NOVEMBER-DECEMBER 2022

BCN Provider News

Final Provider Secured Services and web-DENIS retirement dates announced along with Availity enhancements

What you need to know

The main applications within Blue Cross and BCN's Provider Secured Services and web-DENIS have ended or are ending soon. You will no longer be able to log in to Provider Secured Services beginning Dec. 16. To maintain access to online information, register for Availity Essentials, take advantage of online training and begin using our new provider portal today.

On Oct. 25, Blue Cross Blue Shield of Michigan and Blue Care Network entered the third phase of retirement for Provider Secured Services and web-DENIS. This phase included the removal of:

- The HCPCS lookup tool
- All links to applications for submitting referral and prior authorization requests

The HCPCS lookup tool and links for referral and prior authorization requests are available on our new provider portal – **availity.com**.

TIP: Use the Authorization Request tool or the Referral Request tool if you're not sure whether a prior authorization or referral is required. If you know that a prior authorization or referral is required and where to submit the request, you can link directly to the specific application through the BCBSM and BCN Payer Space Applications tab.

For a complete list of applications that are now only available on our new provider portal, view **Applications removed from Provider Secured Services**.

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

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Future retirement dates

The phased retirement of Blue Cross and BCN's Provider Secured Services and web-DENIS is continuing. If you're still using our old online systems, take note of these key dates:

- Nov. 18, 2022: The eligibility and benefits tool within web-DENIS will no longer be available
- Dec. 16, 2022: You will no longer be able to log in to Provider Secured Services or web-DENIS

To maintain access to Blue Cross and BCN online information, it's important that you register for Availity Essentials, take advantage of online training and begin using our new provider portal today. For help getting started with Availity Essentials, see the Resources section at the end of this article.

Enhancements to our new provider portal

We continue to enhance the information you'll find for Blue Cross and BCN in Availity Essentials. Here are some of the latest changes we're making to help you do your work faster and easier.

- **New claims status fields:** *Coming soon!* When you check claim status in Availity Essentials for your Blue Cross and BCN patients, you'll now find more comprehensive information, including:
  - Member cost share fields (copay, coinsurance and deductible) at both the claim line level as well as a summary
  - Claim received date, received date and other applicable dates (admission date or pended date)
  - Authorization number
  - Allowed amount
  - Non-covered
- **HCPCS Lookup:** *Recently added.* Many of you told us you wanted our new provider portal to include the HCPCS Payment Rule Display tool that we had in the Facility Claims section of web-DENIS. We heard you. You can now find this tool in Availity through the BCBSM and BCN Payer Space Applications tab.
- **BCN capitation tool:** *Recently added.* You can now find BCN capitation reports within Availity. The new report is called BCN Capitation and Zero-Dollar Voucher Lookup. You can find this tool in Availity through the BCBSM and BCN Payer Space Applications tab.

Please see Provider Secured Services and web-DENIS continued on Page 3

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Learn more about updates to our new provider portal

We've created a new document, Provider Portal Change and Status Updates, to keep you informed about:

- New provider portal features and functionality
- Issues we're working to address
- Improvements we've made to the portal

Here's how to find Provider Portal Change and Status Updates:

Log in to our provider portal (availity.com).

1. Click *Payer Spaces* on the menu bar and then click the BCBSM and BCN logo.
2. Click the *News and Announcements* tab.
3. Click *Provider Portal Change and Status Updates.*

Watch for additional announcements

Continue to read our provider alerts within the Blue Cross and BCN Payer Space in Availity Essentials for the latest information on the retirement of Provider Secured Services and web-DENIS. We'll post an alert should there be any changes to the dates listed in this article.

Here are the recent notices about the retirement of Provider Secured Services and web-DENIS:

- Provider alert: **Provider Secured Services and web-DENIS retirement continues on Oct. 25**
- Provider alert: **Next phase of Provider Secured Services and web-DENIS retirement is Sept. 15**
- Sept.-Oct. *BCN Provider News* article: **Next phase of Provider Secured Services and web-DENIS retirement announced**
- July-Aug. *BCN Provider News* article: **Provider Secured Services and web-DENIS end date extended for some functions**
- Provider alert: **Provider Secured Services, including web-DENIS, end date extended for some functions**

Here's how to find provider alerts within Availity Essentials.

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

You can make the *Provider Resources* site 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.

Resources

- Register for **Availity Essentials**. Learn more at **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), from 8 a.m. to 8 p.m. Eastern time, Monday through Friday (excluding holidays).

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal services.

New for 2023: Blue Cross® Local HMO

Blue Cross Local HMO is a new 2023 network available to Michigan residents in Macomb, Oakland and Wayne counties. Members must select a primary care physician within the local network of physicians and hospitals affiliated with Ascension and Trinity Health.

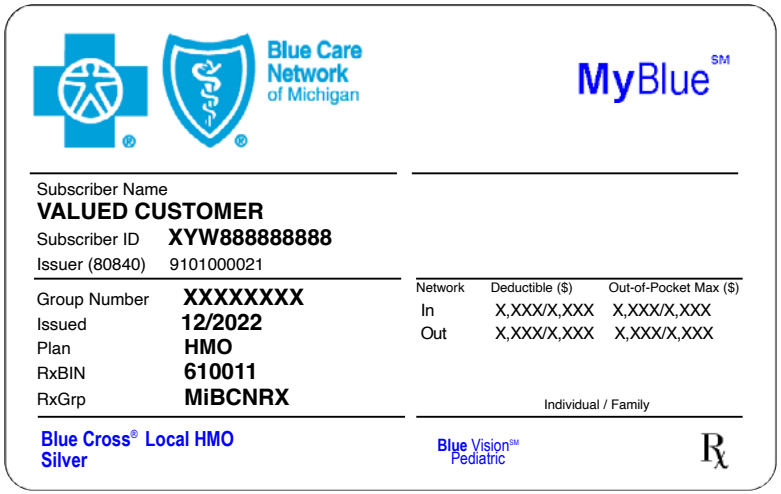
Members must receive services within this local network. The primary care physician coordinates care with the network specialists and hospitals. If a member needs services found outside the network, a referral is required from the primary care physician. BCN will only authorize the service if it is something that can't be performed within the network.

Please see New for 2023 continued on Page 4

Network Operations

Blue Cross Local HMO covers the following benefits at 100%:

- Annual wellness visit, well-care visit for children
- Immunizations
- Diabetes test strips, lancets and connected devices with diabetes, pre-diabetes and hypertension management programs
- Behavioral health app myStrength by Livongo
- Family building and maternity program (see the article on Page 13 for more details)
- Blue Cross Personalized Medicine℠
- Blue Cross Online Visits (medical) with nationwide coverage
- 24-hour nurse hotline for medical advice from a registered nurse
- Blue Cross Coordinated Care Core℠ care management program
- Blue Cross Health & Wellness services and programs powered by WebMD



Blue Cross Local HMO is offered in multiple silver- and bronze-level individual and family plans. Providers will see the Blue Cross Local HMO name on the front of the member's ID card or in our provider portal when you check eligibility. For Medicare members, the BCN Advantage℠ Local HMO plan is also available. See the article on Page 8 for more details.

2023 BCN Advantage℠ plans offer rich supplemental benefits increasing member value and choices

BCN Advantage has enhanced its 2023 plans with a focus on value, options and strong supplemental benefits to help members find the right plan for their needs. See the article on Page 9 for details.

BCN offers virtual primary care plan for 2023

Blue Care Network will offer a new, low-cost plan providing coordinated, virtual access to primary, urgent and behavioral health care starting Jan. 1, 2023. The virtual primary care plan was developed in response to consumer demand in partnership with Included Health, an integrated clinical care and healthcare navigation platform.

The new virtual primary care health plan is being offered as BCN commercial coverage and is called:

- BCN Virtual Primary Care℠ HMO, when sold to fully insured small and large employer groups
- Blue Cross® Preferred HMO Virtual Primary Care, when sold to individual members.

Employer groups that offer this plan to their employees must also offer another health plan option so their employees can choose between this virtual primary care plan or a traditional in-person care plan.

The type of patients this new virtual primary care plan will appeal to include those who:

- Likely do not have a primary care physician and may depend on urgent care services
- Are comfortable using a mobile device
- Have barriers to seeking care in person due to transportation issues, limited local providers, work outside of traditional hours or have difficulty taking time off work to seek care
- Have few or no chronic conditions

Please see BCN offers virtual primary care plan for 2023 continued on Page 5

The plan includes virtual primary care for adult members (age 18 and older) while children (under age 18) will have an in-person primary care physician within the BCN provider network. Virtual urgent care and behavioral health is available to all members. Referrals are required for adult members if in-person care is needed (except for urgent care, emergency room, behavioral health and routine women's health services).

How it works

The clinical team for this new health plan is employed by Doctor On Demand by Included Health. Through the Doctor On Demand dedicated mobile app (or website for those not on a mobile device), members create a profile and choose a board-certified primary care providers who will walk them through their first visit, manage their future visits and coordinate all their health care needs. They can assist with current health concerns, specialist referrals, behavioral health appointments and urgent care visits. Members receive a free primary care kit (one per household), which includes a digital blood pressure monitor and thermometer for their first wellness visit. Chronic care kits are available for members diagnosed with asthma, diabetes, hypertension or chronic kidney disease.

Learn more about Doctor On Demand in the **Welcome to Primary Care overview video**. You can read more about Virtual Primary Care in our **news release**.

For some providers, the process for updating information with us is changing in November

Starting Nov. 3, 2022, some providers may need to complete two forms to update any of the following information in the Blue Cross Blue Shield of Michigan and Blue Care Network online provider directory:

- Name
- Specialty
- Address
- Telephone number
- Digital contact information

We're changing the process of updating information to comply with provisions of the Consolidated Appropriations Act of 2021.

Which providers will be affected

This change will affect all providers except:

- Hospitals
- Group and individual providers

What's changing

When making a change, refer to the table below:

If you're updating this information	Forms to complete
Only your name, specialty, address, telephone number and/or digital contact information.	Complete the new *Provider Directory Change Form.*
Information **other than** the items listed above.	Complete one of the following currently used forms: • Facility providers: *BCBSM/BCN Facility Change Form* • Allied providers: *Allied Provider Change Form*
Updates involving **both**: • Your name, specialty, address, telephone number and/or digital contact information • Information other than the items listed above	Complete two forms: • The new *Provider Directory Change Form* • The currently used *BCBSM/BCN Facility Change Form* or the *Allied Provider Change Form*, as appropriate

Where to find the forms

You'll find a link to the new *Provider Directory Change Form* near the links to the *BCBSM/BCN Facility Change Form* and the *Allied Provider Change Form*.

To access the forms:

1. Visit **bcbsm.com/providers**.
2. Click *Enrollment.*
3. Click *Enroll Now.*
4. Follow the prompts.

Fax the completed forms to Provider Enrollment at 1-866-900-0250. This fax number is shown on each form.

Need help?

Providers who need assistance completing the correct forms can call Provider Enrollment at 1-800-822-2761.

Network Operations

eLearning videos on Medicare Star Ratings updated for 2022

Action item
Complete updated training on Medicare Star Ratings for continuing education credits.

The Quality and Provider Education team has updated an important training resource for health care providers and staff. The *2022 CMS Star measures* overview is now available on the provider training website. The video series discusses the importance of creating positive patient experiences as part of your efforts to close gaps in care.

Topics include:

- Updated information about HEDIS® quality measures, which are also Medicare star ratings measures
- A new, detailed section about the Health Outcomes Survey
- Tips for closing gaps
- Clarifications on quality measure requirements
- Assistance with coding and documentation

The video series has been approved for *AMA PRA Category 1 Credit™*. We've made it even easier to earn continuing education credits this year. You can earn fractional credits for each of the five modules in the course, for a total of 2.5 credits. You don't need to complete the entire course to earn credit.

Log in to the **provider training website** to access the modules. Look in the course catalog under Quality management or search for the lesson with the keyword Star.

Don't have access yet? 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, email ProviderTraining@bcbsm.com.

New on-demand training available

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

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 opportunity:

- Risk Adjustment: Overview for documentation and coding

This e-learning module gives a high-level overview of the risk adjustment program and its covered plans. Learners will be able to identify main requirements and principles for risk adjustment and diagnosis closure, follow best practices on documentation and coding and locate proper resources to support the risk adjustment practices.

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, email ProviderTraining@bcbsm.com.

e-referral training tools updated

The e-referral User Guide, Online Self-paced Learning Modules and Quick Guide have been updated on the ***Training Tools*** page of **ereferrals.bcbsm.com**. The User Guide and Quick Guide are dated September 2022.

What's new

- We've updated the language when extending service on an existing inpatient authorization in e-referral. Providers are instructed to enter dates and number of days in the Confinement Extension(s) section of their inpatient authorization as well as upload any required clinical information in the Case Communication field. This information can be found in the *Submit an Inpatient Authorization* chapter of the **e-referral User Guide** and the ***Submitting an Inpatient Authorization eLearning module***.
- Instructions on checking a member's eligibility and benefits information now shows how to find them in the new provider portal (availity.com). This information can be found in the *Checking member eligibility & benefits* chapter of the **e-referral User Guide**.
- A section was added introducing the provider portal's Authorizations & Referrals Request tool. This tool helps users determine whether an authorization or referral is required for certain services. This information can be found in the *Accessing e-referral* chapter of the **e-referral User Guide**.
- Logging in to e-referral has been updated with step-by-step instructions for the new provider portal. This information can be found in the *Accessing e-referral* chapter of the **e-referral User Guide** and the **e-referral Quick Guide**.

Precision Medicine and Pharmacogenomics education opportunities

As previously announced in the July-August 2022 issue of ***BCN Provider News***, Blue Care Network is launching an end-to-end precision medicine pharmacogenomics (PGx) program called Blue Cross Personalized Medicine℠. This program uses PGx to personalize medication treatments based on FDA recognized gene-drug interactions. BCN has contracted with OneOme®, an independent precision medicine company co-founded by Mayo Clinic, to provide this program for eligible BCN and BCN Advantage℠ members with pharmacy benefit. The program is scheduled to launch in January 2023.

You can learn more about pharmacogenomics by attending one of our free upcoming educational sessions. These sessions will focus on specific case studies as they pertain to various disease states and specialties. They'll also focus on your role in the program and on your patients' experience from invitation through testing completion and medication treatment options tailored to their individual needs. Use the links below to register. Prescribers, clinical pharmacists and supportive staff are welcome to attend.

Session date/time	Case Study Focus	Registration
Thursday, Nov. 10, 2-3:00 p.m. Eastern time (online only)	Primary Care	**Register here**
Tuesday, Nov. 15, 10-11:00 a.m. Eastern time (in person or online)	Behavioral Health	**Register here** Lyon Meadows Conference Center 53200 Grand River Ave. New Hudson, MI 48165
Thursday, Dec. 8, noon to 12:45 p.m. Eastern time (online only)	Cardiology	**Register here**

Sessions will be recorded. If you're unable to attend, you can visit our provider training website to watch the previously hosted sessions.

Click **here** if you are already registered for the provider training website.

1. To request access to the provider training website: Click **here** to register.
2. Complete the registration. Use the same email you use to communicate with Blue Cross Blue Shield of Michigan for other provider-related needs. This will be your login ID.

To find additional pharmacogenomics information in our provider portal:

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.
5. Choose *Blue Cross Personalized Medicine* from the *Member Care* drop-down menu.

BCN Advantage

New for 2023! BCN Advantage℠ Local HMO

BCN Advantage Local HMO is a new 2023 HMO plan available to Michigan residents in Macomb, Oakland and Wayne counties who would like to choose from a network of local doctors centered around our key partners, Ascension and Trinity. It will have a $0 premium, a leaner formulary, and offer rich benefits, including:

- $0 monthly premium with a $0 medical deductible, $0 copays for primary care provider visits, and $45 copays for specialist visits
- Embedded preventive and comprehensive dental with an annual $1,500 allowance, annual eyewear allowance of $150 and routine hearing coverage, plus optional enhanced dental and vision packages
- $85/quarter over-the-counter/grocery allowance (unused over-the-counter allowance can be rolled over within the plan year)*
- In-home support services**
- Caregiver support and limited meals (eligibility requirements may apply)
- $20 individual or group mental health therapy copays
- Annual wellness visit transportation (one round trip in Michigan)
- Nationwide access to SilverSneakers® fitness
- Worldwide emergency and urgent care and worldwide emergency transportation

The member's primary care physician must be part of the BCN Advantage Local HMO network. Specialty care should remain in the Local network. BCN authorization is required for care outside the Local network.

Note: For BCN commercial members, a new Blue Cross® Local HMO network plan is also available. See the article on Page 3 for more details.

*Food option is available to plan-identified members with history of any of the following chronic conditions: diabetes, COPD, CHF, stroke, hypertension, CAD and/or rheumatoid arthritis.

**Members must self-identify as living alone and needing assistance with instrumental activities of daily living.

2023 BCN Advantage℠ plans offer rich supplemental benefits increasing member value and choices

BCN Advantage has enhanced its 2023 plans with a focus on value, options and strong supplemental benefits to help members find the right plan for their needs. For 2023, all BCN Advantage plans offer a $0 medical deductible, $0 in-network copay for primary care provider visits, $0 in-network telehealth copay for primary and behavioral care, $0 prescription deductible (for plans with prescription drug coverage), and a $1,500 annual allowance for preventive and comprehensive dental. To further enrich these plans, all have $20 in-network mental health individual and group therapy copays (outpatient services), as well as support for caregivers and a quarterly over-the-counter allowance that rolls over within the calendar year. For members with a qualifying chronic health condition, the over-the-counter allowance can also be used for healthy foods.*

BCN Advantage plans available in 2023 include:

- BCN Advantage Elements (HMO-POS); Medicare Advantage only (no prescription drug coverage)
- BCN Advantage Classic (HMO-POS)
- BCN Advantage Prestige (HMO-POS)
- BCN Advantage ConnectedCare (HMO)
- BCN Advantage Prime Value (HMO-POS)
- BCN Advantage Community Value (HMO-POS)
- **New for 2023!** BCN Advantage Local HMO

Please see 2023 BCN Advantage℠ plans continued on Page 9

Other key benefits include:

- Increased embedded vision allowance of $150 for all HMO-POS plans and Local HMO.
- Embedded hearing aid allowance is included in all HMO-POS plans and Local HMO.
- Meal benefits included in all plans for members acute post-discharge.
- All Prime Value regions now have an $85/quarter over-the-counter allowance that rolls over within the plan year.
- Prime Value now has a $0 prescription deductible.
- All plans offer one round-trip per calendar year within the State of Michigan to an Annual Wellness Visit, without referral.
- All plans include worldwide emergency and urgent care as well as worldwide emergency transportation.
- All plans include SilverSneakers® fitness.
- Senior Savings insulin coverage is included in all plans except Elements and Community Value.
- Optional supplemental benefit plans are also available for additional coverage and premium.

*Food option available to plan-identified members with history of any of the following chronic conditions: diabetes, COPD, CHF, stroke, hypertension, CAD, and/or rheumatoid arthritis.

Medicare Advantage plans transitioning to Optum Rx® pharmacy benefit manager

We notified providers earlier this year that the pharmacy benefit manager for our Medicare Advantage individual and group members would transition from Express Scripts, Inc., to Optum Rx beginning on Jan. 1, 2023. Our commercial plans transitioned on Jan. 1, 2022, as detailed in this **January 2022 article** in *The Record*.

The transition will be seamless for our health care providers and pharmacists. However, Optum Home Delivery will provide mail-order drugs for preferred out-of-pocket costs, starting Jan. 1, 2023. Be prepared for patients using our current mail-order pharmacy to ask for new prescriptions for controlled substances, expired prescriptions or prescriptions without refills, so they can be filled by Optum Home Delivery.

We'll mail new ID cards to our Medicare Advantage Part D members. They must show their new cards at the pharmacy, starting Jan. 1, 2023, to help ensure their prescriptions are covered correctly under their benefits.

Continue to submit electronic prior authorizations for BCN Advantage and Medicare Plus Blue members using your current electronic medical record system or CoverMyMeds® through Availity. Keep in mind that the BIN number changes to 610011, effective Jan. 1, 2023, for all BCN Advantage and Medicare Plus Blue members.

2023 annual wellness visit

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

Please see 2023 annual wellness visit continued on Page 10

Welcome to Medicare visit

New Medicare Plus Blue℠ PPO members should be scheduling their Welcome to Medicare preventive visit, also known as the initial preventive examination. This is a one-time appointment for new Medicare patients to be scheduled within their first 12 months of enrollment. Medicare pays for one Welcome to Medicare visit per member, per lifetime.

This visit is a great way to get up-to-date information on health screenings, shot records, family medical history and other preventive care services. For more information on the components of a Welcome to Medicare visit, see the **Medicare Learning Network Educational Tool**.

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

Annual wellness visit

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

The annual wellness visit is a chance for you to develop or update your patient's personalized prevention plan based on his or her current health situation and risk factors. A health risk assessment is part of the annual wellness visit. It includes self-reported information from your patient to be completed before or during the visit. For more information on the components of an annual wellness visit, see the **Medicare Learning Network Educational Tool**.

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

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

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

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

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

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 (PCR) 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.

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

According to the *American Journal of Managed Care*, the ineffective transferring of a patient from one care setting (e.g., 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 (TRC) 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, as well as accessible by the PCP 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.

Source: *American Journal of Managed Care*

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

Three additional medications require prior authorization for Medicare Advantage members, starting Aug. 8

For dates of service on or after Aug. 8, 2022, the following drugs require prior authorization for Medicare Plus Blue℠ and BCN Advantage℠ members:

- Alymsys® (bevacizumab-maly), HCPCS code J9999
- Amvuttra™ (vutrisiran), HCPCS code J3490
- Releuko® (filgrastim-ayow), HCPCS code J3590

See the article on **Page 16** for details.

We've changed how we manage Skyrizi SC and Stelara SC, starting Aug. 15

For dates of service on or after Aug. 15, 2022, Blue Cross Blue Shield of Michigan and Blue Care Network have changed how we manage the following medications for Medicare Plus Blue℠ and BCN Advantage℠ members:

- Skyrizi® SC (risankizumab-rzaa), HCPCS code J3590
- Stelara® SC (ustekinumab), HCPCS code J3357

See the article on **Page 16** for details.

We reprocessed claims that denied in error for same-day IPPE/AWV and E&M visits

On Aug. 29, 2022, we updated our system so procedure codes *99385, *99386, *99387, *99395, *99396 and *99397 are payable when billed with Medicare wellness visits. We've also reprocessed claims with dates of service from Jan. 1, 2022, through Aug. 28, 2022, that were denied in error. See the article on **Page 28** for details.

Cimerli™ requires prior authorization for Medicare Advantage members starting Oct. 3

For dates of service on or after Oct. 3, 2022, we've added prior authorization requirements for Medicare Plus Blue℠ and BCN Advantage℠ members for Cimerli (ranibizumab-eqrn), HCPCS code J3590. See the article on **Page 23** for details.

Spevigo® requires prior authorization for Medicare Advantage members, starting Sept. 26

For dates of service on or after Sept. 26, 2022, we've added a prior authorization requirement for Medicare Plus Blue℠ and BCN Advantage℠ members for Spevigo (spesolimab-sbzo), HCPCS code J3590. See the article on **Page 26** for details.

Opdualag™ to require prior authorization for most members, starting Dec. 1

For dates of service on or after Dec. 1, 2022, the following drug will require prior authorization through AIM Specialty Health®:

- Opdualag (nivolumab and relatlimab-rmbw), HCPCS code J9298

See the article on **Page 21** for details.

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:

Medical Policy Updates

Covered services

- Surgical Treatment of Femoroacetabular Impingement
- Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease
- Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation
- Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders
- Skin and tissue substitutes
- Ambulatory blood pressure monitoring for screening and diagnosis of hypertension
- Bronchial valves
- Genetic testing-assays of genetic expression in tumor tissue as a technique to determine prognosis in patients with breast cancer
- Leadless cardiac pacemakers
- Private duty nursing

Noncovered services

- Remote electrical neuromodulation for migraines

New family building and maternity support solution for commercial members

Blue Cross Blue Shield of Michigan and Blue Care Network are working with Maven, an independent company, to provide a family building and maternity support solution that supports all backgrounds, lifestyles and phases of starting or growing a family and helps to improve clinical outcomes for parents and babies.

This solution includes three programs, which will be available starting Jan. 1, 2023. The programs include access to:

- **A dedicated care advocate** who can provide personalized, one-on-one care and benefits navigation to answer questions, recommend practitioners for specific needs, and refer members to high-quality, in-network providers.
- **Personalized resources**, including content related to prenatal health, postpartum depression and returning to work with more confidence. They also include clinical-based articles, community forums, groups, live classes and quizzes.
- **Clinical virtual support** through 24/7 on-demand video appointments available within one hour. Members can speak with providers from more than 30 specialties, including OB-GYNs, mental health specialists, lactation consultants, nutritionists, and career and sleep coaches. Appointments are available in more than 35 languages.

Keep reading to learn more, including which members have access to each program.

- **Family Building program** — Provides support and information for different paths to parenthood, such as fertility treatments, surrogacy and adoption. This program will be available to members who have coverage through Blue Cross and BCN commercial self-funded groups that purchase this program.

  In addition, Maven Wallet is an optional add-on to the family building program. It enables self-funded groups to help their employees with reimbursement of adoption and surrogacy costs.
- **Maternity program** — Offers support during the nine months of pregnancy and for three months postpartum. This program will be available to all members who have coverage through Blue Cross and BCN commercial fully insured groups and to all members who have individual coverage. It's also available to members who have coverage through self-funded groups that purchase this program.

Please see New Family Building continued on Page 14

- **Parenting & Pediatrics program** — Supports parents as they raise their children from ages 1 to 10. This 12-month, renewable program will be available to members who have coverage through Blue Cross and BCN commercial self-funded groups that purchase this program.

These programs won't change your patients' current fertility and maternity benefits or replace their health care providers. Rather, they provide supplemental support and education in between regularly scheduled, in-person prenatal and postpartum appointments, when it's often needed most.

Look for additional information about this solution in upcoming issues of this newsletter.

Maven is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing family building and maternity support services.

Estimate Your Cost tool to launch Jan. 1

Blue Cross Blue Shield of Michigan is excited to announce that it will be launching the Estimate Your Cost tool through the member portal on January 1, 2023. The tool will empower members to compare prices for in-network providers and their services and get an estimation of Blue Cross' payment for out-of-network services.

This innovative web-based tool will be available to all commercial underwritten and commercial self-funded members, as well as all federal employees with a BCN plan. Blue Cross and Blue Shield Federal Employee Program® members will have access via fepblue.org. It won't be available to Medicare, Medicare Advantage or Medicaid members.

The Estimate Your Cost tool will support two federal mandates: The Payer Transparency Final Rule and the Consolidation Appropriation Act - Price Comparison Tool.

Payer Transparency Final Rule

Provide members with personalized, out-of-pocket expense estimates for all covered health care items and services.

The tool will make available:

- 500 shoppable items and services, beginning January 1, 2023
- All other items and services, beginning January 1, 2024

Consolidation Appropriation Act – Price Comparison Tool

Issuers to offer price comparison guidance by telephone or mail within two business days and make available a price comparison tool through a website. The web-based tool must allow members to compare out-of-pocket cost information under their plan or coverage for specific health care items or services delivered by in-network providers. The information provided will be specific to the plan year, geographic region and provider participation status for the respective plan or coverage type.

More information to come

Be sure to look to future issues of this newsletter for more information on how members will be able to use this new web-based tool to select cost-effective items and services that meet both their health care and financial needs.

We're continuing our yearly flu shot campaign

Each year Blue Cross Blue Shield of Michigan and Blue Care Network launch a flu shot campaign geared toward members, group customers, the public and health care providers. This year is no different.

Throughout the entire flu season, we're using our various communication channels to encourage everyone to get their annual flu shot. You may see flu shot content on Blue Cross social media channels, blogs, news articles and more.

Messages for our members

We're sending emails and direct mail from October to January to our members who haven't yet received a flu shot. Here are some of our key messages for members:

- Don't wait, check the flu shot off your to-do list today. It's a service that can take five minutes and can save you five days.

Please see Flu Shot Campaign continued on Page 15

- A flu shot is a safe, quick and convenient way to keep you healthier this season.
- Flu strains vary from year to year, and flu shots are proven to be one of the most effective measures against the virus.
- Get your flu shot at your next scheduled doctor's appointment.
- If you've already received your flu shot this year, encourage your friends and family to get one as well to better protect themselves.
- It's not too late to get one at any point during peak season.

Our campaign is expected to reach people of all ages.

What you can do

We encourage you to continue discussions with your patients about the importance of a yearly flu shot and suggest they get one as soon as possible when they're at your office or at their next scheduled appointment.

More information on flu and pneumonia shots for members with Blue Cross or BCN coverage is available at **bcbsm.com/preventflu** and **bcbsm.com/medicareflushot**. You're welcome to share the information on these sites with your patients.

Blue Cross committed to coordination of care and exchange of information among practitioners

Blue Cross Blue Shield of Michigan collects and analyzes data each year to facilitate the coordination of care and exchange of information among specialists, behavioral health providers and primary care physicians following inpatient and outpatient visits.

Good two-way information exchange is especially important as we work to improve continuity and coordination of care within our network. For example, we not only need primary care providers to share information with specialists (including behavioral health specialists), but we need specialists to share patient information with the primary care providers as well.

Patient care that isn't coordinated across care settings results in confusion for members, increased risks to patient safety and unnecessary costs due to duplicate testing or procedures. Collaboration among health care providers can also greatly improve member satisfaction.

We can work together to accomplish our goal of 100% coordination of care among all providers by:

- Ensuring that specialists and behavioral health care providers have the correct contact information about the patient's primary care provider at the time of the visit
- Requesting that specialists and behavioral health providers forward post-visit information to the patient's primary care provider
- Ensuring that primary care providers forward a patient's medical information to any specialists or behavioral health providers who are treating the patient, as needed
- Asking behavioral health patients to sign an authorization for release of information or including a note of refusal in their chart if a patient declines to share information

We encourage all heath care providers to continue to take steps to enhance the coordination of care and information exchange across the continuum of care to improve member satisfaction and care quality.

Three additional medications require prior authorization for Medicare Advantage members, starting Aug. 8

For dates of service on or after Aug. 8, 2022, the following drugs require prior authorization for Medicare Plus Blue℠ and BCN Advantage℠ members:

- Alymsys® (bevacizumab-maly), HCPCS code J9999
- Amvuttra™ (vutrisiran), HCPCS code J3490
- Releuko® (filgrastim-ayow), HCPCS code J3590

Submit prior authorization requests through the NovoLogix® online tool.

These drugs are part of members' medical benefits, not their pharmacy benefits.

When prior authorization is required

These medications require prior authorization when they are administered by a health care provider in sites of care such as outpatient facilities or physicians' offices and are billed in one of the following ways:

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

Submit prior authorization requests through the NovoLogix tool

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.

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've updated the list to reflect the changes for these drugs.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal services.

We've changed how we manage Skyrizi SC and Stelara SC

For dates of service on or after Aug. 15, 2022, Blue Cross Blue Shield of Michigan and Blue Care Network have changed how we manage the following medications for our Medicare Advantage members:

- Skyrizi® SC (risankizumab-rzaa), HCPCS code J3590
- Stelara® SC (ustekinumab), HCPCS code J3357

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

Note: This change doesn't affect Skyrizi IV, HCPCS code J3590, and Stelara IV, HCPCS code J3358, which will continue to be managed as part of members' Part B medical benefits.

What changed

For dates of service on or after Aug. 15, Medicare Plus Blue and BCN Advantage members who previously received Skyrizi SC or Stelara SC under the Part B medical benefit are required to continue their treatment under their Part D pharmacy benefits.

Please see We've changed how we manage Skyrizi SC and Stelara SC continued on Page 17

We made this change because these therapies can be safely and conveniently self-administered at home. The Centers for Medicare and Medicaid Services added these medications to the **Self-Administered Drug Exclusion List: (SAD List)**.

As a result:

- These drugs are no longer covered when administered by a doctor or other health care professional under the Part B medical benefit.
- Skyrizi SC isn't included in our Medicare Advantage Part D formularies, but health care providers can request prior authorization for it as an exception. (See the "How to submit prior authorization requests for Skyrizi SC and Stelara SC" section of this article.)

  Note: Skyrizi IV still requires prior authorization through the Part B medical benefit, using the NovoLogix® web tool.
- Stelara SC is now covered only through Medicare Advantage members' Part D prescription drug plans. Prior authorization is required through members' Part D benefits. (See the "How to submit prior authorization requests for Skyrizi SC and Stelara SC" section of this article.)

  Note: Stelara IV still requires prior authorization through the Part B medical benefit, using the NovoLogix web tool.
- Your patients can obtain these medications at pharmacies that dispense specialty drugs. They can also obtain these drugs through an AllianceRx Walgreens Pharmacy.

Note: For members who don't have Part D pharmacy benefits through Blue Cross or BCN, providers need to work with the pharmacy vendor that provides each member's Part D coverage.

How to submit prior authorization requests for Skyrizi SC and Stelara SC

For members who have Part D pharmacy benefits through Medicare Plus Blue or BCN Advantage, providers need to submit prior authorization requests for Skyrizi SC and Stelara SC as follows:

- **Electronically**: Through CoverMyMeds® or another free ePA tool, such as Surescripts® or ExpressPAth®. See **Save time and submit your prior authorization requests electronically for pharmacy benefit drugs** for more information.
- **By phone**: Call 1-800-437-3803 and follow the prompts for medications billed through the pharmacy benefit.
- **By fax**:
  - For Medicare Plus Blue requests, fax to 1-866-601-4428.
  - For BCN Advantage requests, fax to 1-800-459-8027.

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've updated this list to reflect the changes related to these drugs.

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

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
Priorix®	Measles, mumps, rubella vaccine (MMR)	None	August 2, 2022

Please see Blue Cross and BCN are covering an additional vaccine continued on Page 18

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 out-of-pocket costs.

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
M-M-R II®	Measles, mumps, rubella vaccine (MMR)	None
Prorix	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

Please see Blue Cross and BCN are covering an additional vaccine continued on Page 19

Vaccine	Common name and abbreviation	Age requirement
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
Pneumovax 23®	Pneumococcal 23-valent polysaccharide vaccine (PPSV23)	None
IPOL®	Poliovirus vaccine (IPV)	None

Vaccine	Common name and abbreviation	Age requirement
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

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.

Blue Cross and BCN commercial will use the Audaire Health™ provider portal to capture clinical outcomes on select therapies, starting Oct. 1

Blue Cross Blue Shield of Michigan and Blue Care Network will use the Audaire Health provider portal to track and capture clinical outcomes for all Blue Cross commercial and all BCN commercial members for select gene and cellular therapies, starting Oct. 1, 2022.

The data that providers enter in the Audaire provider portal will enable Blue Cross and BCN to capture and assess the clinical benefit of these therapies. The goal of collecting this data is to ensure member access to therapies while maintaining affordability.

Which therapies are affected?

Starting Oct. 1, Blue Cross and BCN commercial will capture clinical outcomes for the following therapies in the Audaire provider portal.

Please see Audaire Health™ continued on Page 20

Pharmacy News

Brand name	Generic name	Benefit covered under
Evrysdi®	risdiplam	Pharmacy benefit
Spinraza®	nusinersen	Medical benefit
Zolgensma®	onasemnogene abeparvovec-xioi	Medical benefit

Note: Current requirements will continue to apply to these drugs, including prior authorization requirements.

What will change on Oct. 1?

Starting Oct. 1:

- The first time Blue Cross or BCN approves a prior authorization request you submitted for one of these therapies, you (the requesting provider) must attest that you'll enter clinical outcome information in the Audaire provider portal as requested by Blue Cross or BCN. Attestation is required for the therapies to be covered by a member's benefit. (See "How should you prepare for this change?" below to learn more about attestation.)

  Note: If you have patients for whom we approved an authorization request for one of these therapies prior to Oct. 1 and who currently have active coverage with Blue Cross or BCN, you'll also be required to attest.
- For any member who is approved for one of these therapies, we'll automatically add their basic information to the Audaire provider portal. We'll also add basic information for any members who were approved for one of these therapies prior to Oct. 1.
- Providers will receive email reminders from Audaire on a regular basis to remind them to submit clinical information. The email messages will be sent by **hello@audaire.com**, and they'll include a direct link to the portal for easy access.
- Providers can use either of these submission methods:
  - Enter clinical information in the Audaire provider portal.
  - Call **512-643-5099.** After stating your name, you'll be connected to an Audaire representative, who can enter the clinical information on your behalf.

  Note: To get help entering information in the Audaire provider portal, call **512-643-5099** to schedule an appointment with an Audaire representative.

How should you prepare for this change?

You don't need to take action.

The first time Blue Cross or BCN approves a prior authorization request you submitted for one of these therapies, an Audaire representative will reach out to you to set up a 30-minute phone call during which they'll:

- Create your Audaire Health profile, which will complete your attestation.
- Provide training on how to use the Audaire provider portal.
- Answer your questions about the Audaire provider portal.

Note: An Audaire representative will also reach out to you if you have patients for whom we approved an authorization request for one of these therapies prior to Oct. 1 and who have active coverage with Blue Cross or BCN.

Why are we making this change?

Blue Cross and BCN continually evaluate strategies to help manage drug costs.

Gene and cellular therapies hold significant promise for managing a wide range of diseases, but these therapies have high costs. Our goal is to ensure member access to therapies while maintaining affordability.

Questions?

If you have questions about this change, send them to Allison Olmsted, Pharm.D., at aolmsted@bcbsm.com.

Audaire Health is a contracted vendor that provides select services to Blue Cross and BCN commercial members.

Opdualag™ to require prior authorization for most members, starting Dec. 1

For dates of service on or after Dec. 1, 2022, the following drug will require prior authorization through AIM Specialty Health®:

- Opdualag (nivolumab and relatlimab-rmbw), HCPCS code J9298

Prior authorization requirements apply when this drug is administered in outpatient settings for:

- Blue Cross Blue Shield of Michigan commercial
  - Members who have coverage through fully insured groups
  - Members with individual coverage
  - UAW Retiree Medical Benefits Trust members with Blue Cross non-Medicare plans
- Medicare Plus Blue℠ members
- Blue Care Network commercial members
- BCN Advantage members

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

How to submit prior authorization requests

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

- Through the AIM ProviderPortal, which you can access by doing one of the following:
  - Logging in to our provider portal (availity.com), clicking on *Payer Spaces* and then clicking on the BCBSM and BCN logo. This takes you to the Blue Cross and BCN Payer Space, where you'll click on the *AIM Provider Portal* tile.
  - Logging in directly to the AIM ProviderPortal at **providerportal.com**.
- Call the AIM Contact Center at 1-844-377-1278

More about the authorization requirements

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

For additional information on requirements related to drugs covered under the medical benefit, refer to the following drug lists:

- 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**
- URMBT members with Blue Cross non-Medicare plans:
  - **Medical oncology prior authorization list for UAW Retiree Medical Benefits Trust PPO non-Medicare members**
  - **Medical Drug Management with Blue Cross for UAW Retiree Medical Benefit Trust PPO non-Medicare Members**
- Medicare Plus Blue and BCN Advantage members:
  - **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**

We'll update the drug lists to reflect the information in this message prior to the effective date.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal services.

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.

Skyrizi® IV to have site-of-care requirement for most commercial members, starting Dec. 1

For dates of service on or after Dec. 1, 2022, we're adding a site-of-care requirement for Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for the following drug covered under the medical benefit:

- Skyrizi intravenous (risankizumab-rzaa), HCPCS code J3590

You'll be prompted to select a site of care when you submit prior authorization requests for Skyrizi IV.

If the member meets clinical criteria for the drug, requests for the following sites of care will be approved automatically:

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

Additional information or documentation may be required for requests to administer Skyrizi IV in an outpatient hospital setting.

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 courses of treatment with Skyrizi IV before Dec. 1, 2022, will be able to continue receiving the drug in their current location until their existing authorization expires. If those members then continue treatment under a new prior authorization, the site-of-care requirements outlined above will apply.

Reminder: Skyrizi SC is covered under the pharmacy benefit

Skyrizi® SC (risankizumab-rzaa), HCPCS code J3590, isn't covered under members' medical benefits. Subcutaneous injections are self-administered and are covered under members' pharmacy benefits.

Some Blue Cross commercial groups not 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**.

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 prior to Dec. 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.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal services.

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 July through September 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	Effective date	
			Prior authorization	Site of care
J9999/C9399*	Alymsys®	bevacizumab-maly	✓	
J3590*	Amvuttra™	vutrisiran	✓	
J3590*	Cimerli™	ranibizumab-eqrn	✓	
J1306	Leqvio®	inclisiran		✓
J3590*	Skyrizi® IV	risankizumab-rzaa	✓	
J3590*	Zynteglo®	betibeglogene autotemcel	✓	

*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, 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.

Cimerli™ requires prior authorization for Medicare Advantage members starting Oct. 3

For dates of service on or after Oct. 3, 2022, we've added prior authorization requirements for Medicare Plus Blue℠ and BCN Advantage℠ members for the following drug:

- Cimerli (ranibizumab-eqrn), HCPCS code J3590

Please see Cimerli™ continued on Page 24

For Lucentis®, Cimerli is the second biosimilar and the first interchangeable biosimilar.

Both Cimerli and Lucentis continue to require that the member first try and fail Avastin® (bevacizumab). The HCPCS codes for Avastin are J3590 for Medicare Plus Blue and J9035 for BCN Advantage.

As a reminder, Lucentis already requires prior authorization. Avastin doesn't require prior authorization when used for retinal conditions.

All these drugs are part of members' medical benefits, not their pharmacy benefits.

When prior authorization is required

Cimerli requires prior authorization when it is administered by a health care provider in an outpatient facility or a physician's office and billed in one of the following ways:

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

Submit prior authorization requests through the NovoLogix tool

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 continue to 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
- Byooviz® (ranibizumab-nuna) HCPCS code Q5124
- 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've updated the list to reflect the changes for Cimerli.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal services.

Starting January 1, 2023, we'll change how we cover some prescription drugs

Our goal at Blue Cross Blue Shield of Michigan and Blue Care Network is to provide our members with safe, high-quality prescription drug therapies. We continuously review prescription drugs to provide the best value for our members, control costs and make sure our members are using the right drug for the right situation.

Starting January 1, 2023, we'll change how we cover some medications on the drug lists associated with our prescription drug plans.

We'll send letters to notify affected members, their groups and their health care providers about these changes.

Read the following explanation of these changes:

Please see Starting January 1, 2023 continued on Page 25

Drugs that won't be covered

We'll no longer cover the following drugs. Unless noted, both the brand name and available generic equivalents won't be covered. For drugs with a generic equivalent available, the example brand names are listed for reference. If members fill a prescription for one of these drugs on or after January 1, 2023, they'll be responsible for the full cost.

The drugs that won't be covered are listed along with suggested covered preferred alternatives that have similar effectiveness, quality and safety. When pharmacies fill prescriptions with preferred alternatives, the generic equivalents are dispensed, if available. Additional coverage requirements may apply for preferred alternatives, such as prior authorization.

Drugs that won't be covered	Affected drug list	Common use or drug class	Preferred alternatives
Basaglar®, Levemir® (all forms), Tresiba® (all forms)	Preferred	Long-acting insulin	Lantus® (all forms), Toujeo® (all forms)
Extavia®, Plegridy®	Custom Select	Multiple sclerosis	Avonex®, Bafiertam®, Betaseron®, Copaxone®, Kesimpta®, Tecfidera®, Vumerity®
meperidine hcl oral tablet (Demerol®)	Custom Select	Pain	eneric codeine sulfate tablet, hydrocodone/ibuprofen tablet, hydrocodone/acetaminophen tablet, hydromorphone tablet, morphine sulfate tablet, oxycodone tablet
famotidine/ibuprofen (Duexis®)	Custom Select	Arthritis pain and GI protection	generic famotidine plus ibuprofen

Drugs that will have a higher copayment

The brand-name drugs that will have a higher copayment are listed along with suggested covered preferred alternatives that have similar effectiveness, quality and safety. When pharmacies fill prescriptions with preferred alternatives, the generic equivalents are dispensed, if available. Additional coverage requirements may apply for preferred alternatives.

Drugs that will have a higher copayment*	Affected drug list	Common use or drug class	Preferred alternatives
Emgality® 120mg/mL	All	Migraine prevention	Aimovig®, Ajovy®
Dentagel®, Denta 5000 Plus®	Custom, Preferred	Dental fluoride	generic sodium fluoride (such as Cavarest® or PreviDent®)
fluoxetine tablet (Sarafem®)	Custom**	Premenstrual dysphoric disorder (PMDD)	fluoxetine capsule or tablet
timolol maleate tablet	Custom**, Custom Select**	Hypertension	propranolol tablet, atenolol tablet, metoprolol tablet
Gilenya®, Mayzent®	Custom Select	Multiple sclerosis	Avonex®, Bafiertam®, Betaseron®, Copaxone®, Kesimpta®, Tecfidera®, Vumerity®
Rebif® (Will also require step therapy prior to coverage)			

*Nonpreferred brand drugs are not covered for members with a closed benefit.

**Applies for HMO only.

Please see Starting January 1, 2023 continued on Page 26

Drugs that will have quantity limit changes

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

Drugs that will have quantity limit changes	Affected drug list	Common use or drug class	Current quantity limit	New quantity limit
Ozempic® 8mg/3ml	All	Diabetes	2 pens per 28 days	1 pen per 28 days
Phexxi®	All	Contraceptive	N/A	12 units per 30 days

Preventive drug coverage updates

Drugs that won't be covered	Affected drug list	Common use or drug class	Rationale
aspirin 325mg	All	Pain and inflammation; prevention of certain vascular-related complications	No longer recommended for prevention of cardiovascular disease or colorectal cancer by the USPSTF.

Under the Affordable Care Act, also known as national health care reform, most health care plans must cover certain preventive services and prescription drugs with no out-of-pocket costs based on recommendations by the U.S. Preventive Services Task Force, or USPSTF. The USPSTF is a panel of national experts in prevention and evidence-based medicine that works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services and preventive medications.

The USPSTF no longer recommends the use of aspirin for prevention of cardiovascular disease or colorectal cancer, so we're no longer covering aspirin 325mg. Aspirin 81mg will remain covered for members at high risk of preeclampsia per the USPSTF's recommendations.

If members fill a prescription for aspirin 325mg on or after January 1, 2023, they'll be responsible for the full cost. Aspirin 325mg is available for purchase over the counter.

For a complete list of preventive drugs and coverage requirements go to **bcbsm.com/pharmacy**.

Spevigo® requires prior authorization for Medicare Advantage members, starting Sept. 26

For dates of service on or after Sept. 26, 2022, we've added a prior authorization requirement for Medicare Plus BlueSM and BCN Advantage℠ members for the following medication:

- Spevigo (spesolimab-sbzo), HCPCS code J3590

Submit prior authorization requests through the NovoLogix® online tool.

This medication is part of members' medical benefits, not their pharmacy benefits.

When prior authorization is required

This medication requires prior authorization when it is administered by a health care provider in an outpatient facility or a physician's office and billed in one of the following ways:

- 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

Please see Spevigo® requires prior auth continued on Page 27

Submit prior authorization requests through the NovoLogix tool

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.

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've updated the list to reflect the change for Spevigo.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal services.

New prior authorizations are required for opioid medications exceeding 90 MMEs, starting Dec. 1

Blue Cross Blue Shield of Michigan and Blue Care Network remain committed to battling our country's opioid crisis through various programs and initiatives. Starting Dec. 1, 2022, health care providers must submit a new prior authorization to extend prescriptions for members who are taking opioids with a dosage exceeding 90 morphine milligram equivalents, or MMEs, if these members don't have a current prior authorization in place.

Providers use MMEs to measure and compare different drugs, using morphine as the standard. Blue Cross requires a prior authorization for opioid dosages that exceed 90 MMEs per day.

Prescription opioids are powerful pain-reducing medications. Examples include prescription medications containing oxycodone, hydrocodone or codeine, and may go by the brand names of Vicodin®, Norco® and Tylenol® No. 3, among others.

We'll notify affected members and recommend they reach out to their providers.

Medicare Advantage plans transitioning to Optum Rx® pharmacy benefit manager

The pharmacy benefit manager for our Medicare Advantage individual and group members will be transitioning from Express Scripts, Inc., to Optum Rx, beginning Jan. 1, 2023.

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

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 Screening Papanicolaou smear to Blue Care Network Advantage
- Reminders Prior to Submitting a Clinical Editing Appeal
- Wound Care with an Evaluation and Management Service

Clinical editing billing tips

We reprocessed claims that denied in error for same-day IPPE/AWV and E&M visits

In February, we published a **provider alert** stating that, effective Jan. 1, 2022, an evaluation and management procedure code — including a code for an annual physical examination — is payable for BCN Advantage members on the same date of service as a Medicare wellness visit without submitting an appeal.

Medicare wellness visits are:

- G0402 — An initial preventive physical examination, or IPPE. This is also known as a "Welcome to Medicare" visit.
- G0438 or G0439 — Annual wellness visit, or AWV.

Annual physical examinations are not Medicare wellness visits.

Here's the issue

We recently discovered that the procedure codes for annual physical examinations weren't updated in our systems to reflect this change.

On Aug. 29, 2022, we updated our system so those procedure codes (*99385, *99386, *99387, *99395, *99396 and *99397) are payable when billed with Medicare wellness visits. We've also reprocessed claims with dates of service from Jan. 1, 2022, through Aug. 28, 2022, that were denied in error.

What you need to do

If your denied claims have been adjusted, you don't need to do anything.

If you have denied claims that haven't been adjusted, confirm that they were billed correctly and submit corrected claims. Don't file appeals for those claims.

Billing and coding guidelines

When billing for both a Medicare wellness visit and an annual physical examination on the same date of service, you must follow proper billing and coding guidelines. Guidelines include but aren't limited to the following:

- The member must be eligible for both services.
- Both services must be medically necessary and reasonable.
- All components of both services must be provided and fully documented in the patient's medical record.
- You must include modifier 25 with the procedure code for the annual physical examination.

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.

Please see Lunch and learn continued on Page 29

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
Nov. 16	Coding Scenarios for Specialty Providers and PCPs	**Register here**
Dec. 8	E/M Coding Review and Scenarios	**Register here**

Action item

Register now for webinars that can improve your coding processes.

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
Sept. 22	Coding Heart Failure, COPD, CHF
Oct.11	2023 Updates for ICD-10-CM

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.

Estimate Your Cost tool to launch Jan. 1

Blue Cross Blue Shield of Michigan will be launching the Estimate Your Cost tool through the member portal January 1, 2023. The tool will empower members to compare prices for in-network providers and their services and get an estimation of Blue Cross' payment for out-of-network services.

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

SNF outpatient therapies: How to submit prior authorization requests for BCN members

Skilled nursing facilities that submit prior authorization requests for physical, occupational or speech therapy for BCN commercial or BCN Advantage members in a Basic bed should submit the request to BCN Utilization Management through the e referral system.

Don't submit the request to eviCore healthcare®.

We're updating our provider portal (availity.com) to show that prior authorization requests for therapies by SNFs should be submitted through the e referral system and not to eviCore.

In the e-referral system:

- Submit an outpatient prior authorization request. Refer to the instructions in the "Submit an Outpatient Authorization" section of the **e-referral User Guide**.
- For the Place of Service, select "Off Campus Outpatient Hospital."
- For the Procedure Code, enter CPT code *97110 for PT, *97535 for OT or *92507 for ST. Enter only these codes regardless of the actual PT, OT or ST service to be performed.
- For the Servicing Provider/Servicing Facility, enter the name of the skilled nursing facility providing the therapy.
- Enter data into the other fields.
- Submit separate requests for different therapy types (PT, OT and ST).

We've updated the document **Outpatient rehabilitation services: Frequently asked questions for rehab providers** to include the above information. Look for the question "Which therapy requests need to be submitted directly to BCN through the e-referral system?"

To access the e-referral system:

1. Log in to availity.com.
2. Click *Payer Spaces* and then click the BCBSM and BCN logo.
3. Click the *e-referral* tile on the Applications tab.

Vision therapy: How to decrease wait times for determinations on prior authorization requests

Here are some ways you can decrease your wait time on prior authorization requests for orthoptic or pleoptic vision therapy for BCN commercial and BCN Advantage members:

- Submit the required clinical documentation.
- Complete the questionnaire in the e-referral system.
- Request no more than eight visits at a time.
- Request no more than 30 days of therapy at a time.

Submit the required clinical documentation

We'll be able to make a determination more quickly if you submit the clinical documentation along with the prior authorization request. Attach the documentation to the request in the e-referral system.

Here's what to submit:

- **Initial evaluation**: Include measurable data that supports the diagnosis and establishes a baseline against which follow-up evaluations can be measured.

Please see Vision therapy continued on Page 31

- **Written treatment plan:** Include the projected period of treatment.
- **Documentation showing expected improvement:** Show there's an expectation that vision therapy will produce improvement that can be measured in a reasonable time period.

  Note: If there's no improvement after the first two months of therapy, the need for additional therapy will be questioned.
- **Monthly re-evaluations:** Monthly re-evaluations are required. Each re-evaluation should show the percentage of improvement from the start of therapy.
- **Changes in the treatment plan:** Include documentation of all progress made and changes needed.
- **Compliance:** Show the member's compliance or noncompliance with both office visits and the home treatment program.
- **Number of visits:** Document the number of visits per week and the total number of visits.

  Note: Vision therapy programs may require 24 to 32 visits over the course of a few months (once or twice a week in an optometrist or ophthalmologist office), with follow-up instructions for continuing the program in the home.

For the complete guidelines and criteria for these services, refer to our medical policy, **Orthoptic Training/ Vision Therapy for the Treatment of Vision or Learning Disabilities**.

Complete the questionnaire in the e-referral system

When you complete the questionnaire that opens in the e-referral system, your prior authorization requests will be automatically approved if the questionnaire threshold is met and the request doesn't exceed the limits allowed for therapy visits.

To see the questions that are on the questionnaire that opens in the e-referral system, refer to the **preview questionnaire for orthoptic and pleoptic visual training**. You can access the preview questionnaire on the **BCN Authorization Requirements & Criteria** page on our **ereferrals.bcbsm.com** website.

What we'll approve

When the criteria are met and the member has the benefit, we'll approve prior authorization requests:

- For no more than eight visits per month

  Note: We approve visits for only one month at a time. Monthly reevaluations are required.
- For a maximum of 32 visits

New and updated questionnaires in the e-referral system

On Aug. 28 and Sept. 11, 2022, we added and updated questionnaires in the e-referral system. We also added and 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 prior authorization requests.

New questionnaires

We added the following questionnaires for BCN commercial and BCN Advantage members:

- *Breast elastography* — For adult members. Opens for procedure codes *76391, *76981 and *76982.
- *Responsive neurostimulator/deep brain stimulation trigger* — For pediatric and adult members. Opens for procedure codes *61863, *61864, *61868, *61880, *61885 and *61888.
- *Responsive neurostimulation for the treatment of refractory partial epilepsy* — For adult members. Opens for procedure codes *61863, *61864, *61868, *61880, *61885, *61888 and *95836.

Please see New and updated questionnaires continued on Page 32

Updated questionnaires

We updated the following questionnaires:

- *Cosmetic or reconstructive surgery* — For adult Medicare Plus Blue, BCN commercial and BCN Advantage members. This questionnaire now opens for procedure codes *21742, *21743 and *36468.
- *Deep brain stimulation* — For adult Medicare Plus Blue, BCN commercial and BCN Advantage members. This questionnaire no longer opens for procedure code *61850 because this code no longer requires prior authorization.
- *Dermal chemical peels* — For adult and pediatric BCN commercial and BCN Advantage members. We updated a question.
- *Hyperbaric oxygen therapy* — For adult and pediatric BCN commercial and BCN Advantage members. There are separate questionnaires for BCN commercial and BCN Advantage. We updated questions in both questionnaires.
- *Orthognathic surgery* — For adult and pediatric BCN commercial and BCN Advantage members. We updated a question.
- *Prostatic urethral lift* — For adult BCN commercial and BCN Advantage members. We updated a question.
- *Varicose vein* — For adult BCN commercial and BCN Advantage members. This questionnaire now opens for procedure code *36466. It no longer opens for procedure codes *37765, *37766 or *36468. Note that procedure codes *37765 and *37766 no longer require prior authorization.

Preview questionnaires

You can access preview questionnaires at **ereferrals.bcbsm.com**. They show the questions you'll need to answer in the questionnaires that open in the e-referral system so you can prepare your answers ahead of time.

To find the preview questionnaires:

- Click *Blue Cross* and then click **Authorization Requirements & Criteria**. Scroll down and look under the "Authorization criteria and preview questionnaires – Medicare Plus Blue" heading.
- Click *BCN* and then click **Authorization Requirements & Criteria**. Scroll down and look under the "Authorization criteria and preview questionnaires" heading.

Authorization criteria and medical policies

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

Requirements changed for some commercial medical benefit drugs

From July through September 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 article on **Page 23** for details.

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