and timely care, while helping patients manage their health. Here are several steps provider practices can take to make a big difference in the health of their patients:

- Promote timely and appropriate screenings, tests and treatment.
- Provide education to staff members for proper documentation of care delivered.
- Strengthen patient-provider relationships through open communication regarding health care needs and quality of care.
- Work with patients on developing chronic condition care plans and coordinating care among all the other providers involved with the patient.
- Follow up with patients about medications and medication adherence.
- Assess timeliness of care and work with office staff to help ensure that patients can get appointments when they need them.

4. How can taking such steps benefit older patients?

These practices promote patient safety, preventive medicine, early disease detection and chronic disease management, all of which are especially beneficial for the Medicare Advantage population.

5. How can my staff and I find out more about star ratings measures?

I would recommend you check out our *Star Measure Tips*, a series of tip sheets on select star measures; they've been recently updated for 2022. You can find them by following these steps:

1. Log in to Availity.
2. Click *Payer Spaces* at the top of any Availity screen.
3. Click the *Resources* tab.
4. Click *Secure Provider Resources* (Blue Cross and BCN).
5. Go to Member care in the top navigation.
6. Click on *Clinical quality*.

We're ending the temporary suspension of clinical review requirements for admission to skilled nursing facilities

The temporary suspension of clinical review requirements for admission to skilled nursing facilities for all Michigan hospitals and for hospitals in certain other states ended on Feb. 28, 2022.

See article on **Page 34** for details.

BCN Advantage

Update: Nonclinical, transitional care program to reduce readmissions for Medicare Advantage members discharged directly to their homes

Last year, we announced that Blue Cross Blue Shield of Michigan and Blue Care Network had contracted with naviHealth to reduce avoidable inpatient readmissions through a nonclinical, transitional care program.

This program is available to Medicare Plus Blue℠ and BCN Advantage℠ members discharged from inpatient facilities in Michigan and is being implemented in two phases:

- The first phase was implemented Nov. 1, 2021. In this phase, naviHealth is supporting members discharged to certain post-acute care facilities in Southeast Michigan for up to 30 days after discharge.
- The second phase of the program will begin May 1, 2022. In this phase, naviHealth will support members who are discharged directly to their homes. (We previously communicated that this phase of the program would start on Feb. 1, 2022.)

For more detailed information about the nonclinical, transitional care program, see the November 2021 **Record article** or the November-December 2021 ***BCN Provider News* article**.

Enjaymo, Vabysmo and Byooviz require prior authorization for Medicare Advantage members

We've added prior authorization requirements for the following drugs covered under the medical benefit for Medicare Plus Blue℠ and BCN Advantage℠ members:

- **For dates of service on or after March 7, 2022:**
  - Enjaymo™ (sutimlimab-jome), HCPCS code J3590
  - Vabysmo™ (faricimab-svoa), HCPCS code J3590
- **For dates of service on or after June 6, 2022:**
  - Byooviz® (ranibizumab-nuna), HCPCS code Q5124

Submit prior authorization requests through the NovoLogix® online tool.

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.

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**.

BCN Advantage

For BCN Advantage members: Don't issue ABNs or bill with ABN modifiers

For BCN Advantage℠ members, follow **Medicare Advance Written Notices of Non-coverage (MLN006266)** guidelines related to advance beneficiary notices, or ABNs.

Here are the important things to know:

- **Don't** issue an advance written notice of noncoverage to BCN Advantage members for items and services you provide under Medicare Advantage (Part C) or the Medicare Prescription Drug Plans (Part D).

  Under Part C and Part D, you're not required to notify members before you provide items or services that are not Medicare benefits or that Medicare never covers.
- **Don't** bill BCN Advantage claims with modifiers related to ABNs. These modifiers are GA, GK, GL, GX, GY and GZ.

  Starting May 29, 2022, claim lines billed with these ABN modifiers will be denied and you'll have to resubmit those claim lines without the modifiers.

Additional information

You'll find additional information about advance beneficiary notices of noncoverage in the **Medicare Advance Written Notices of Non-coverage (MLN006266)** guidelines document.

Star tip sheets updated for 2022

We recently updated our Medicare Star Ratings tip sheets for 2022 and posted them in the member care section of *Secure Provider Resources* on Availity. The tip sheets were developed to assist health care providers and their staff in their efforts to improve overall health care quality and prevent or control diseases and chronic conditions.

The new tip sheets are up to date as of this publication. As updated versions are produced, we'll post the new ones and announce them in our newsletters. For example, after the National Committee for Quality Assurance publishes final updates to the 2022 HEDIS specifications, we may need to update the tip sheets again.

The *Star Measure Tips* highlight select measures in the Medicare star ratings program. Most of the measures featured in the *Star Measure Tips* are HEDIS measures. HEDIS is one of the most widely used performance improvement tools in the U.S.

Note: The Transitions of Care Tip Sheet was revised Feb. 1, 2022. Only refer to the tip sheet that was available after that date. All previous versions should be discarded.

Custom measure: A new tip sheet for 2022

A new tip sheet was developed for Medicare Wellness Visits. This tip sheet is intended to educate providers and their staff on Blue Cross Blue Shield of Michigan's new custom quality measure that was implemented in 2022.

Accessing the tip sheets

These *Star Measure Tips* and the new custom measure tip sheet are housed on the secure Provider Resources site in Availity. You can get there by following these steps:

1. Log in to Availity.
2. Click *Payer Spaces* at the top of any Availity screen.
3. Click the *Resources* tab.
4. Click *Secure Provider Resources* (Blue Cross and BCN).
5. Go to Member care in the top navigation
6. Click on *Clinical quality*.

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

Providers don't need to submit new authorization requests for Neulasta due to HCPCS code change

Providers who received an authorization from AIM Specialty Health® for Neulasta under HCPCS code J2505 **do not** need to submit a new authorization request due to the code change. The HCPCS code for Neulasta/Neulasta® Onpro® (pegfilgrastim) changed from J2505 to J2506 on Jan. 1, 2022.

See article on **Page 28** for details.

Carvykti requires prior authorization for Medicare Advantage members

For dates of service on or after March 7, 2022, Carvykti™ (ciltacabtagene autoleucel), HCPCS code J9999, requires prior authorization for Medicare Plus Blue℠ and BCN Advantage℠ members. Submit prior authorization requests using the NovoLogix® online tool.

For details, see the article on **Page 28**.

New HEDIS measure: Follow-up after an emergency department visit is important patient care

Many patients discharged from the emergency department require urgent follow-up care with their providers due to high-risk chronic conditions. Often, an emergency department discharge is based on the presumption of continued care.

The Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions is a new HEDIS® measure for star ratings. It focuses on the percentage of members 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.

There are many ways to conduct a follow-up visit, including outpatient, telephone, transitional care management, case management, complex care management, outpatient or telehealth behavioral health, intensive outpatient encounter or partial hospitalization, community mental health center, electroconvulsive therapy, telehealth, observation, e-visit or virtual check-in.

Read the tip sheet to learn more about this measure, including information about eligible chronic conditions, exclusions, best practices, documentation requirements and more.

Follow-up After Emergency Dept. Visit

Revised HEDIS measure focuses on helping prevent unnecessary hospital readmissions

According to the Centers for Medicare & Medicaid Services, readmission to the hospital within 30 days of discharge is frequently avoidable and can lead to adverse patient outcomes and higher costs.

The Plan All-Cause Readmissions HEDIS® measure assesses the percentage of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. This is a returning measure to the program for 2022.

Coordinating care from the hospital to home and ensuring a follow-up visit with the primary care physician can help your patients avoid a readmission.

Read the tip sheet to learn more about this measure, including information about exclusions, best practices and tips for success while talking with patients.

Plan All-Cause Readmissions

BCN Advantage

Importance of statin therapy for patients with cardiovascular disease and diabetes

Cardiovascular disease is the leading cause of death in the United States. It's estimated that 92.1 million American adults have one or more types of cardiovascular disease (Benjamin et al., 2017). People with diabetes also have elevated cardiovascular risk, thought to be due, in part, to elevations in unhealthy cholesterol levels. Having unhealthy cholesterol levels places people at significant risk for developing atherosclerotic cardiovascular disease.

American College of Cardiology and American Heart Association guidelines state that statins of moderate or high intensity are recommended for adults with established clinical ASCVD. The American Diabetes Association and ACC/AHA guidelines also recommend statins for primary prevention of cardiovascular disease in patients with diabetes, based on age and other risk factors. Guidelines also state that adherence to statins will aid in ASCVD risk reduction in both populations.

The Centers for Medicare & Medicaid Services has two star measures to support statin therapy's importance. To learn more about these measures, read these tip sheets:

- **Statin Therapy for Patients with Cardiovascular Disease (SPC)**
- **Statin Use in Persons with Diabetes (SUPD)**

Source: Statin Therapy for Patients With Cardiovascular Disease and Diabetes - NCQA

[1]Benjamin, E.J., et al. 2017. "Heart disease and stroke statistics-2017 update: a report from the American Heart Association." Circulation 135(10): e146–e603. doi:10.1161/CIR.0000000000000485.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Statin Use in Persons with Diabetes (SUPD)

Transitions of Care HEDIS measure focuses on medication management and care coordination for Medicare beneficiaries

According to the *American Journal of Managed Care*, the ineffective transferring of a patient from one care setting (for example, a hospital, nursing facility, primary care physician, long-term care, home health care, specialist care) to another often leads to confusion about treatment plans, missed follow-up appointments, patient dissatisfaction, medication nonadherence and, most importantly, unnecessary readmissions.

The Transitions of Care HEDIS® measure for star ratings focuses on the percentage of members 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

Documentation of all four components must be in any outpatient record and accessible by the primary or ongoing care provider.

We encourage you to establish an office practice that explains to patients why it's critical they inform your office about their hospital admissions and discharges. Let them know this is important because it can improve their care coordination and maintain their safety.

Read the tip sheet to learn more about the measure, including exclusions, best practices and documentation requirements.

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

Source: American Journal of Managed Care
Contributor: Why Medicare Advantage Plans Must Transform Post Discharge to Medication-Focused Transitions of Care (ajmc.com)

Transitions of Care tip sheet

Blue Cross advances efforts to transform care delivery, including support for physicians

For nearly 20 years, Blue Cross Blue Shield of Michigan has worked closely with health care providers to make meaningful improvements in the quality and affordability of care.

We've done this through such innovative initiatives as the Physician Group Incentive Program, Patient-Centered Medical Home, Collaborative Quality Initiatives and Blueprint for Affordability — all of which provide reimbursement models that reward quality and outcomes.

Despite the many successes of our joint efforts with health care partners, we recognize that we need to do even more to ensure our members get the personalized care they need — in the right setting at the right time, at the right cost. We believe value-based care models will best enable these goals and recognize we need to do more to support physicians and help them be successful in these types of arrangements.

"While the health care industry continues to experience rapid change, health plans and providers are increasingly accountable for member outcomes, cost of care and the overall experience," said Daniel J. Loepp, Blue Cross president and CEO. "Blue Cross is addressing these expectations through stronger partnerships with our providers and working more proactively and directly with our members."

We're helping to meet these needs by further advancing value-based care models and transforming the way care is delivered to members. And we're evaluating opportunities that:

- Build on our existing foundation of value-based programs
- Offer new solutions to meet the needs of specific segments of the population
- Partner with providers to deliver the support they need to be successful in value-based reimbursement programs

New solutions

We began implementing several elements of this strategy last year. Here are three examples of our efforts to develop, deploy and manage new targeted solutions to meet the needs of providers and specific segments of the population:

- **Helping to reduce the administrative burden of health care providers to enable success in value-based arrangements** — We announced the acquisition of a management services organization in August. The MSO works with specialists to deploy clinical pathway tools and practice transformation efforts to ensure success in value-based care payment models. In addition, they offer practice management solutions, billing and payment services, and care management tools that help practices track and monitor patients' health and coordinate their care, allowing physicians and their staff more time to spend on patient care.
- **Assisting members who need integrated, in-home care** — We joined forces with Landmark Health to launch a high-intensity, in-home care program for members with multiple chronic conditions. The program offers care management, behavioral health care, medication management, 24/7 nurse triage and urgent care services to complement office-based primary care.
- **Ensuring care for residents who live in underserved areas** — We partnered with Dedicated Senior Medical Centers, a subsidiary of ChenMed, to establish six new primary care centers in underserved areas of Metro Detroit. The clinics will provide health care for moderate- to low-income seniors who have complex chronic conditions.

Please see Blue Cross advances efforts to transform care delivery continued on Page 16

Blue Cross advances efforts to transform care delivery,

continued from Page 15

"Using deep understanding of member needs, we've identified areas where opportunities to offer new care models exist," said James Grant, M.D., Blue Cross senior vice president and chief medical officer. "Now we're developing partnerships and programs that offer defined patient populations more targeted care. This should result in better overall health for our members and reduced costs for our customers."

He added that Blue Cross is committed to offering physicians and their staffs the tools they need to:

- Identify and close gaps in care
- Coordinate care across the health care spectrum
- Support practice transformation for success in value-based care models

Market demands

These efforts allow us to stay ahead of shifting demands in the market as we develop and offer solutions that reflect customer and member preferences, such as:

- A continued push for evolved value-based care models
- A shift in member preferences toward more convenient, cost-effective sites

"Blue Cross is well-positioned within the industry to facilitate improvements in care delivery and payment models," said Todd Van Tol, Blue Cross executive vice president, Health Care Value. "We have comprehensive insight into members' needs. And our strong foundation of collaboration with health care providers allows us to work together to implement new strategies and partnerships efficiently."

Additional partnerships and programs will launch later this year, and the care delivery strategy will evolve over time in relation to the shifting needs of our members and customers.

"This is a long-term strategy," Van Tol added. "We'll continually work to understand member needs and monitor market conditions so we can provide care delivery models to support our population."

Update: EMS providers can be reimbursed for administering monoclonal antibody COVID-19 infusions in any location

Blue Cross Blue Shield of Michigan and Blue Care Network are reimbursing EMS providers for monoclonal antibody COVID-19 infusions administered in any location retroactive to the effective date of the pertinent HCPCS code.

Previously, we reimbursed EMS providers for this service only when the infusions were administered in members' homes, as we communicated in July 2021.

For the most current list of billing codes, payment allowances, effective dates and descriptions for currently authorized monoclonal antibody products, see the **Monoclonal Antibody COVID-19 infusion webpage** on **cms.gov**.

For information about enrolling as a mass immunizer for Medicare Advantage members, see the **Enrollment for Administering COVID-19 Vaccine Shots page** on **cms.gov**.

Reminder: You'll receive a clinical edit for vitamin D testing when it doesn't meet CMS criteria

Blue Care Network supports the appropriate screening for vitamin D deficiency in individuals at risk. As a reminder, BCN implemented a clinical edit effective July 1, 2021, related to vitamin D testing. This edit is in accordance with the Centers for Medicare & Medicaid Services and outlined in their ***Billing and Coding: Vitamin D Assay Testing (A57484)*** article. Any claims submitted with diagnoses and other criteria not listed in the article receive the clinical edit. The claim rejects and the provider is liable for payment of the test.

If you receive an edit, you may submit a clinical editing appeal with documentation supporting the clinical need for ordering the test. Instructions on submitting clinical editing appeals can be found in the January-February 2022 ***Clinical editing billing tips*** **document**.

Information about the vitamin D testing clinical edit was previously published in the **May-June 2021** ***BCN Provider News*** and **July-August 2021** ***BCN Provider News***.

Behavioral health resources to discuss with your patients

We recently published a new document titled ***Behavioral health resources to discuss with your patients***.

The document includes information about the following behavioral health resources:

- The behavioral health phone numbers for Blue Cross Blue Shield of Michigan and Blue Care Network
- Resources available at **bcbsm.com/behavioral-mental-health**
- Online therapy
- Local and national behavioral health crisis resources

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

- **Blue Cross Behavioral Health**
- **BCN Behavioral Health**

Blue Distinction Centers for Substance Use Treatment and Recovery program expands

Blue Cross Blue Shield of Michigan has taken numerous actions over the past several years to battle the national opioid crisis. We've also worked closely with the Blue Cross and Blue Shield Association on developing the Blue Distinction® Centers for Substance Use Treatment and Recovery program, which we wrote about most recently in an **article** in the May-June 2021 issue of *Physician & Hospital Update*.

Since then, the Blue Distinction® Centers for Substance Use Treatment and Recovery program has expanded from three designated treatment facilities in Michigan to 14.

The national Blue Distinction Centers for Substance Use Treatment and Recovery program aims to improve patient outcomes and value by focusing on the treatment of substance use disorders, including opioid use disorder. Facilities with residential, inpatient, intensive outpatient or partial hospitalization services are considered for this designation.

A growing issue

"Substance misuse was a growing issue in our communities prior to COVID, as the number of overdoses grew year after year. Unfortunately, the stressors of COVID only made the situation worse. It's critically important that we all fight against the stigma and encourage our loved ones to get the help and support that they need," said Michelle Fullerton, senior director, group customer advocate.

"We have heard stories of nonaccredited treatment centers that lure patients and families into a program that delivers poor results and large bills. With the Blue Distinction designation, we can reassure our members and employer groups that they are accessing a program that has met national accredited standards of care."

There are currently 367 designated providers across 42 states. To receive this designation, treatment facilities must offer:

- Multidisciplinary, coordinated care
- Medication-assisted treatment and other evidence-based therapies
- Nationally accredited care that recognizes specific quality standards and value-focused care

This highly respected designation acknowledges the expertise providers have demonstrated, their commitment to improving quality and affordability, and their delivery of timely, coordinated, multidisciplinary, evidence-based care with a focus on quality improvement and patient-centered care.

For more information

- To learn more about Blue Distinction Specialty Care and for a complete list of designated facilities in 11 areas of specialty, including substance use treatment and recovery, visit **bcbsm.com/bluedistinction**.
- For a look at Blue Cross Blue Shield of Michigan's strategy and efforts to battle the opioid epidemic, see our **flyer**.
- Our Behavioral and Mental Health **website** is a good source of information for your patients who may be struggling with mental or behavioral health challenges.

Patient Care/ Quality

Criteria corner

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

The following is intended for Acute Adult Inpatient reviews for the General Surgical subset for complex wound care.

Question:

What would be considered a complex wound?

Answer:

The note attached to the complex wound criteria defines complex wound care as "when a patient requires care at the acute level, such as high frequency wound care required, prolonged length of time required performing the procedure and the type or amount of medication required to keep the patient comfortable during the procedure."

Question:

What does it mean by the criteria points: greater than or equal to three times in 24 hours and greater than 30 minutes in duration?

Answer:

Wound care greater than three times in 24 hours means there must be at least three dressing changes per day to satisfy the criteria point. Greater than 30 minutes in duration means the dressing change itself must take at least 30 minutes to complete.

Medical policy updates

Blue Care Network's medical policy updates are posted on **bcbsm.com/providers**. To find them:

1. Go to **bcbsm.com/providers**.
2. Click *Resources*
3. Scroll to "Looking for medical policies?" and click *Search medical policies.*

Recent updates to the medical policies include:

Covered services

- Knee scooters — crutch substitute
- Genetic testing and counseling
- Ambulatory event monitors and mobile cardiac outpatient telemetry
- Assisted reproductive techniques
- Laser interstitial thermal therapy
- Phrenic nerve stimulation and diaphragm pacing
- Pneumococcal conjugate vaccine 15-valent (VAXNEUVANCE™)
- Pneumococcal conjugate vaccine 20-valent (PREVNAR 20™)
- Prenatal (fetal) surgery for diagnosed malformations
- Genetic testing — carrier screening for genetic diseases
- Cryoablation of tumors located in the kidney, lung, breast, pancreas, or bone
- Cosmetic and reconstructive surgery
- Meniscal allografts and other meniscal implants
- Transcatheter mitral valve procedures

Noncovered services

- Peripheral subcutaneous field stimulation and peripheral nerve stimulation
- Autologous platelet-derived growth factors as a treatment of wound healing and other non-orthopedic conditions
- Miscellaneous and genetic and molecular diagnostic tests
- Prostatic artery embolization (PAE) for benign prostatic hypertrophy (BPH)
- Serologic genetic and molecular screening for colorectal cancer

Medical Policy Updates

It's now easier to find medical policies

We've made it easier to find medical policies on our public website, **bcbsm.com/providers**. And you don't even need to log in.

- Go to **bcbsm.com/providers**.
- Click *Resources* in the top navigation.
- Scroll down to "Looking for medical policies?" and click *Search medical policies.*

Try our new search feature

We added a search feature that allows you to search by keywords (for example, transplant, heart transplant) or by CPT code. You can put up to two CPT codes in the search box.

If you're already in the Availity provider portal, you can find medical policies by navigating to *Payer Spaces*. Then:

- Click our logo.
- Click the *Resources* tab.
- Click *Secure Provider Resources.*
- Click *Billing and Claims.*
- Scroll down to medical policies.

Blue Care Network promotes continuity of care in some situations

Continuity of care services are available for the following members:

- Blue Care Network members whose primary care physician, specialist or behavioral health provider voluntarily or involuntarily disaffiliates from BCN
- New Blue Care Network members who require an ongoing course of treatment

Members can't see their current physician if that physician was terminated from BCN for quality reasons. In this instance, the member is required to receive treatment from an in-network provider.

BCN provides continuity of care notification to members at least 30 days prior to the practitioner's termination date.

BCN permits the member to continue treatment in the situations described below provided that the practitioner:

- Continues to accept as payment in full, reimbursement from BCN at rates applicable prior to the termination
- Adheres to BCN standards for maintaining quality health care and provides the necessary medical information related to the care
- Adheres to BCN policies and procedures regarding referral and clinical review requirements

Primary care physicians may offer continuity of care for a member in the situations described in the table below. Specialty providers may offer continuity of care for a member receiving an ongoing course of treatment in the situations described in this table.

Situation	Length of continuity of care
General care	Up to 90 days after the practitioner's termination date.
This pregnancy	Through postpartum care directly related to the pregnancy.
Terminal illness	For the remainder of the member's life for treatment directly related to the terminal illness, if the member was being treated for the terminal illness prior to the practitioner's disaffiliation.

An active course of treatment is defined as:

- An ongoing course of treatment for a life-threatening condition: A disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted
- An ongoing course of treatment for serious acute condition: A disease or condition requiring complex ongoing care, which the covered person is currently receiving, such as chemotherapy, postoperative visits or radiation therapy
- An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes
- Pregnancy through the postpartum period

A disaffiliating physician who wishes to offer a member continuity of care in accordance with the conditions of payment and BCN policies must notify BCN and the member who desires approval of continuity of care.

Providers may contact BCN's Care Management department at **1-800-392-2512** to arrange for continuity of care services.

Members should contact Customer Service by calling the number on the back of their member ID card.

A nurse provides written notification of the decision to the member and practitioners.

Newly enrolled members must select a primary care physician before requesting continuity of care services and within the first 90 days of their enrollment.

Blue Care Network promotes coordination of care between practitioners

Blue Care Network has a process to promote continuity and coordination of care among specialists and primary care physicians and behavioral health and primary care physicians.

We encourage all heath care providers to continue to enhance the coordination of care and bidirectional information exchange across the continuum of care among specialists, behavioral health providers and primary care providers, to improve member satisfaction and quality of care.

We collect and analyze data each year to assess the exchange of information between specialists, behavioral health and primary doctors following both inpatient and outpatient consultations. Many studies have identified fragmentation of care as a problem in the medical system.

The information we collect is important as we work to improve continuity and coordination of care within our network.

Patient care that isn't coordinated between providers and across settings confuses members and increases risks to patient safety due to errors and unnecessary costs due to duplicate testing. The collaboration between practitioners can greatly improve both member satisfaction and health outcomes.

Our goal for exchange of information between the specialist and the primary doctor is 100%. This goal can be accomplished by ensuring that the specialist has the correct primary care provider information at the time of the visit and by forwarding the post visit information to the primary care provider.

We encourage all providers to continue to take steps to enhance the information exchange across the continuum of care.

Medical record guidelines policies require providers to maintain member records

Blue Cross Blue Shield of Michigan and Blue Care Network have a policy for content of medical records to ensure clinical records are maintained for each of our members and organized in a manner that facilitates easy access for reviewing and reporting purposes. The medical record should be stored or electronically secured to comply with HIPAA regulations.

Content of the medical record should include:

- Member demographics
- Health assessment
- Reason for visit
- Diagnosis
- Documentation of discussion about the following: advanced directives, preventive health and health maintenance, patient education, follow-up plan, consultation review and referred services review

Our medical recordkeeping policies support Centers for Medicare & Medicaid Services and National Committee for Quality Assurance standards and contain elements from the Michigan Quality Improvement Consortium Guidelines.

Quality management coordinators in our Quality Management department conduct medical record reviews of our contracted health providers for a variety of reason including, but not limited to, member complaints, identified deficiencies during a site visit, member surveys, suspicion of fraud, waste or abuse, or random reviews to monitor compliance with established standards for adequacy of medical recordkeeping.

The performance expectation is an overall score of at least 80%.

Information regarding screening guidelines can be found on the **MQIC** website.

Clarification: Billing for IOP services provided by telemedicine for some members

For behavioral health IOP services provided through telemedicine with dates of service on or after Oct. 1, 2021, bill revenue code 0905 or 0906, the applicable procedure code, and modifier GT or 95. We use these modifiers to identify IOP services that are delivered by telemedicine.

Follow this guidance when billing for behavioral health IOP services provided to Blue Cross commercial, BCN commercial and BCN Advantage℠ members by telemedicine. For information about billing IOP services provided to Medicare Plus Blue℠ members by telemedicine, follow guidance from the Centers for Medicare & Medicaid Services.

What you need to know

The information in this message is intended to clarify billing instructions for intensive outpatient program, or IOP, services provided through telemedicine. We originally communicated about this in a web-DENIS message that was posted Sept. 17, 2021, and in a November-December 2021 BCN Provider News **article**.

Important

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

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

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

You can find these documents on our public website at **bcbsm.com/coronavirus**.

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

Quality corner: Michigan Quality Improvement Consortium Clinical Practice Guidelines

The Michigan Quality Improvement Consortium publishes clinical practice guidelines for various medical and behavioral health disorders; they're 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 other medical conditions, such as diabetes, that may be comorbid with behavioral health disorders. There's also a recent guideline on opioid prescribing (excluding palliative and end-of-life care). The MQIC guidelines are intended for behavioral health practitioners and 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

Opioid prescribing

Prescribing guideline update alert

Opioid prescribing in adults (excluding palliative and end-of-life care) guideline

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 **mqic.org**.

Purchasing and billing for Spravato

We've developed a document with information about Spravato® that we think you'll find useful.

See the document titled **Spravato: Purchasing and billing information** to learn about options for purchasing Spravato and how to bill for Spravato commercial and Medicare Advantage members.

See the full article on **Page 30**.

Behavioral health resources to discuss with your patients

We recently published a new document titled *Behavioral health resources to discuss with your patients*.

See the full article on **Page 17** for more information and links to other resources.

Use C9399 to bill new drugs and biologicals for first year after FDA approval, for Medicare Advantage

Use HCPCS code C9399 when billing drugs and biologicals that have been approved by the U.S. Food and Drug Administration but haven't been assigned a specific HCPCS code.

Use the C9399 code for **new** drugs and biologicals; after the first year, that code will typically be replaced by a specific code.

If no specific code has been established after the first year, bill with one of these codes:

- Use HCPCS code J3490 for unclassified or NOC drugs.
- Use HCPCS code J3590 for unclassified or NOC biologics.

These instructions are based on coding guidelines published by the Centers for Medicare & Medicaid Services. They apply to Medicare Plus Blue℠ and BCN Advantage℠ members.

For additional information, refer to the **CMS Article A55913: Billing and Coding: Hospital Outpatient Drugs and Biologicals Under the Outpatient Prospective Payment System (OPPS)**.

Avsola and Inflectra are the preferred infliximab products for commercial members

Starting April 1, 2022, the following drugs were designated as the preferred infliximab products for adult Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members:

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

The following products are designated as nonpreferred infliximab products:

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

Because the change in preferred drugs isn't retroactive, existing authorizations aren't affected. Prior authorization and site-of-care requirements continue to apply.

Some Blue Cross commercial groups aren't subject to these requirements

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.**

To determine whether this change affects Blue Cross and Blue Shield Federal Employee Program® members and UAW Retiree Medical Benefits Trust (non-Medicare) members, refer to the group-specific drug lists, which you can find on the **Blue Cross Medical Benefit Drugs** page on our **ereferrals.bcbsm.com** website.

List of requirements

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

Kimmtrak and Tivdak to require prior authorization for most members, starting May 23

For dates of service on or after May 23, 2022, we're adding prior authorization requirements for the following drugs covered under the medical benefit:

- Kimmtrak® (tebentafusp-tebn), HCPCS code J3490, J3590, J9999, C9399
- Tivdak® (tisotumab vedotin-tftv), HCPCS code J9273

Prior authorization requirements apply when these drugs are administered in outpatient settings for:

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

  Exceptions: These requirements don't apply to Blue Cross members who have coverage through the Blue Cross and Blue Shield Federal Employee Program®, to UAW Retiree Medical Benefits Trust non-Medicare members or to other Blue Cross commercial members with coverage through self-funded groups.
- Medicare Plus Blue℠ members
- Blue Care Network commercial members
- BCN Advantage℠ members

How to submit authorization requests

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

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

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

More about the authorization requirements

Authorization isn't a guarantee of payment. As always, health care practitioners need to verify eligibility and benefits for members.

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

- **Blue Cross commercial and BCN commercial:**
  - **Medical oncology prior authorization list for Blue Cross commercial fully insured and BCN commercial members**
  - **Blue Cross and BCN utilization management medical drug list**
- **Medicare Advantage: Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**

We'll update the appropriate drug lists to reflect this information before the effective date.

Requirements changed for some commercial medical benefit drugs

From October 2021 through March 2022, we added prior authorization requirements, site-of-care requirements, or both for Blue Cross commercial and BCN commercial members for the following medical benefit drugs:

HCPCS code	Brand name	Generic name
J3590*	Susvimo®	ranibizumab injection, for ocular implant
J3590*	Cortrophin™	corticotrophin
J3590*	Vyvgart™	efgartigimod alfa-fcab
J3590*	Leqvio®	inclisiran
J3590*	Tezspire™	tezepelumab-ekko
J3590*	Vabysmo™	faricimab-svoa

*Will become a unique code

For additional details, 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

Carvykti requires prior authorization for Medicare Advantage members

For dates of service on or after March 7, 2022, Carvykti™ (ciltacabtagene autoleucel), HCPCS code J9999, requires prior authorization for Medicare Plus Blue℠ and BCN Advantage℠ members.

Submit prior authorization requests using the NovoLogix® online tool.

We require prior authorization for this drug for all sites of care in which it is administered.

Submitting prior authorization requests

Submit prior authorization requests for these drugs using the NovoLogix online tool. It offers real-time status checks and immediate approvals for certain medications.

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**.

Providers don't need to submit new authorization requests for Neulasta due to HCPCS code change

Providers who received an authorization from AIM Specialty Health® for Neulasta under HCPCS code J2505 **do not** need to submit a new authorization request due to the code change. The HCPCS code for Neulasta/Neulasta® Onpro® (pegfilgrastim) changed from J2505 to J2506 on Jan. 1, 2022.

We have updated the Blue Cross / BCN e-referral system so the new HCPCS code, J2506, is assigned to the existing Neulasta authorizations.

Check the e-referral system to confirm that your authorizations have been updated to HCPCS code J2506. This change may not be reflected in the AIM provider portal.

In the future, submit prior authorization requests for Neulasta as follows:

- For dates of service on or after Jan. 1, 2022, use HCPCS code J2506.
- For dates of service before Jan. 1, 2022, use HCPCS code J2505.

We've updated the following drug lists to reflect the code change:

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

Coding and billing of Spravato for Blue Cross Blue Shield of Michigan and Blue Care Network providers

There are several pathways for purchasing Spravato and coding considerations for evaluation and management services. Please see article on **Page 30** for important details.

Outpatient facilities must bill self-administered medications through Medicare Part D

If Medicare Advantage members don't bring their self-administered medications with them when receiving services at an outpatient facility, the facility should obtain the medications through its onsite ambulatory pharmacy, if one is available.

Facilities that obtain these medications through an onsite ambulatory pharmacy must bill them under the member's Medicare Part D pharmacy benefits. The member is responsible for the copayment amount.

If facilities bill these medications through the member's Medicare Part B medical benefits, the claims will be denied.

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

Enjaymo, Vabysmo and Byooviz require prior authorization for Medicare Advantage members

We've added prior authorization requirements for the following drugs covered under the medical benefit for Medicare Plus Blue℠ and BCN Advantage℠ members:

- **For dates of service on or after March 7, 2022:**
  - Enjaymo™ (sutimlimab-jome), HCPCS code J3590
  - Vabysmo™ (faricimab-svoa), HCPCS code J3590
- **For dates of service on or after June 6, 2022:**
  - Byooviz® (ranibizumab-nuna), HCPCS code Q5124

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

Save time when submitting prior authorization requests for prescription drugs

For the fastest response, use an electronic prior authorization, or ePA, tool such as CoverMyMeds® or SureScripts® to submit prior authorization requests for prescription drugs.

Here are some of the advantages of submitting authorization requests through an ePA tool:

- Faster response times on your requests
- Approvals within minutes (Some requests require more time.)
- Reduced administrative time
- Streamlined questions (only those needed for the authorization)
- The ability to attach documentation if required
- Clinical criteria to guide you in submitting the proper information
- Secure and efficient prior authorization administration all in one place
- The ability to renew existing authorizations up to 60 days before they expire

For information about submitting electronic prior authorization requests, see the following documents:

- **For Blue Cross commercial and BCN commercial: Save time and submit your prior authorization requests electronically for pharmacy benefit drugs**
- **For Medicare Plus Blue℠ and BCN Advantage℠: Save time and submit your prior authorization requests electronically for pharmacy benefit drugs**

Billing Bulletin

Purchasing and billing for Spravato

We've developed a document with information about Spravato® that we think you'll find useful.

See the document titled ***Spravato: Purchasing and billing information to learn*** about:

- Two options for purchasing Spravato: Buy and bill and assignment of benefit

  Note: The buy and bill option is available for both commercial and Medicare Advantage members; the assignment of benefit option can be used only for commercial members.
- How to bill for Spravato: Which codes to use for our commercial members and which to use for our Medicare Advantage members

The document points out the differences you should be aware of when purchasing and billing Spravato for members with Blue Cross Blue Shield of Michigan commercial, Blue Care Network commercial, Medicare Plus Blue℠ and BCN Advantage℠ plans.

You can access this document on these pages on our **ereferrals.bcbsm.com** website:

- **Blue Cross Behavioral Health**
- **BCN Behavioral Health**

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:

- Billing for appropriate levels of evaluation and management services
- Screening ultrasound edits for abdominal aortic aneurysm
- Condition code requirements when submitting a corrected claim
- Payment policy reminder for Unna boot with wound debridement
- Tips for submitting clinical editing appeals in Availity

Clinical editing billing tips

Use C9399 to bill new drugs and biologicals for Medicare Advantage for first year after FDA approval

You should use HCPCS code C9399 when billing drugs and biologicals that have been approved by the U. S. Food and Drug Administration but haven't been assigned a specific HCPCS code. This applies to Medicare Plus Blue℠ and BCN Advantage℠ members.

See article on **Page 25** for details.

Clarification: Billing for IOP services provided by telemedicine for some members

For behavioral health IOP services provided through telemedicine with dates of service on or after Oct. 1, 2021, bill revenue code 0905 or 0906, the applicable procedure code, and modifier GT or 95. We use these modifiers to identify IOP services that are delivered by telemedicine.

See the full article on **Page 23**.

Outpatient facilities must bill self-administered medications through Medicare Part D

If Medicare Advantage members don't bring their self-administered medications with them when receiving services at an outpatient facility, the facility should obtain the medications through its onsite ambulatory pharmacy, if one is available, and bill them under the member's Medicare Part D pharmacy benefits.

See full article on **Page 29**.

Reminder: You'll receive a clinical edit for Vitamin D testing when it doesn't meet CMS criteria

Blue Care Network supports the appropriate screening for vitamin D deficiency in individuals at risk. As a reminder, BCN implemented a clinical edit effective July 1, 2021, related to vitamin D testing. This edit is in accordance with the Centers for Medicare & Medicaid Services and outlined in their ***Billing and Coding: Vitamin D Assay Testing (A57484)* article**. Any claims submitted with diagnoses and other criteria not listed in the article receive the clinical edit. The claim rejects and the provider is liable for payment of the test

See the full article on **Page 17** for more information.

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**
	Thursday, May 12	Noon to 1 p.m.	**Register here**
	Wednesday, May 18	2 to 3 p.m.	**Register here**
	Tuesday, May 24	8 to 9 a.m.	**Register here**
	Thursday, June 2	2 to 3 p.m.	**Register here**
	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.

Referral Roundup

Update: We'll stop accepting faxed requests for commercial SNF admissions starting June 1

Starting June 1, 2022, we'll stop accepting prior authorization requests for commercial skilled nursing facility admissions that are submitted by fax. These requests must be submitted through the e-referral system.

This applies to SNF requests for initial admissions and additional days for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

We previously communicated that we'd stop accepting faxed requests on Jan. 1, 2022, but we're allowing additional time for SNFs to sign up for access to the e-referral system and learn how to use it.

Starting June 1, we'll accept faxes **only** for urgent requests when the e-referral system isn't available. In those instances, fax the form using the instructions on the document titled **e-referral system planned downtimes and what to do**.

Sign up now to use the e-referral system

Refer to our **ereferrals.bcbsm.com** website:

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

How to submit through the e-referral system

For tips on how to use the e-referral system when submitting commercial SNF prior authorization requests, refer to the **article** in the May-June 2021 issue of *BCN Provider News*, Page 38.

Submit Medicare Advantage requests to naviHealth

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

Reminder: Starting March 1, we aligned our Local Rules for acute inpatient medical admissions

As a reminder, for acute inpatient medical admissions of members with certain conditions, authorization requests should be submitted only after the member has spent two days in the hospital.

This update to our Local Rules went into effect for all members admitted to Michigan hospitals 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℠ and BCN Advantage℠ members.

For non-Michigan hospitals, this update to our Local Rules applies only to Medicare Plus Blue members.

About observation orders

Some hospitals have asked whether an observation order is required when billing Blue Cross or BCN for observation.

Blue Cross and BCN don't require an observation order when reimbursing an observation claim. This applies to all lines of business: Blue Cross Blue Shield of Michigan commercial, Medicare Plus Blue, BCN commercial and BCN Advantage.

Additional information

For other important details about this change, refer to these documents:

- **Blue Cross and BCN Local Rules for 2022 (non-behavioral health)**
- **Blue Cross and BCN Local Rules: Frequently asked questions**

We communicated about this change earlier, in our provider newsletters. Refer to these articles:

- **February 2022 issue** of *The Record*
- **March-April 2022 issue** of *BCN Provider News*, Pages 18 and 19

Use the *Criteria request form* to obtain the criteria used in making a specific determination

When you submit an authorization request, we use medical necessity criteria to make a determination. Those criteria are available to you on request.

To obtain the criteria we used in making a determination on a specific authorization request, complete and submit the ***Criteria request form***.

Here are some things to keep in mind:

- Use this form for non-behavioral health authorization requests for which the Blue Cross Blue Shield of Michigan and Blue Care Network Utilization Management departments made the determination.
- Don't use this form for determinations on authorization requests you submitted to our contracted vendors.

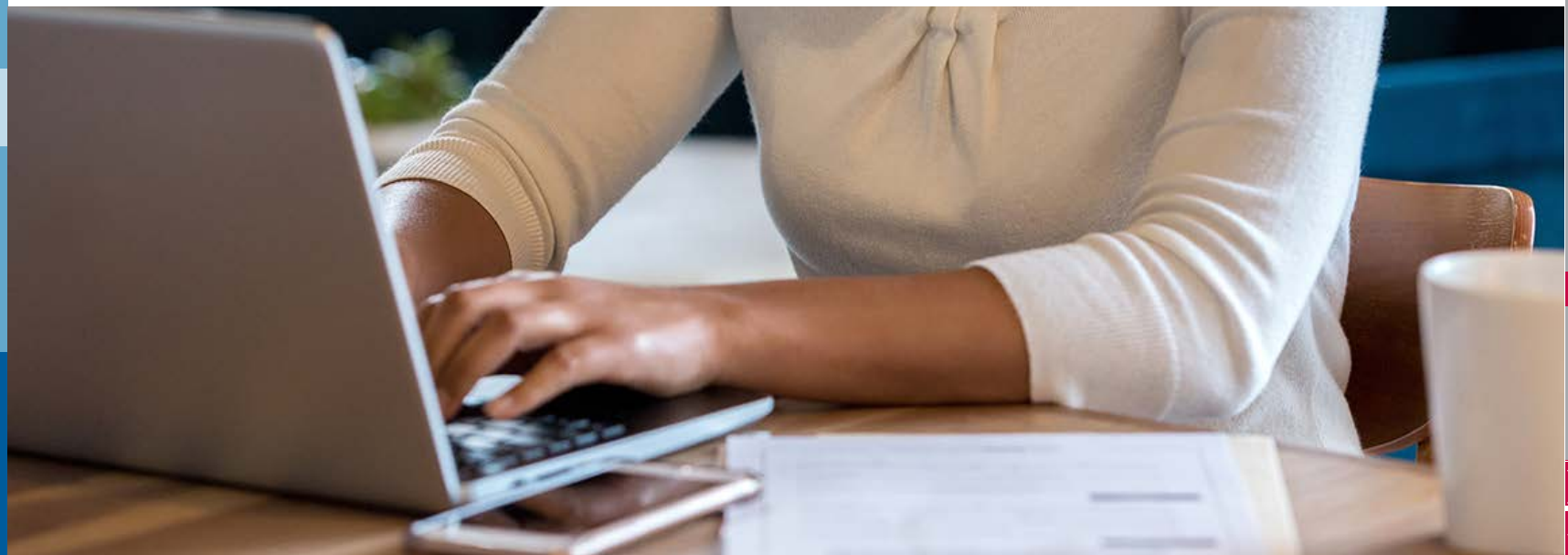
This form is available for Blue Cross commercial, Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ requests. Previously, it was used only for BCN requests.

Here's what to do:

1. Complete every field on the form.
2. Fax the completed form to us at the number on the form.

You can access this form on these pages on our **ereferrals.bcbsm.com** website:

- **Blue Cross Authorization Requirements & Criteria.** Look under the "Forms – Blue Cross commercial" or the "Forms – Medicare Plus Blue" heading.
- **BCN Authorization Requirements & Criteria.** Look under the "Referral and authorization information" heading.
- We're updating our provider manuals to include information about this form.



Referral Roundup

We ended the temporary suspension of clinical review requirements for admission to skilled nursing facilities

The temporary suspension of clinical review requirements for admission to skilled nursing facilities for all Michigan hospitals and for hospitals in certain other states ended on Feb. 28, 2022.

For SNF stays starting on or after March 1, 2022, clinical review is required on the first day of the stay.

The temporary suspension went into effect for Blue Cross Blue Shield of Michigan commercial, Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠ members in September for admission to SNFs in Michigan and certain other states.

These changes are reflected in the following documents, available on our public website at **bcbsm.com/coronavirus** (click the *Health Care Providers* tab).

- *Temporary changes due to the COVID-19 pandemic*
- *Ends Feb. 28, 2022: Clinical review requirements temporarily suspended for admissions to skilled nursing facilities from hospitals in certain states*

In addition, the change for hospitals in certain states is reflected in the following documents for out-of-Michigan providers, which are available from the **Medical Policy & Pre-Cert/Pre-Auth Router** page of our **bcbsm.com** website:

- ***Provider Preauthorization and Precertification Requirements*** for Blue Cross commercial and Medicare Plus Blue members
- ***Non-Michigan providers: Referral and authorization requirements*** for BCN commercial and BCN Advantage members

TurningPoint authorizations for musculoskeletal surgical and related procedures are valid for six months

Prior authorization requests approved by TurningPoint Healthcare Solutions LLC on or after Jan. 1, 2022, are valid for six months from the planned date of service for all outpatient musculoskeletal procedures, including pain management procedures.

For example, if TurningPoint approves an authorization request for a service planned for June 1, the approval will be valid from June 1 through November 30. If the surgery is performed during that time period, the authorization will match the claim without any changes to the authorization.

We updated the following documents to reflect this change:

- **Musculoskeletal procedure authorizations: Frequently asked questions for providers**
- **Musculoskeletal procedure authorizations: Quick reference for providers**

Prior authorization requests that were approved on or before Dec. 31, 2021, are valid for 30 days from the planned date of service.

TurningPoint Healthcare Solutions LLC is an independent company that manages authorizations for musculoskeletal surgical and related procedures for Blue Cross Blue Shield of Michigan and Blue Care Network.

Musculoskeletal procedure authorizations: Reminders for facilities

Here's how to change the place of service from outpatient to inpatient for musculoskeletal surgical and related procedures that require authorization from TurningPoint Healthcare Solutions LLC.

- **Prior to inpatient admission:** If TurningPoint approved an authorization with an outpatient place of service and you need to change it to inpatient before surgery, the ordering provider should contact TurningPoint to make the change. Call TurningPoint toll-free at 1-833-217-9670 or locally at 313-908-6040.
- **After inpatient admission when the setting must be inpatient based on Centers for Medicare & Medicaid Services requirements:** If TurningPoint approved an outpatient setting for a procedure that's on the CMS list of inpatient-only procedures, call TurningPoint toll-free at 1-833-217-9670 or locally at 313-908-6040. TurningPoint will update the setting on the authorization.
- **Due to a change in a member's condition during outpatient stay:** If a change in a member's condition during their outpatient stay requires an extended stay, the facility should submit an inpatient request to Blue Cross Blue Shield of Michigan or Blue Care Network. To do this, submit procedure code *99222 as outlined in the ***e-referral User Guide***; see the "Submitting an emergency or urgent admission (includes Blue Cross member submissions)" subsection within the "Submit an inpatient authorization" section for more information. The request must meet InterQual® criteria.

What you need to know

- Review this article to learn how to change the place of service for a musculoskeletal procedure.
- Musculoskeletal surgeries don't require prior authorization from TurningPoint when they're performed in an emergency during an inpatient admission that originated in the emergency department.
- To update the procedure codes on an authorization after a musculoskeletal surgery has taken place, see the *Postservice change request form* link below.

Additional reminders

- When TurningPoint approves an authorization request from an ordering physician, the authorization covers both the procedure and the site of service. Facilities **don't** need to submit a separate authorization request for an inpatient request if TurningPoint already approved an inpatient place of service.
- Musculoskeletal surgeries don't require prior authorization from TurningPoint when they're performed in an emergency during an inpatient admission that originated in the emergency department. For more information, see "Do musculoskeletal procedures that are performed during an inpatient admission that originated in the emergency department require prior authorization from TurningPoint?" in the document titled ***Musculoskeletal procedure authorization: Frequently asked questions for providers***.
- To update the date of service on a prior authorization, call TurningPoint.
- To update the procedure codes on an authorization after a musculoskeletal surgery has taken place, see the ***Postservice change request form***.
- You can request additional days for an inpatient stay through the e-referral system. In the e-referral system, you'll need to search for the member, not for the TurningPoint authorization number.

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

Note: See the document titled ***Musculoskeletal procedure codes that require authorization by TurningPoint*** to determine which codes require authorization. Only the codes on this list require prior authorization. Incidental codes don't require prior authorization.

TurningPoint fax form and site-of-care guideline have been updated

In January, the following documents were updated for the TurningPoint Healthcare Solutions LLC musculoskeletal surgical quality and safety management program:

- **Pain management: Epidural steroid injections authorization request fax form** — The form reflects updated criteria from the Centers for Medicare & Medicaid Services. When faxing authorization requests, be sure to use the form that's dated January 2022.

  You can access this form through the **Blue Cross Musculoskeletal Services** and **BCN Musculoskeletal Services** pages of our **ereferrals.bcbsm.com** website.

  Note: TurningPoint made the same updates to the questionnaire in their provider portal.

- **TurningPoint Site-of-Care Guideline (GN-1004)** — The updated guideline reflects the site-of-care changes that went into effect on Jan. 3, 2022, for total hip and total knee surgeries for Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ members. (For more information about the requirement, see this **news item** on our **ereferrals.bcbsm.com** website.)

  You can access the updated guideline by logging in to the TurningPoint provider portal and clicking *Help* in the menu at the top of the screen.

TurningPoint Healthcare Solutions LLC is an independent company that manages authorizations for musculoskeletal surgical and related procedures for Blue Cross Blue Shield of Michigan and Blue Care Network.

AIM authorization IDs now include alpha characters

Starting mid-April 2022, authorization IDs from AIM Specialty Health® include randomly placed alpha characters. The authorization IDs with the alpha characters will be visible in any communication involving AIM Specialty Health, including those within the AIM ProviderPortal® and the Blue Cross and BCN e-referral system.

This change will affect all authorizations managed by AIM Specialty Health. This includes the following services: cardiology; high-tech radiology; in-lab sleep management; radiation oncology; and medical oncology and supportive care drugs.

More details about the change

Here's more information about this change:

Before the change: The authorization IDs in the AIM ProviderPortal contained eight characters, all of which were numeric. Example: 23456789

After the change: The authorization IDs in the AIM portal still contain eight characters but those characters are a mix of alphabetic and numeric. Example: 2J6Y789M

What's not affected by this change

This change will not affect how determinations are made on authorization requests that AIM manages for Blue Cross and Blue Shield of Michigan commercial, Medicare Plus Blue, Blue Care Network commercial and BCN Advantage or the claims related to them. In addition, this change does not affect authorization IDs issued before the change; those remain the same.

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. For more information, go to our **ereferrals.bcbsm.com** website.

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