SEPTEMBER-OCTOBER 2022

BCN Provider News

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Next phase of Provider Secured Services and web-DENIS retirement announced

On Sept. 15, 2022, Blue Cross Blue Shield of Michigan and Blue Care Network will conduct the second phase of retiring Provider Secured Services and web-DENIS which will include the removal of the Internet Claims Submission Tool and some additional applications.

The last day to use these applications on Blue Cross and BCN's Provider Secured Services is Sept. 14, 2022. For a complete list of applications that are only available on our new provider portal, view **Applications removed from Provider Secured Services**.

Use our new provider portal

We continue to enhance the information you'll find in our new provider portal (**availity.com**). You are encouraged to learn and use our new portal. However, Provider Secured Services will be available for a limited time. For help getting started with Availity Essentials, see the Resources section at the end of this article.

Watch for information on the final retirement of Provider Secured Services and web-DENIS

Read our provider alerts within Availity for the latest information on the retirement of Provider Secured Services and web-DENIS. We'll post an alert at least one week before the final retirement. Here's how to find provider alerts within **availity.com**.

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

Feedback | Subscribe

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

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Provider Secured Services and web-DENIS,

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1. Click *Payer Spaces* on the menu bar.
2. Click the BCBSM and BCN logo.
3. Click the *Resources* tab.
4. Click *Secure Provider Resources (Blue Cross and BCN).*
5. Click *Read Alerts.*

You can make the Provider Resources website a favorite by clicking on the heart icon next to *Secure Provider Resources (Blue Cross and BCN)* in step 4 above. Once you've done this, you'll find a link to Provider Resources when you click on *My Favorites* in the top menu bar.

Additional information for Internet Claims Submission Tool users

If you currently use the Internet Claims Submission Tool, it's important for you to know the last day to use it is Sept. 14. If you need to keep lists and reports from the Internet Claims Submission Tool, you should obtain these before Sept. 14. Instructions for printing and downloading lists and reports are in the Knowledge Center. Here's how to find them while in your Internet Claims Submission Tool dashboard:

1. Click on *Resources.*
2. Click on *Knowledge Center.*
3. Click on *Miscellaneous.*

Availity offers two options for providers who need a direct data entry claims submission tool:

- Claims submission for Blue Cross and BCN plans at no cost to you
- Claims submission to other payers in addition to Blue Cross and BCN at a low monthly fee

Learn more about the Availity claims submission tool by viewing the **DDE (direct data entry) claim submission for BCBSM providers webinar recording** on the **Availity Get Up to Speed with training webpage**.

Resources

- **Register for Availity Essentials**. Learn more at **Register and Get Started with Availity Essentials**.
- Learn how to use Availity Essentials on **Get Up to Speed with Training**.
- Check out our **frequently asked questions about transitioning to the Availity® provider portal**.
- Need help? Call Availity Client Services at **1-800-AVAILITY** (282-4548), Monday through Friday from 8 a.m. to 8 p.m. Eastern time (excluding holidays).

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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:

- NDC billing for medical drug benefits: The eLearning module provides an overview of National Drug Code for medical drug benefits, explain NDC billing requirements and how to fill out professional paper and electronic claims for NDC payment.
- Training and resources guide for private duty nursing: This document serves as a quick guide to training and resources available for private duty nurses who join our network.

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

To request access, complete the following steps:

1. Open the **registration page**
2. Complete the registration. We recommend using the same email you use to communicate with Blue Cross for provider-related needs. This will become your login ID.
3. Follow the **link** to log in.

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

Pharmacogenomics training opportunities

OneOme, co-founded by the Mayo Clinic, is an independent precision medicine company that has contracted with Blue Care Network to introduce a new precision medicine program for eligible BCN members. OneOme is recommending some educational opportunities for physicians, pharmacists and other clinicians to learn about pharmacogenomics, or PGx, the study of how an individual's genetic makeup affects how they respond to medications.

BCN's new program, Blue Cross Personalized Medicine℠, will help physicians tailor the medication regimen of patients to their specific needs. BCN is currently testing this new program with a limited number of eligible members. The full launch of a PGx program for all eligible BCN members will begin in January 2023. You can read more about this program in the **July-August issue of *BCN Provider News***, as well as these publications:

- **May-June issue of *Hospital and Physician Update***
- **May issue of *The Record***

We're sharing the following educational opportunities with you and encourage you to participate if you'd like to learn more about pharmacogenomics. BCN's Chief Medical Officer and Vice President of Strategy and Affordability Scott Betzelos, M.D., and OneOme's Medical Director Julie England, M.D., will be panelists on Sept. 28 at the Orlando conference. There is a cost to participate in these trainings.

- Sept. 21 to 23: **University of Minnesota Pharmacogenomics Conference 2022 live virtual conference**
- Sept. 28 to 29: **GenomeWeb and The Precision Medicine Leaders' Summit Updates in Precision Medicine: Pharmacogenomics and Pharmacovigilance in Orlando, Florida**

If you're unable to attend, visit **oneome.com/bcbsm-webinar** to view previous educational webinars and contact information to reach out to OneOme's clinical team directly.

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Post-acute care providers need direct access to naviHealth's provider portal

The way post-acute care providers access naviHealth's provider portal, nH Access, is changing with Blue Cross Blue Shield of Michigan and Blue Care Network's transition to Availity Essentials. Post-acute care providers will need direct access to nH Access.

Current method of entering the nH Access portal

In Blue Cross and BCN's Provider Secured Services, you can click on the *Medicare Advantage Post-Acute Care Authorization* link and type in your NPI to enter nH Access. **This method of access ends when Provider Secured Services retires.**

New method of entering the nH Access portal

Here are the steps you'll use after logging into Availity Essentials:

1. Click on *Payer Spaces* in the Availity menu bar.
2. Click on the BCBSM and BCN logo.
3. Click on *naviHealth Provider Portal.*

This will take you to a login screen where you'll need to type in your email address and password. You can also access this login screen outside of Availity by going to **access.navihealth.com**.

Either way, if you don't already have a naviHealth nH Access account, you'll need one. To register for direct access to naviHealth's nH Access portal, visit **partners.navihealth.com/partner/nh-access** and scroll to the "nH Access – Setting Up Your Account" section. Follow the instructions in the Account Creation Guide.

After naviHealth creates your account, you'll receive an email from naviHealth with instructions on how to log in.

While you're waiting to get direct access to naviHealth's nH Access, you may submit authorization requests to naviHealth by faxing **1-844-899-3730** or calling **1-855-851-0843**.

For any questions about nH Access, call naviHealth at **1-888-276-5777**. Go to **nH Access Fundamentals** for nH Access training.

Background

Post-acute care admission authorizations for Medicare Advantage plans from Blue Cross and BCN (Medicare Plus Blue℠ and BCN Advantage℠) are managed by naviHealth through nH Access™. Providers involved in post-acute care include skilled nursing, rehabilitation and long-term care facilities as well as acute care hospitals.

Blood pressure coding can reduce HEDIS medical record requests

The Controlling High Blood Pressure HEDIS® star measure assesses patients 18 to 85 who had a diagnosis of hypertension reported on an outpatient claim and whose blood pressure was adequately controlled (<140/90 mm Hg) as of Dec. 31 of the measurement year.

Per HEDIS specifications, blood pressure CPT® II codes can now establish patient compliance with the CBP measure. We will no longer need to review medical records to confirm blood pressure values when you add the CPT II codes to your patients' claims billed with an office visit, including telehealth, telephone, e-visit or virtual visit.

Blood pressure readings can be captured during a telehealth, telephone, e-visit or virtual visit. Please note:

- Patient-reported readings taken with a digital device are acceptable and should be documented in the medical record.
- Providers don't need to see the reading on the digital device; the patient can verbally report the digital reading.

Read the tip sheet to learn more about the measure and view a chart with blood pressure CPT II codes.

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

CPT® is a registered trademark of the American Medical Association.

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Submit clinical documentation timely for faster Medicare Advantage DME authorizations

For durable medical equipment authorization requests, providers must submit all required clinical documentation that supports medical necessity and appropriateness for treatment of the member's diagnosis. Blue Cross Blue Shield of Michigan and Blue Care Network, or our delegated entity, must receive this information with the request to respond within certain timeframes required by the National Committee for Quality Assurance and the Centers for Medicare & Medicaid Services.

Blue Cross and BCN contract with the following vendors to manage durable medical equipment authorizations and diabetic supplies for Medicare Advantage members.

Northwood, Inc. — DME, prosthetics and orthotics, including diabetic shoes and inserts

With the prior authorization request, include supporting documentation of medical necessity of the prescribed equipment, including prescriptions and letter or certificate of medical necessity in the medical record.

Contact Northwood at **1-800-393-6432** Monday through Friday from 8:30 a.m. to 5 p.m. Eastern time to submit the request. Northwood will identify a contracted DME supplier. Contracted providers can access the Northwood provider portal for authorization submission using our provider portal, Availity Essentials.

J&B Medical Supply — Continuous glucose monitors, insulin pumps and supplies, test strips (if quantity is over standard parameter)

When submitting requests for the supplies listed above, include the following criteria in the medical record:

- Evidence the member has diabetes
- A dated and signed standard written order containing the following:
  - Prescribing physician's name, address and telephone number
  - Patient's name, address and birth date
  - Diagnosis related to the services or items provided
  - Detailed description of the patient's condition to substantiate the necessity for services or items
  - Description and quantity of all items, accessories and options ordered
  - Estimated duration of need and frequency of use
  - Physician's written signature and date (We don't accept stamps. Electronic prescriptions are acceptable but must adhere to all privacy, security and electronic signature rules.)

  Note: We cannot accept "PRN" (Latin for pro re nata, or as the situation demands) or "as needed" as estimates for supply replacement, use or consumption.
- Supporting documentation that the member, or caregiver, has the necessary training on the diabetic supply or device, met by the standard written order
- Supporting evidence that the member meets Medicare's Local Coverage Determination for continuous glucose monitoring and/or insulin pumps and supplies

To request higher quantities of test strips and lancets, include the following documentation:

- Evidence of the member's in-person practitioner visit to evaluate his or her diabetes control within the six months prior to submitting the request
- Supporting evidence that the member needs a supply quantity that exceeds the usual amount
- Verification every six months that the member's adherence to a high-use testing regimen requires prescribing quantities that exceed the usual amount

Submit information to J&B Medical Supply by one of the methods below:

- Email: ProviderServices@jandbmedical.com
- Fax: **1-248-255-0157**
- Phone: **1-888-896-6233** Monday through Friday from 8 a.m. to 5 p.m. Eastern time.

Please see Clinical documentation continued on Page 6

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Clinical documentation, *continued from Page 5*

The J&B Medical Supply provider portal is currently in process of development.

Out-of-state providers

Bill claims for Medicare Advantage members traveling or living outside of Michigan through the nationwide network of Blue Plan providers through the Blue Cross and Blue Shield Association.

For more information about utilization management, refer to our provider manuals:

- ***Medicare Plus Blue PPO Provider Manual***
- **BCN Advantage chapter in the *BCN Provider Manual* (accessed from our e-referrals website)**

Remind your eligible patients to get regular mammograms

One in eight women in the United States will be diagnosed with invasive breast cancer in her lifetime, making it the second most common cancer in women, according to the American Cancer Society. Early detection is key to a better outcome for your patients, and you play an integral role by recommending regular screenings.

The Breast Cancer Screening HEDIS® star measure assesses female patients ages 50 to 74 who had a mammogram to screen for breast cancer in the past two years.

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

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

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

Breast Cancer Screening_BCS

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Some BCN Advantage claims paid in error

We've identified payment errors that were made when we processed two types of claims for BCN Advantage℠ members. These errors affect claims for:

- Procedure code *92015 (determination of refractive state)
- Procedure codes billed with status indicator N (noncovered); B (bundled); or I (invalid for Medicare)

Keep reading for more information on what the errors were and how they'll be resolved.

Refractive services billed with procedure code *92015

BCN Advantage has been reimbursing services billed with procedure code *92015 under members' medical benefits.

However, claims for these services are reimbursable only under members' vision benefits, for members who have vision coverage. This is in line with members' Evidence of Coverage.

BCN Advantage is adjusting its claims system to ensure that procedure code *92015 is not reimbursed under members' medical benefits, in line with the Centers for Medicare & Medicaid Services guidelines.

Important: Providers should resubmit these claims under each member's vision benefits, for members who have such benefits. Members who don't have vision benefits will be responsible for the cost of the services.

Procedure codes billed with status indicator N, B or I

BCN Advantage has been reimbursing providers for procedure codes billed with status indicator N, B or I.

However, according to the Relative Value files published by CMS, codes billed with status indicator N (noncovered); B (bundled), or I (invalid for Medicare) aren't typically reimbursable as separate line items. This is the case unless the service is specifically identified as a member benefit (for example, physical exams).

Providers should not expect reimbursement for codes billed with status indicator N, B or I.

BCN Advantage is adjusting its claims system to make sure that codes billed with status indicator N, B or I are reimbursed in line with CMS guidelines.

Important: Providers should ensure that their claims are submitted in line with CMS billing guidelines, unless directed otherwise.

Reminder

The review of the claims described above is part of our larger effort to review our reimbursement of BCN Advantage claims to ensure alignment with the CMS guidelines and BCN Advantage benefit structures. Refer to the **provider alert** we published on June 8, 2022.

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naviHealth improves process for prior authorization requests for initial SNF stays for Medicare Advantage members

Effective Sept. 21, 2022, naviHealth Inc. will add a new tool — the nH Access authorization wizard — to the nH Access portal for Medicare Plus Blue℠ and BCN Advantage℠ members.

When submitting prior authorization requests for initial skilled nursing facility stays for Medicare Plus Blue and BCN Advantage members, providers will be able to submit additional clinical details about members' current needs and abilities through the wizard. The additional information will expedite the review process, resulting in faster authorization determinations and more timely transitions to the next level of care.

To learn more about the nH Access authorization wizard, go to **naviHealth's Provider Resource page** where you'll find a video tutorial, an FAQ document and a resource guide.

Note: If you haven't already done so, you'll have to **register for access** to naviHealth's Provider Resource Page.

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

naviHealth Inc. is an independent company that manages authorizations for post-acute care services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans. To learn more, see ***Post-acute care services: Frequently asked questions for providers***.

Guidelines updated for billing self-administered medications provided in outpatient facilities

We offer some guidelines for situations when a Medicare Advantage member receives services in an outpatient facility but hasn't brought his or her self-administered medications.

See the article on **Page 15** for details.

Byooviz to be the preferred ranibizumab drug for Medicare Advantage members, starting Oct. 4

For dates of service on or after Oct. 4, 2022, we're designating preferred and nonpreferred ranibizumab products for our Medicare Advantage (Medicare Plus Blue℠ PPO and BCN Advantage℠) members.

- **Preferred:** Byooviz® (ranibizumab-nuna), HCPCS code Q5124
- **Nonpreferred:** Lucentis® (ranibizumab), HCPCS code J2778

For details, see the full article on **Page 16**.

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Medicare Advantage members with missing preventive screenings will receive in-home test kits in September

Blue Cross Blue Shield of Michigan and Blue Care Network are contracting with Everlywell, a third-party vendor (formerly Home Access Health), to distribute in-home test kits in September to select Medicare Advantage members who are missing certain preventive screenings.

If your patients receive an advance notice letter about the kits and have questions, encourage them to take advantage of this convenient, no-cost testing.

Members who have an open gap in care for a colorectal cancer screening will receive a FIT kit. If a member also has an open gap in care for hemoglobin A1c, or HbA1c, testing, they will also receive an HbA1c testing kit.

Members will be encouraged to discuss test results with their primary care providers. In 2023, providers will be able to access their patient results in Everlywell's portal.

Test result notification:

	Normal results	Abnormal results
Blue Cross Medicare Advantage member	Mail	Mail and phone call; Certified letter if unable to reach
Primary care provider	Mail	Fax

Important information about billing and requesting prior authorization for denosumab

Part B specialty drugs Prolia® and Xgeva® have the same generic name, denosumab, and HCPCS code, J0897. Both drugs require authorization for Medicare Plus Blue and BCN Advantage members when these drugs are administered by a health care provider in sites of care such as outpatient facilities or physicians' offices.

For details, see the full article on **Page 18**.

Landmark Health high-intensity in-home care program expands Jan. 1

Blue Cross Blue Shield of Michigan and Blue Care Network will expand the high-intensity in-home care program by Landmark Health to include Medicare Advantage members with multiple chronic conditions who live in any county in Michigan's Lower Peninsula, effective Jan. 1.

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

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Medical policy updates

Blue Care Network's medical policies 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

- Circulating tumor DNA for management of non-small-cell lung cancer (liquid biopsy)
- Genetic testing — human leukocyte antigen testing for celiac disease
- Assisted reproductive techniques
- Computed tomography to detect coronary artery calcification
- Fecal microbiota transplantation (fecal bacteriotherapy, fecal transplant)
- Genetic testing-assays of genetic expression in tumor tissue as a technique to determine prognosis in patients with breast cancer
- Infertility related to cancer treatment
- Noninvasive techniques for the evaluation and monitoring of patients with chronic liver disease
- Responsive neurostimulation for the treatment of refractory partial epilepsy

Noncovered services

- Coblation®, radiofrequency ablation for musculoskeletal conditions
- Alternative physical therapy modalities — experimental

Medical Policy Updates

Landmark Health high-intensity in-home care program expands Jan. 1

Blue Cross Blue Shield of Michigan and Blue Care Network will expand the high-intensity in-home care program by Landmark Health to include Medicare Advantage members with multiple chronic conditions who live in any county in Michigan's Lower Peninsula, effective Jan. 1.

For high-level information about the program, see this **provider alert**.

For detailed information about the program, see the document titled ***High-intensity in-home care program: Frequently asked questions for providers***.

Landmark Health L.L.C., is an independent company that provides select services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.

Pharmacogenomics training opportunities

OneOme, co-founded by the Mayo Clinic, is an independent precision medicine company that has contracted with Blue Care Network to introduce a new precision medicine program for eligible BCN members. OneOme is recommending some educational opportunities for physicians, pharmacists and other clinicians to learn about pharmacogenomics, or PGx, the study of how an individual's genetic makeup affects how they respond to medications.

See the article on **Page 3** for details.

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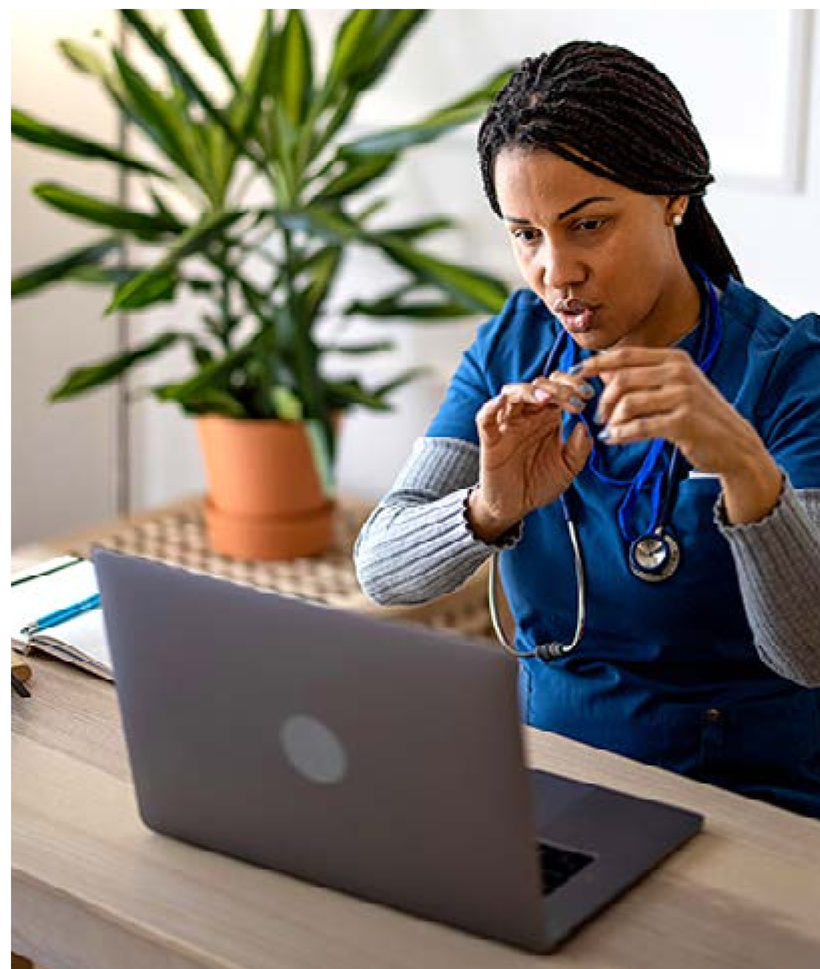
Keeping members involved in treatment for optimal outcomes

When members come to your office or have a telehealth session with you, their issues may have occurred for some time before they make the appointment. However, it's unlikely their issues will stop after just one session, or soon after they start new medication.

So how can you keep members involved in treatment and following the treatment plan so that they can find long term symptom relief? Blue Cross Blue Shield of Michigan and Blue Care Network have resources available to providers and members that can help bolster your efforts and keep members motivated to maintain their treatment.

- The Blue Cross Blue Shield/Blue Care Network Behavioral and Mental Health **website** has a wealth of information for members to use which can augment the treatment they receive from you. There are guides that encourage members to talk with their providers and encourage members to stick with their treatment; self-help articles and guides that can complement formal treatment efforts; and links to podcasts that can help shed additional light on what members go through.
- For primary care providers, the ***Behavioral Health Resources to Discuss with Your Patients*** document has resources for you to help members get referrals to in-network providers, resources for online help through the behavioral health site mentioned above, links to help members begin online telehealth visits with behavioral health providers, and crisis hotline numbers in case of behavioral health emergencies. These can help to bridge the gap between appointments with you, and help to expand a person's emotional safety net in times of crisis.
- Since the beginning of the COVID-19 pandemic, many counselors and behavioral health professionals are seeing members virtually to maintain care and safety. Members can find in-network providers who use telehealth by searching under the **Find a Doctor** tool on **bcbsm.com**, or by calling Behavioral Health at **1-800-482-5982** (BCN or BCN Advantage℠) or **1-888-803-4960** (Medicare Plus Blue℠ PPO).
- Coordinating with a member's behavioral health providers can help spread the responsibility of providing care and help build a stronger safety net for member, especially when it comes to ADHD treatment for children and adolescents. Make sure to get signed releases of information to discuss and coordinate with other providers and request updates on improvement from family and schools. These steps can benefit the member, help to deliver optimal care and prevent overlapping treatment.

With resources we offer and coordinated efforts, overcoming the barriers to maintaining members in treatment can be a shared goal that results in top-notch care and outcomes.



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Clinical quality corner: Coordination of care

This column by Dr. William Beecroft, medical director of behavioral health, features topics recommended by the Clinical Quality Committee.

Blue Cross Blue Shield of Michigan promotes the importance of coordination of care among contracted providers, including the primary care provider and behavioral health specialist. Coordination of care is crucial to ensuring that everyone on the treatment team is aware of others who may be involved in the care of the patient. This helps eliminate so-called silos of care and leads, ultimately, to optimal patient outcomes.

We've added language to our insurance certificates that provides our members with information about this key component of their care. The certificates indicate that the primary care physician is the participating provider a member chooses to provide or coordinate all their medical health care, including specialty and hospital care. The primary care physician is licensed in one of the following medical fields:

- Family practice
- General practice
- Internal medicine
- Pediatrics

We encourage you to explain to your patients why coordination of care is so important and ask them to let you know if they're seeing other health care providers.

The Michigan Department of Health and Human Services has made available a **standard consent form** that providers can use for sharing mental health and substance use disorder treatment information.

For more information, see the *Coordination of care* section of the "Behavioral Health chapter" in your online provider manual.

BCN to use InterQual ABA criteria for prior authorization requests submitted starting Oct. 1

For prior authorization requests submitted for BCN commercial members on or after Oct. 1, 2022, Blue Care Network will use Change Healthcare's InterQual® Applied Behavior Analysis Treatment criteria to make determinations.

For requests submitted prior to Oct. 1, BCN will use its local rules as follows:

- For requests submitted Aug. 1, through Sept. 30, 2022, BCN will use these **local rules for autism spectrum disorder / applied behavior analysis**
- For requests submitted Aug. 2, 2021, through July 31, 2022, BCN uses these **local rules for autism spectrum disorder / applied behavior analysis**

Why we're changing to InterQual criteria for ABA

We're changing to the InterQual Applied Behavior Analysis Treatment criteria for autism spectrum disorders because those criteria:

- Are used nationally, are recognized across both medical and behavioral health care and are based on sound clinical evidence
- Are routinely reviewed and supported throughout the year by a full-time clinical review staff with extensive experience and expertise in applied behavior analysis, or ABA

Please see InterQual ABA criteria continued on Page 13

InterQual ABA criteria, *continued from Page 12*

- Are based on a review of guidelines published by specialty colleges and other reliable sources in evidence-based literature and in general medical literature, with input from consultants
- Have already been updated with criteria specific to patients 19 years of age and older, including moving from school-based criteria to criteria related to workplace or community engagement

What providers can expect to see with the change

As a result of BCN's change to using the InterQual ABA criteria for autism spectrum disorders, here are some (but not all) of the things providers can expect to see:

- A wide range of age-appropriate goal areas, such as social engagement, educational participation, activities of daily living, or ADLs, and instrumental activities of daily living, or IADLs
- More specific percentage ranges for goals achieved and goals in progress
- Footnotes for criteria, to provide guidance to both providers and clinical reviewers in standardizing evaluations and information

How to request criteria

Providers can contact BCN Behavioral Health at **1-800-482-5982**:

- To request the criteria used in a determination for a specific prior authorization request
- With questions about our change to the InterQual criteria for ABA or about the criteria

New emergency line for behavioral health goes live

People struggling with a mental health or substance use crisis — or who are having thoughts of suicide — now have a new number they can use: 988. The number, which went live July 16, 2022, connects to the existing National Suicide Prevention Lifeline.

The move to 988 doesn't mean the National Suicide Prevention Lifeline number at 1-800-273-8255 goes away. Using either number will get callers to Lifeline's network of more than 200 locally operated and funded crisis centers across the country. Text (English only) will also be available through 988.

When someone calls or texts 988, they will be responded to by a crisis counselor within a group of Lifeline crisis centers. The counselor will listen, work to understand the problem, provide support and share resources that may be helpful.

"We were pleased to learn that there will be another lifesaving resource to help people in emotional distress who are coping with mental health and substance use issues," said Dr. Amy McKenzie, Blue Cross Blue Shield of Michigan's vice president for clinical partnerships and associate chief medical officer.

988 is a shorter, easier-to-remember way to connect to the National Suicide Prevention Lifeline, which has been operational since 2005. Congress and the Federal Communications Commission established the 988 number as part of an effort to strengthen and expand the existing Lifeline, which experienced a significant increase in calls following the onset of the COVID-19 pandemic.

"The COVID-19 pandemic and subsequent lockdowns led to an increase in the number of people struggling with mental health conditions and substance use disorder," McKenzie explained. "At Blue Cross, we've put many new initiatives in place over the past two years to help our members get the support they need, and the federal government has also been focused on addressing the behavioral health crisis, which amplifies the impact across the country."

She pointed specifically to our **behavioral health website**, which launched last year as part of our behavioral health member engagement campaign. It provides a wide range of information about mental health and substance use conditions, as well as resources that members can use to address behavioral health concerns.

For more information about 988, see **this information** on the Substance Abuse and Mental Health Services Administration website.

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Oxlumo to have site-of-care requirement for commercial members starting Oct. 1

Starting Oct. 1, 2022, Oxlumo® (lumarisan), HCPCS code J0224, will have a site-of-care requirement for Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members.

When the site-of-care requirement goes into effect, this drug may be covered only when administered at the following sites of care:

- Doctor's or other health care provider's office
- Ambulatory infusion center
- The member's home, from a home infusion therapy provider

As a reminder, this drug already requires prior authorization; providers can submit prior authorization requests using the NovoLogix® online tool. The new site-of-care requirement is in addition to the current prior authorization requirement.

Members who start treatment before Oct. 1, 2022, will be able to continue receiving the drug in their current location until their existing authorization expires. Providers should then transition members to one of the above sites of care.

Note: This drug is part of members' medical benefits, not their pharmacy benefits.

Some Blue Cross commercial groups not subject to these requirements

For Blue Cross commercial groups, these requirements apply only to groups that currently participate in the standard commercial Medical Drug Prior Authorization program for drugs administered under the medical benefit. To determine whether a group participates in the prior authorization program, see the ***Specialty Pharmacy Prior Authorization Master Opt-in/out Group list***.

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.

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***. We'll update this list before Oct. 1.

You can access this list and other information about requesting prior authorization at **ereferrals.bcbsm.com**, at these locations:

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

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

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Guidelines updated for billing self-administered medications provided in outpatient facilities

When a Medicare Advantage member receives services in an outpatient facility but hasn't brought their self-administered medications, follow these guidelines, which include and expand on information we provided in an earlier communication:

What to do

1. Obtain the medication through the onsite ambulatory pharmacy, not from the inpatient pharmacy.
2. Administer it to the member.
3. Have the onsite ambulatory pharmacy do the following:
   - Deliver the medication to the patient's bedside.
   - Bill for the medication under the member's Medicare Part D pharmacy benefits.

The member is responsible for the copayment amount.

What not to do

Avoid obtaining the medication through the inpatient pharmacy and billing for the medication on the facility bill under Medicare Part B.

Here's why: When outpatient facilities administer and bill self-administered medications through Medicare Part B, the claims will be denied as not payable. Members must seek direct reimbursement for the expenses they incur during the outpatient stay.

Questions and answers

Which drugs are considered self-administered?

The Centers for Medicare & Medicaid Services, not Blue Cross or BCN, determines which drugs are self-administered. Refer to the CMS ***Self-Administered Drug Exclusion List (SAD List)***.

Can outpatient facilities bill the self-administered drug on the facility bill?

- **If the outpatient facility does have an onsite ambulatory pharmacy**, that pharmacy should bring the drug to the bedside and bill it to the member's Part D benefits. The member pays the copayment.
- **If the outpatient facility doesn't have an onsite ambulatory pharmacy**, the facility should obtain the drug from the inpatient pharmacy and bill it using revenue code 0637 (self-administered drugs). This claim will be denied for beneficiary responsibility under the member's Part B medical benefits and the provider can bill the member for the item on that line. The member can use the bill they receive to seek reimbursement directly through the Part D plan.

Do Medicare Plus Blue℠ and BCN Advantage℠ handle facility claims submitted with revenue code 0637 differently?

Medicare Plus Blue and BCN Advantage handle these claims the same way:

- Medicare Plus Blue denies facility claims submitted with revenue code 0637 under the member's Part B medical benefits. The member should seek reimbursement under their Part D benefits.
- Earlier this year, BCN Advantage updated its claims system to deny the service billed with revenue code 0637 and tell the member: "This service is not a payable Part B benefit; please consult your Part D benefits to seek any reimbursements. The patient is responsible."

Which members this applies to

This information applies to our Medicare Advantage (Medicare Plus Blue and BCN Advantage) members during their outpatient stays. It doesn't apply to Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

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Byooviz to be the preferred ranibizumab drug for Medicare Advantage members, starting Oct. 4

For dates of service on or after Oct. 4, 2022, we're designating preferred and nonpreferred ranibizumab products for our Medicare Advantage (Medicare Plus Blue℠ and BCN Advantage℠) members.

- **Preferred:** Byooviz® (ranibizumab-nuna), HCPCS code Q5124
- **Nonpreferred:** Lucentis® (ranibizumab), HCPCS code J2778

Before requesting authorization to use Lucentis, providers will now need to show that they've tried Byooviz as a step therapy requirement. This change goes into effect for dates of service on or after Oct. 4, 2022.

Both Byooviz and Lucentis will still require that the member first try and fail Avastin (bevacizumab), HCPCS code J3590 for Medicare Plus Blue and HCPCS J9035 for BCN Advantage. Avastin does **not** require prior authorization when used for retinal conditions.

These drugs are covered under members' medical benefits.

Prior authorization still required

Lucentis and Byooviz will continue to require prior authorization when administered in any site of care other than inpatient hospital (place of service code 21) and billed as follows:

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

Submitting prior authorization requests

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

If you have access to the Availity® Essentials provider portal (**availity.com**), you already have access to NovoLogix. If you need to request access to Availity, follow the instructions on the **Register for webtools** webpage at **bcbsm.com/providers**.

After you've logged in to Availity, click *Payer Spaces* and then click the BCBSM and BCN logo. This will take you to the Blue Cross and BCN payer space, where you'll find links to the NovoLogix tools on the Applications tab.

Reminder about requirements for other retinal drugs

As a reminder, all other intravitreal medications for retinal conditions still have Avastin as a step therapy requirement. These are:

- Eylea® (aflibercept), HCPCS code J0178
- Beovu® (rolucizumab-dbll), HCPCS code J0179
- Vabysmo® (facricimab-svoa), HCPCS codes C9097 and J3590
- Susvimo™ (ranibizumab injection, for ocular implant), HCPCS code J2779

List of requirements

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

We'll update the list to reflect these changes before the effective date.

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BCN commercial follows CMS guidelines for use of JW modifier to indicate drug waste

As a reminder, Blue Care Network commercial follows the Centers for Medicare & Medicaid Services' standard billing guidelines for the use of the JW modifier to identify unused drugs or biologicals from single-use vials or single-use packages that are appropriately discarded. (Multiuse vials aren't subject to payment for discarded amounts of drug.) This applies to professional claims only.

The JW modifier, billed on a separate line, will provide payment for the amount of the discarded drug or biological.

Example: A single-use vial that is labeled to contain 100 units of a drug has 95 units administered to the patient and five units discarded. The 95-unit dose is billed on one line, while the discarded five units will be billed on another line by using the JW modifier. Both line items would be processed for payment. Providers must record the discarded amounts of drugs and biologicals in the patient's medical record.

Beginning in the fourth quarter of this year, some drug waste will be reimbursed at a reduced rate for BCN commercial. Refer to future minimum fee schedules for details.

In the **June 2022 issue** of *The Record*, we communicated that Blue Cross commercial will also reimburse at a reduced rate for some drug waste.

For more information, check out the CMS article ***Billing and Coding: JW Modifier Billing Guidelines***.

Requirements changed for some commercial medical benefit drugs

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

From March through June 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
Q5124	Byooviz™	ranibizumab-nuna
C9098	Carvykti™	ciltacabtagene autoleucel
C9094	Enjaymo™	sutimlimab-jome

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

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Important information about billing and requesting prior authorization for denosumab

Part B specialty drugs Prolia® and Xgeva® have the same generic name, denosumab, and HCPCS code, J0897. Both drugs require authorization for Medicare Plus Blue and BCN Advantage members when these drugs are administered by a health care provider in sites of care such as outpatient facilities or physicians' offices.

Here's some important information about billing and requesting prior authorization for denosumab drugs.

Include the NDC when billing for these drugs

To ensure appropriate and timely reimbursement of claims, be sure to enter the following National Drug Code numbers along with the HCPCS code (J0897):

- Prolia — Enter NDC 55513071001
- Xgeva — Enter NDC 55513073001

We can reimburse claims submitted for these drugs more quickly when you:

- Included the NDC along with the HCPCS code
- Submitted a prior authorization request and it's been approved

Submitting prior authorization requests

To submit prior authorization requests for these drugs, log in to our provider portal (**availity.com**). Click *Payer Spaces* and then click the BCBSM and BCN logo. On the Applications tab, do the following:

- For Prolia, which is used to treat osteoporosis, scroll down and find the links to the NovoLogix® tools. Click the appropriate link.
- For Xgeva, which is primarily used to treat bone metastases due to solid tumors, click the *AIM Provider Portal* link.

Additional information

As a reminder:

- Prolia and Xgeva are part of members' medical benefits, not their pharmacy benefits.
- Authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.

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Blue Cross and BCN are covering an additional vaccine

To increase access to vaccines and decrease the risk of vaccine-preventable disease outbreaks, Blue Cross Blue Shield of Michigan and Blue Care Network will add the following vaccine to our list of vaccines covered under the pharmacy benefit.

Vaccine	Common name and abbreviation	Age requirement	Effective date
PreHevbrio™	Hepatitis B (HepB)	None	June 1, 2022

The following lists all the vaccines that are covered under eligible members' prescription drug plans. Most Blue Cross and BCN commercial (non-Medicare) members with prescription drug coverage are eligible. If a member meets the coverage criteria, the vaccine is covered with no cost sharing.

Vaccine	Common name and abbreviation	Age requirement
Dengvaxia®	Dengue vaccine	None
Daptacel®	Diphtheria, tetanus, and acellular pertussis vaccine (DTaP)	None
Infanrix®	Diphtheria, tetanus, and acellular pertussis vaccine (DTaP)	None
Diphtheria and tetanus toxoids	Diphtheria, tetanus vaccine (DT)	None
Kinrix®	DTaP and inactivated poliovirus vaccine (DTaP-IPV)	None
Quadracel®	DTaP and inactivated poliovirus vaccine (DTaP-IPV)	None
Pediarix®	DTaP, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV)	None
Pentacel®	DTaP, inactivated poliovirus, and Haemophilus influenzae type b vaccine (DTaP-IPV/Hib)	None
Vaxelis®	DTaP, inactivated poliovirus, Haemophilus influenzae type b, and hepatitis B vaccine (DTaP-IPV-Hib-HepB)	None
ActHIB®	Haemophilus influenzae type b vaccine (Hib)	None
Hiberix®	Haemophilus influenzae type b vaccine (Hib)	None
PedvaxHIB®	Haemophilus influenzae type b vaccine (Hib)	None
Havrix®	Hepatitis A (HepA)	None
Vaqta®	Hepatitis A (HepA)	None
Engerix-B®	Hepatitis B (HepB)	None
Heplisav-B®	Hepatitis B (HepB)	None
PreHevbrio™	Hepatitis B (HepB)	None
Recombivax HB®	Hepatitis B (HepB)	None
Twinrix®	Hepatitis A & B (HepA-HepB)	None
Gardasil 9®	Human papillomavirus vaccine (HPV)	9 to 45 years old
Influenza virus	Influenza vaccine (Flu)	Younger than 9: 2 vaccines per 180 days 9 and older: 1 vaccine per 180 days

Please see Additional vaccine continued on Page 20

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Additional vaccine, *continued from Page 19*

Vaccine	Common name and abbreviation	Age requirement
M-M-R II®	Measles, mumps, rubella vaccine (MMR)	None
ProQuad®	Measles, mumps, rubella and varicella vaccine (MMRV)	None
Menveo®	Meningococcal serogroups A, C, W, Y vaccine (MenACWY-CRM)	None
Menactra®	Meningococcal serogroups A, C, W, Y vaccine (MenACWY-D)	None
MenQuadfi®	Meningococcal serogroups A, C, W, Y vaccine (MenACWY-TT)	None
Bexsero®	Meningococcal serogroup B vaccine (MenB-4C)	None
Trumenba®	Meningococcal serogroup B vaccine (MenB-FHbp)	None
Prevnar 13®	Pneumococcal 13-valent conjugate vaccine (PCV13)	65 and older
Vaxneuvance™	Pneumococcal 15-valent conjugate vaccine (PCV15)	None
Prevnar 20™	Pneumococcal 20-valent conjugate vaccine (PCV20)	None

Vaccine	Common name and abbreviation	Age requirement
Pneumovax 23®	Pneumococcal 23-valent polysaccharide vaccine (PPSV23)	None
IPOL®	Poliovirus vaccine (IPV)	None
Rotarix®	Rotavirus vaccine (RV1)	None
RotaTeq®	Rotavirus vaccine (RV5)	None
Tdvax™	Tetanus and diphtheria vaccine (Td)	None
Tenivac®	Tetanus and diphtheria vaccine (Td)	None
Adacel®	Tetanus, diphtheria, and acellular pertussis vaccine (Tdap)	None
Boostrix®	Tetanus, diphtheria, and acellular pertussis vaccine (Tdap)	None
Varivax®	Varicella vaccine (VAR) (chickenpox)	None
Shingrix®	Zoster vaccine (RZV) (Shingles)	None

If a member doesn't meet the age requirement for a vaccine, Blue Cross and BCN won't cover the vaccine under the prescription drug plan, and the claim will reject.

Vaccines must be administered by certified, trained and qualified registered pharmacists.

Pharmacogenomics training opportunities

OneOme, co-founded by the Mayo Clinic, is an independent precision medicine company that has contracted with Blue Care Network to introduce a new precision medicine program for eligible BCN members. OneOme is recommending some educational opportunities for physicians, pharmacists and other clinicians to learn about pharmacogenomics, or PGx, the study of how an individual's genetic makeup affects how they respond to medications.

See the article on **Page 3** for details.

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BCN Provider News

Feedback

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:

- Local and national coverage determinations
- Updates to the clinical editing appeal process

Clinical editing billing tips

CS modifier limited to specific codes that result in COVID-19 testing for commercial plans, starting Sept. 1

To make provider billing practices more uniform, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans will limit the use of the CS modifier to a list of codes that is similar to the list published by the Centers for Medicare & Medicaid Services on Feb. 4, 2021. This change for our commercial plans will start with dates of service on or after Sept. 1, 2022.

The CS modifier identifies that the services resulted in a COVID-19 test and are subject to the member cost-sharing waiver during the public health emergency.

Starting with dates of service on or after Sept. 1, 2022, for Blue Cross and BCN Commercial plans, you should only bill the CS modifier with one of the procedure codes on the ***Services that result in a COVID-19 test and the CS modifier*** document. We will only waive member cost sharing when the CS modifier is billed with one of these codes.

As a reminder, the procedure code may not be eligible for the member cost-sharing waiver if you bill with a diagnosis code that indicates the service was administrative or routine, such as an examination for an employer, school, sports team or research study. Always check the member's eligibility and benefits.

You should follow CMS guidance for our Medicare Advantage plans, Medicare Plus Blue℠ and BCN Advantage℠. If you submit a CS modifier with a procedure code that is not allowed by CMS, the claim will be denied. The latest CMS code list is available in this **CMS guidance**.

Reminder: These claims are subject to a post-service review (audit).

We have updated the ***COVID-19 patient testing recommendations for physicians*** document, which can be found on our new provider portal or our public website as follows.

Our provider portal:

Log in to our provider portal (**availity.com**) and follow these steps:

1. Click *Payer Spaces* in the menu bar.
2. Click on the BCBSM and BCN logo.
3. Click the *Resources* tab.
4. Click *Secure Provider Resources (Blue Cross and BCN).*
5. Under Easy Access, click *Coronavirus information.*

Our public website: COVID-19 webpage for health care providers

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Lunch and learn webinars focus on risk adjustment, coding

Physicians and coders are invited to attend webinars that provide new information on documentation and coding of common and challenging diagnoses. These live, lunchtime educational sessions will include an opportunity to ask questions.

Action item

Register now for webinars that can improve your coding processes.

Current schedule

All sessions start at noon Eastern time and generally run for 30 minutes.
Click on a link below to sign up.

Session Date	Topic	Registration
Sept. 22	Coding Heart Failure, COPD, CHF	Register here
Oct. 11	2023 Updates for ICD-10-CM	Register here
Nov. 16	Coding Scenarios for Specialty Providers and PCPs	Register here
Dec. 8	E/M Coding Review and Scenarios	Register here

You can watch previously hosted sessions on our provider training website. Use the keyword “Lunch” to search for the courses. You’ll also find them listed in the “Quality management” section of the course catalog.

Click **here** if you are already registered for the site.

To request access to the provider training website:

1. Click **here** to register.
2. Complete the registration. We recommend using the same email you use to communicate with Blue Cross Blue Shield of Michigan for other provider-related needs. This will become your login ID.

Previously recorded	Topic
April 19	Coding and Documentation for HCC Capture and Risk Adjustment
May 5	Coding for Cancer and Neoplasms
June 16	Coding for Heart Disease and Heart Arrythmias
July 19	Coding for Vascular Disease

If you have any questions about the sessions, email April Boyce at aboyce@bcbsm.com. If you have questions about registration, email Patricia Scarlett at pscarlett@bcbsm.com.

Guidelines updated for billing self-administered medications provided in outpatient facilities

We offer some guidelines for situations when a Medicare Advantage member receives services in an outpatient facility but hasn’t brought his or her self-administered medications.

See the article on **Page 15** for details.

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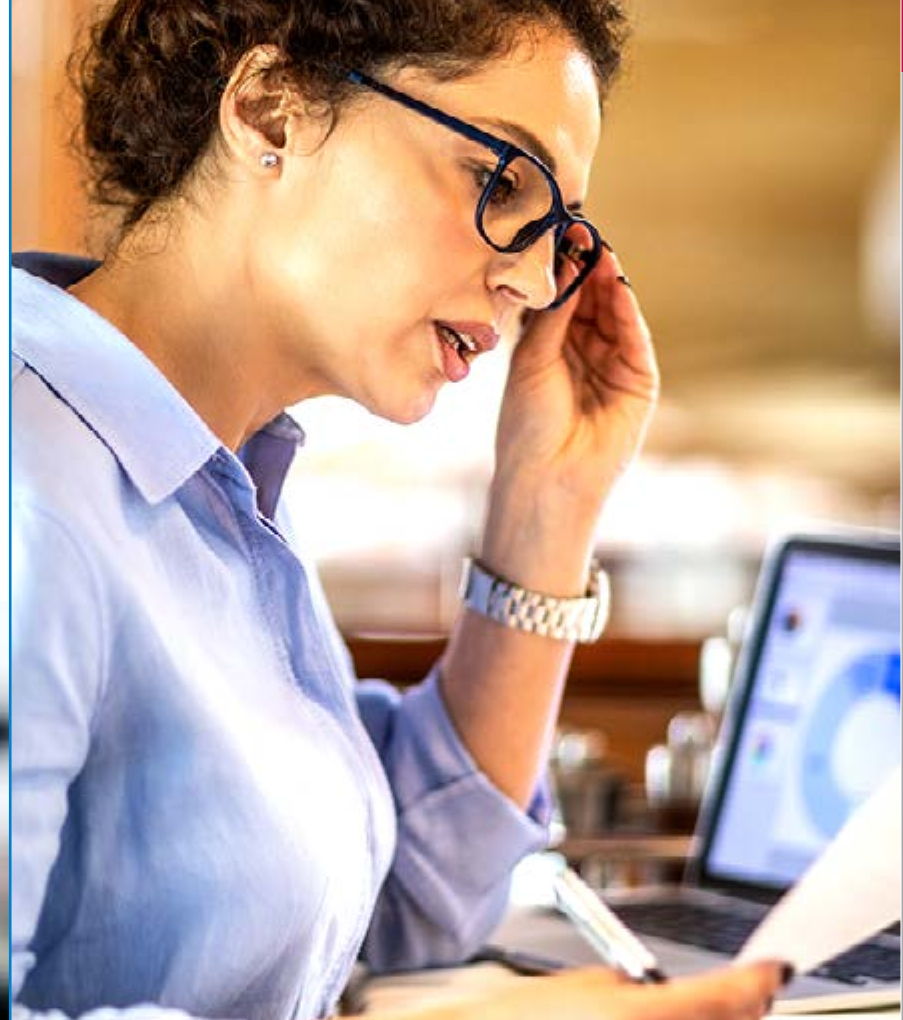
Some BCN Advantage claims paid in error

We've identified payment errors that were made when we processed two types of claims for BCN Advantage℠ members. These errors affect claims for:

- Procedure code *92015 (determination of refractive state)
- Procedure codes billed with status indicator N (noncovered); B (bundled); or I (invalid for Medicare)

See the article on **Page 7** for details.



Important information about billing and requesting prior authorization for denosumab

Part B specialty drugs Prolia® and Xgeva® have the same generic name, denosumab, and HCPCS code, J0897. Both drugs require authorization for Medicare Plus Blue and BCN Advantage members when these drugs are administered by a health care provider in sites of care such as outpatient facilities or physicians' offices.

For details, see the full article on **Page 18**.

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Submit requests for commercial inpatient rehabilitation admissions and extensions only through e-referral, starting Jan. 1, 2023

Beginning Jan. 1, 2023, we'll require inpatient rehabilitation, or IPR, providers located in Michigan to submit prior authorization requests through the e-referral system and **not** by fax. This applies to requests for our Blue Cross and Blue Care Network commercial members for:

- Initial admissions
- Additional days (extensions)

Many inpatient rehabilitation providers are now using the Blue Cross and BCN *SNF/acute IPR assessment form* to submit their prior authorization requests for inpatient rehabilitation services.

What's changing on Jan. 1

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

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

We'll offer training

In October, we'll schedule webinars for IPR providers so you can learn how to use the e-referral system. Watch for upcoming communications about these webinars.

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***.

How to access the e-referral system

Access the e-referral system through our provider portal:

1. Log in to **availity.com**.
2. On the Payer Spaces menu, click the BCBSM and BCN logo.
3. On the Applications tab, scroll down and click on the e-referral tile.

You'll first need to register for access to our portal, if you haven't already done that. Refer to the **Register for web tools** webpage for instructions on how to:

- Register for access to Availity.
- Set up the e-referral tool within Availity.

Submit Medicare Advantage requests to naviHealth

naviHealth manages prior authorization requests for post-acute care admissions for our Medicare Plus Blue℠ and BCN Advantage℠ members.

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

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We made questionnaire changes in the e-referral system

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

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

New questionnaires

We added a *Medicare implantable ambulatory event monitors* questionnaire for pediatric and adult Medicare Plus Blue℠ and BCN Advantage℠ members. This questionnaire opens for procedure code *33285.

Updated questionnaires

We updated the following questionnaires:

- *Endovenous ablation for treatment of varicose veins* — For adult Medicare Plus Blue, BCN commercial and BCN Advantage members. We updated some of the questions in this questionnaire.
- *Implantable ambulatory event monitors* — This questionnaire opens only for pediatric and adult BCN commercial members. (The *Medicare implantable ambulatory event monitors* questionnaire will open for Medicare Plus Blue and BCN Advantage members, as noted above.)
- *Sacral nerve neuromodulation/stimulation* — For adult Medicare Plus Blue, BCN commercial and BCN Advantage members. We updated the possible answers for some of the questions.
- *Sleep studies — outpatient facility or clinic-based setting* — For adult BCN commercial and BCN Advantage members. This questionnaire no longer opens for procedure codes *95782 and *95783. It will continue to open for other procedure codes.

Removed questionnaires

We removed the questionnaires below, which previously opened for procedure code *64568. These questionnaires no longer open for any members, as this procedure code no longer requires prior authorization.

- *Hypoglossal nerve stimulator — condition trigger*
- *Hypoglossal nerve stimulator — adolescent or young adult*
- *Hypoglossal nerve stimulator — adolescents with Down syndrome*
- *Hypoglossal nerve stimulator — adults*

Accessing preview questionnaires, authorization criteria and medical policies

You can access the preview questionnaires, authorization criteria and medical policies on the following pages of the **ereferrals.bcbsm.com** website:

- **Blue Cross Authorization Requirements & Criteria**
- **BCN Authorization Requirements & Criteria**

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Oxlumo to have site-of-care requirement for commercial members, starting Oct. 1

Starting Oct. 1, 2022, Oxlumo® (lumarisan), HCPCS code J0224, will have a site-of-care requirement for Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members.

See the full article on **Page 14** for details.

Requirements changed for some commercial medical benefit drugs

From March through June 2022, we added prior authorization requirements, site-of-care requirements or both for Blue Cross commercial and BCN commercial members for some medical benefit drugs.

See the full article on **Page 17** for details.

Use updated forms for post-acute care prior authorization requests for commercial members

Providers should use our updated and aligned forms when submitting prior authorization requests for post-acute care for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

Among other changes, we combined the Blue Cross and BCN forms, which were previously separate, so providers can now use the same form to submit post-acute care requests for both Blue Cross and BCN commercial members.

Follow the instructions on each form for completing and submitting it:

- ***Skilled nursing facility and acute inpatient rehabilitation form***

  Attach this form to the case in the e-referral system. For skilled nursing facility, or SNF, and for acute inpatient rehabilitation, or IPR, requests, attach the completed form and the required documentation to the case in the e-referral system.
- ***Long-term acute care hospital form***

  Fax this form. For long-term acute care hospital, or LTACH, requests, fax the completed form along with the required documentation to one of the numbers shown on the form.

In July, we posted the forms in the following locations:

- On the **For Providers: Forms and Documents** page at **bcbsm.com/providers**
- On our **ereferrals.bcbsm.com** website, on the BCN **Forms** page and on the Blue Cross **Authorization Requirements & Criteria** page, in the "For Blue Cross commercial members" section.
- In the secure Provider Resources area of our provider portal at **availity.com**. On the Forms menu, click *Assessment*.

In addition to combining the Blue Cross and BCN forms, we updated the forms to make these requests easier to submit. Specifically:

- We included more fields, so providers can now enter more complete information on each form.
- We clarified the instructions for submitting the requests. See the instructions on the form.

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Post-acute care providers need direct access to naviHealth's provider portal

The way post-acute care providers access naviHealth's provider portal, nH Access, is changing with Blue Cross Blue Shield of Michigan and Blue Care Network's transition to Availity Essentials. Post-acute care providers will need direct access to nH Access.

See the full article on **Page 4** for details.

naviHealth improves process for prior authorization requests for initial SNF stays for Medicare Advantage members

Effective Sept. 21, 2022, naviHealth Inc. will add a new tool — the nH Access authorization wizard — to the nH Access portal for Medicare Plus Blue℠ and BCN Advantage℠ members.

See the full article on **Page 8** for details.

BCN to use InterQual ABA criteria for prior authorization requests submitted starting Oct. 1

For prior authorization requests submitted for BCN commercial members on or after Oct. 1, 2022, Blue Care Network will use Change Healthcare's InterQual® Applied Behavior Analysis Treatment criteria to make determinations.

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

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