ARCHIVES 2022

BCN Provider *News*

Note:

The search process process may differ depending on the browser you're using.

2022 *BCN Provider News* Archives

To search the entire PDF

Simple search (all browsers)

1. Hold down the “Ctrl” key on your keyboard and press the “F” key.
2. Insert the search word in the Find field.
3. Click *Search* or an arrow to move from one location to the other.

Advanced search (Adobe Acrobat Reader)

1. Hold down the “Ctrl” key on your keyboard and press the “F” key.
2. Open the drop-down menu in the “Find” field.
3. Select *Open Full Acrobat Search* (or *Open Full Reader Search*).

In the Search dialogue box that opens ...

1. Insert the search word.
2. Make other selections, as appropriate.
3. Click *Search*.

In the Results ...

1. Scroll to review all the results.
2. Click to open the option you want.

To open a specific issue

In Microsoft Edge, click the *Content* icon in the toolbar and select *List view* to display the issue dates. In Google Chrome, click the *Document outline* icon in the left-hand column to display the issue dates. Click an issue date to go to a specific issue.

JANUARY-FEBRUARY 2022

BCN Provider News

BCN Provider News User Guide

Alerts and provider resources within Availity

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

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

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

New way to find alerts and provider resources

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

Alerts and provider resources, *continued on Page 2*

Previous articles about Availity

We're providing a series of articles focusing on our move to Availity for our provider portal. Here are the articles we've already published, in case you missed them:

- New, secure provider website coming in 2021 (September-October 2020 **issue**)
- Availity multi-payer provider portal brings advantages to providers (November-December 2020 **issue**)
- After moving to Availity in 2021, many of our current online tools will still be available (November-December 2020 **issue**)
- Get ready for Availity — How to select an administrator (January-February 2021 **issue**)
- Get ready for Availity — Technical requirements (January-February 2021 **issue**)
- Availity will bring new online search and favoriting capabilities (March-April 2021 **issue**)
- The move to Availity expected in late 2021 or early 2022 (May-June 2021 **issue**)
- We're moving to Availity in 2022 (November-December 2021 **issue**)

Inside this issue…

Alerts and provider resources, *continued from Page 1*

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

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

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

Improvements

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

Questions?

If you have questions about the move to Availity, please check our ***Frequently Asked Questions*** document first. If your question isn't already answered there, submit your question to ProviderPortalQuestions@bcbsm.com so we can consider adding it to the FAQ document.

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Network Operations

Availity training opportunities

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

Training specific for Blue Cross and BCN providers

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

Training available within Availity

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

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

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

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

Blue Cross updates continuity of care to align with law

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

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

What is continuity of care?

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

What does the CAA say about continuity of care?

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

Complex care circumstances where you can continue treatment

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

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

Requirements to provide services under continuity of care

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

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

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

Network Operations

Blue Cross 2022 individual plans include an HMO value plan

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

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

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

The Value plan covers the following benefits at 100%:

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

2022 offerings include:

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

Ask to see the latest member ID card

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

Direct reimbursement available to acupuncturists, effective March 1, 2022

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

Participating acupuncturists can bill their professional services using codes *97810, *97811, *97813 and *97814 Acupuncturists can also bill using codes *20560 and *20561 for Medicare Advantage members only. They can receive direct reimbursement for covered services within the scope of their licensure at 85% of the applicable fee schedule, minus any member deductibles and copayments.

This change, effective for outpatient services provided on or after March. 1, applies to Blue Cross and BCN benefit plans that cover services that these providers are licensed to provide. To find out if a member has coverage, check web-DENIS for member benefits and eligibility or call Provider Inquiry at 1-800-344-8525.

Requirements

Prior authorization is not required for acupuncture services for any member. For BCN commercial members who have a primary care physician that is part of a medical care group based in the East or Southeast region, their primary care physician must submit a referral for a specialist office visit. Referrals are not required for other members.

Enrollment forms

Acupuncturists can find enrollment forms and practitioner agreements on **bcbsm.com/providers**. To find enrollment information, click on *Enroll* to become a provider. Specific qualification requirements are identified within each agreement.

All applicants must pass a credentialing review before participation. We'll notify applicants in writing of their approval status.

Network Operations

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

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

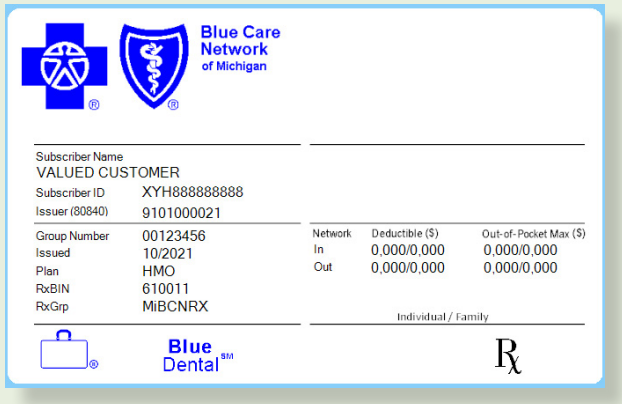
The new CAA mandate requires that issued ID cards contain the following:

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

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

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

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



Enrollment flyers help new providers joining our networks

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

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

New on-demand training available

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

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

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

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

Action item

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

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

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

To request access, complete the following steps:

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

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

Blue Cross and BCN receive high Medicare star ratings from CMS

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

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

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

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

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

Medicare considers five categories when assigning a star rating:

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

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

The role of health care providers

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

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

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

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

Get ready for 2022 Medicare wellness visits

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

Welcome to Medicare visit

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

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

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

Annual wellness visit

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

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

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

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

BCN Advantage

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

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

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

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

More information

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

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

Reminder

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

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

Action item

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

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

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

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

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

Overview of care management and utilization management programs now available

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

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

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

What you need to know

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

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

In the overview document, we've:

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

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

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

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

Quality Corner: MQIC Clinical Practice Guidelines

The Michigan Quality Improvement Consortium publishes clinical practice guidelines for various medical and behavioral health disorders. Guidelines are updated every two years. The MQIC committee is comprised of medical directors from a wide variety of insurers and professional organizations across Michigan and is devoted to publishing evidence-based guidelines to improve service delivery and outcomes.

MQIC **guidelines** include information on the diagnosis and treatment of attention deficit hyperactivity disorder, depression and medical conditions that may be comorbid with behavioral health disorders, including diabetes.

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

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

Below is a list of some of the guidelines available for the specific issues noted above:

ADHD

Diagnosis guidelines

Treatment guidelines

Depression

Primary care diagnosis guidelines

Treatment guidance update alert

Diabetes

Diabetes mellitus management guidelines:

Substance Use

Screening, diagnosis, and referral for substance use disorders guideline

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

HEDIS 2021 results

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

HEDIS is part of an integrated system to establish accountability in managed care organizations. It was originally designed to address private employers' needs as purchasers of health care and has been adopted for use by public purchasers, regulators, and consumers. It's also used by Centers for Medicare & Medicaid Services for their star ratings.

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

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

Commercial

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

2021 HEDIS® results BCN commercial

2021 HEDIS® results Marketplace/QHP

2021 HEDIS® results for BCN Advantage — Medicare

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

Medicare

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

HEDIS 2021 results, *continued on Page 14*

Patient Care/ Quality

Please see HEDIS 2021 results continued from Page 13

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

Marketplace

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

Thank you to all our affiliated practitioners for providing quality care to our members and allowing access to conduct medical record reviews for HEDIS and various audits.

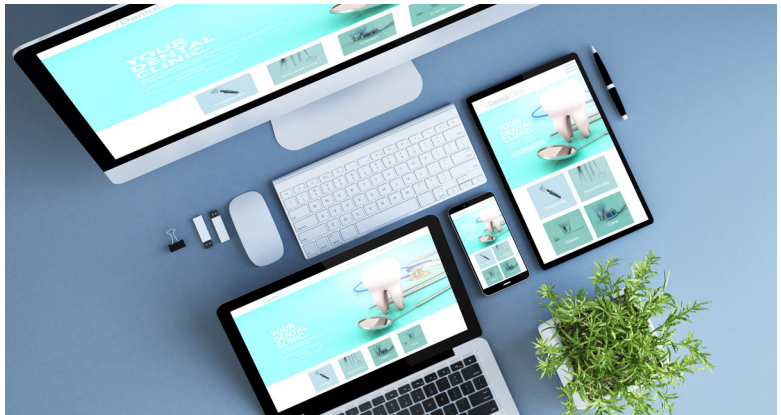
Primary care practitioners can still find opportunities to provide aggressive intervention in the management and care of our members with diabetes and high blood pressure, and in ordering procedures for breast, cervical and colorectal cancer screening.

We're actively involved in activities throughout the year that positively affect our HEDIS rates, including:

- Physician Quality Rewards Program which is tied to some of the HEDIS measures
- Health e-Blue℠ website
- Member gaps in care letters
- Member outreach reminder telephone calls
- Member and physician education through publications
- Member health fairs
- Care Management calls and letters
- Member incentive programs
- HEDIS interventions

We look forward to working with you to promote continued improvement in all areas of patient care.

If you'd like more information about HEDIS, call the Clinical Data Operations at 1-855-228-8543.



Medical policy updates

Blue Care Network's medical policy updates are posted on Provider Secured Services. Go to *BCN Provider Publications and Resources* and click *Medical Policy Manual*. Recent updates to the medical policies include:

Covered services

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

Medical Policy Updates

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

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

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

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

Reminders

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

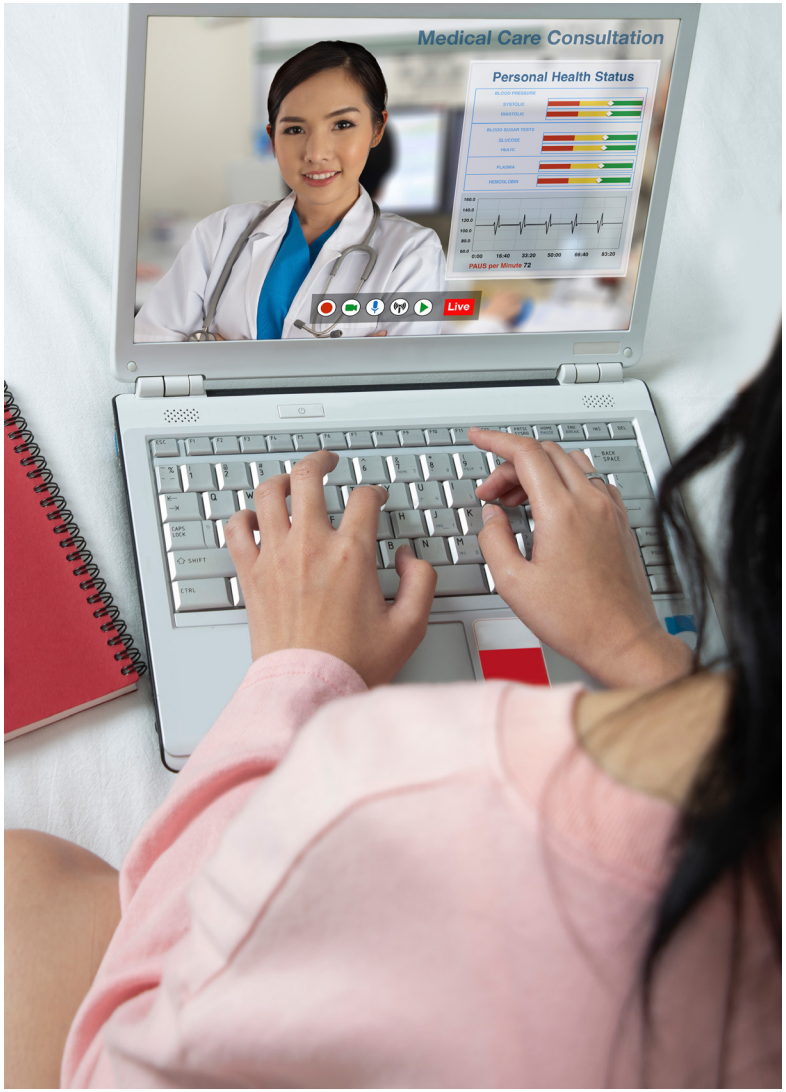
Updated documents

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

Services that are now payable by telemedicine

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

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

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

Restrictions lifted on protocol modification

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

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

Reminder

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

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

What you need to know

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

Updated documents

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

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

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

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

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

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

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

Reason for the change

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

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

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

Which providers this applies to

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

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

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

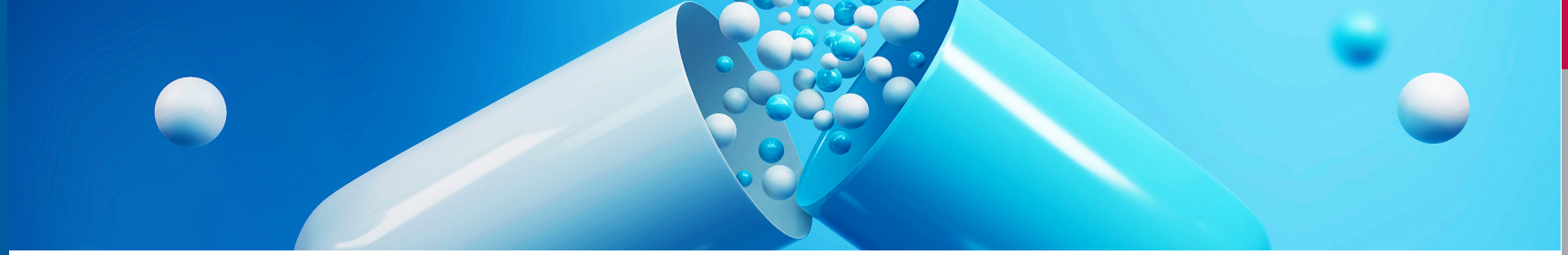
- Subacute detoxification
- Residential treatment
- Partial hospital program
- Intensive outpatient program
- Individual treatment

MQIC clinical practice guidelines

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

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

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



Quarterly update: Requirements changed for some commercial medical benefit drugs

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

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

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

Note: The code shown above will become unique codes.

For a detailed list of requirements, see the **Blue Cross and BCN utilization management medical drug list**. This list is available on the following pages of the **ereferrals.bcbsm.com** website:

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

As a reminder, an authorization approval isn't a guarantee of payment. Health care providers need to verify eligibility and benefits for members.

Additional information

For Blue Cross commercial groups, this authorization requirement applies only to groups that currently participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit. To determine whether a group participates in the prior authorization program, see the **Specialty Pharmacy Prior Authorization Master Opt-in/out Group list**. A link to this list is also available on the **Blue Cross Medical Benefit Drugs** page of the **ereferrals.bcbsm.com** website.

Note: Blue Cross and Blue Shield Federal Employee Program® members and UAW Retiree Medical Benefits Trust (non-Medicare) members don't participate in the standard prior authorization program.

Pharmacy News

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

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

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

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

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

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

Reminder: Starting Jan. 1, we'll change how we cover some drugs

We're making some changes to how we cover some drugs on the Clinical, Custom, Custom Select and Preferred Drug Lists starting Jan. 1, 2022. We'll send letters to affected members and their groups and providers.

Changes are being made to make sure members receive safe, high-quality care that meets their needs.

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

Clinical editing billing tips

In most issues, we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and the performed procedure is correctly reported to us.

This issue's tips:

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

Clinical editing billing tips

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

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

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

Topics include:

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

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

- New users must c**lick here to register**.
- Existing users can follow this link to **log in**.

Once logged in, users can access the modules in two ways:

- Look in the course catalog under *Quality management*.
- Enter "lunch and learn" in the search box at the top of the screen.

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

Referral Roundup

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

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

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

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

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

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

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

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

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

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

What you need to know

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

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

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

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

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

Effective dates for this change

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

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

Conditions this applies to

This applies to members with the following conditions:

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

Please see Aligning local rules, continued on Page 25

Aligning local rules, *continued from Page 24*

How determinations will be made

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

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

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

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

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

Reason for the change

We expect that this change will:

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

Additional information

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

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

Updated questionnaire opens in the e-referral system

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

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

Preview questionnaires

You can access preview questionnaires at **ereferrals.bcbsm.com** so you can prepare your answers ahead of time.

To find the preview questionnaires, click *BCN* and then click **Authorization Requirements & Criteria**. Scroll down and look under the "Authorization criteria and preview questionnaires" heading.

Authorization criteria and medical policies

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

Overview of care management and utilization management programs now available

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

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

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

Referral Roundup

Prior authorization requirements expanding for Medicare Plus Blue, BCN commercial and BCN Advantage members on Jan. 1

We're expanding our prior authorization requirements for Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ members. For certain procedure codes, you'll need to complete questionnaires in the e-referral system when you submit prior authorization requests for dates of service on or after Jan. 1, 2022.

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

Quarterly update: Requirements changed for some commercial medical benefit drugs

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

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

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

TurningPoint Healthcare Solutions LLC will review the site of care for total hip and knee surgeries as part of each authorization determination for dates of service on or after Jan. 3, 2022. Based on medical necessity review, TurningPoint may approve authorization requests for select total hip and knee cases only when scheduled in an outpatient setting.

This applies to members with the following coverage:

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

If TurningPoint approves an authorization for a hip or knee surgery in an outpatient setting and the member experiences a change in condition that requires an inpatient admission, you'll need to submit an authorization request for the inpatient admission (procedure code *99222) through the e referral system; see the "Submit an inpatient authorization" section of the **e-referral User Guide** for more information. Blue Cross or BCN will review the request using InterQual® criteria.

Performing total hip and knee surgeries in outpatient settings is supported by both evidence-based guidelines and the Centers for Medicare & Medicaid Services.

For more information about the TurningPoint musculoskeletal surgical quality and safety management program, see these pages on the **ereferrals.bcbsm.com** website:

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

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

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

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

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

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

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

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

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

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

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

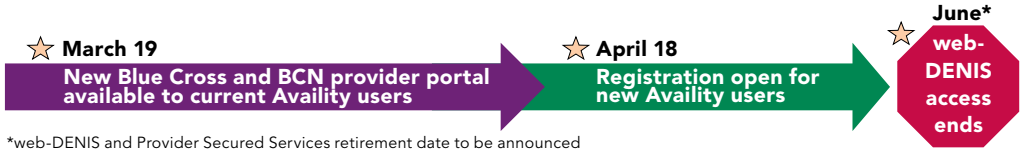
- The test has received or is waiting to receive approval for use (including emergency use) by the Food and Drug Administration or falls within one of the other categories of tests required to be covered by the Families First or CARES Acts.
- The test is administered or ordered by a qualified health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

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

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

Inside this issue…

Network Operations



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

Watch for special edition newsletter about our move to Availity

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

The Availity portal is now called Availity Essentials

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

Questions?

If you have questions about the move to Availity Essentials, please check our **Frequently Asked Questions** document first. If your question isn't already answered there, submit your question to **ProviderPortalQuestions@bcbsm.com** so we can consider adding it to the FAQ document.

Previous articles about Availity

We're providing a series of articles focusing on our move to Availity Essentials for our provider portal. Here are the articles we've already published, in case you missed them:

- New, secure provider website coming in 2021 (September-October 2020 **issue**)
- Availity multi-payer provider portal brings advantages to providers (November-December 2020 **issue**)
- After moving to Availity in 2021, many of our current online tools will still be available (November-December 2020 **issue**)
- Get ready for Availity — How to select an administrator (January-February 2021 **issue**)
- Get ready for Availity — Technical requirements (January-February 2021 **issue**)
- Availity will bring new online search and favoriting capabilities (March-April 2021 **issue**)
- The move to Availity expected in late 2021 or early 2022 (May-June 2021 **issue**)
- We're moving to Availity in 2022 (November-December 2021 **issue**)
- Alerts and provider resources within Availity (January-February 2022 **issue**)

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Provider web update includes enhancements

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

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

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

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

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

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

Resources on bcbsm.com/providers

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

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

HEDIS medical record reviews began in February

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

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

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

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

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

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

New on-demand training available

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

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

We recently added the following new learning opportunities:

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

Action item

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

We also added an updated online course:

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

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

To request access, complete the following steps:

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

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

BCN medical directors are a resource for physicians

Plan medical directors work throughout the state with affiliated practitioners and providers to ensure appropriate care and service for Blue Care Network members. They:

- Provide clinical support for utilization management activities, including investigation and adjudication of individual cases
- Assist in the design, development, implementation and assessment of clinical protocols, practice guidelines and criteria that support the appropriate use of clinical resources
- Adjudicate provider appeals
- Work with physicians and other health care providers to improve clinical outcomes, appropriate use of clinical resources, access to services, effectiveness of care and costs
- Serve as a liaison with the physician community

Providers may discuss decisions with BCN physician reviewers

Blue Care Network demonstrates its commitment to a fair and thorough process of determining utilization by working collaboratively with participating physicians. BCN's plan medical directors may contact the treating health care practitioner for additional information about any review deemed necessary. When BCN doesn't approve a request, we send written notification to the appropriate practitioners and providers, and the member. The notification includes the reason the service wasn't approved as well as how to contact BCN's plan medical directors to discuss the decision.

If you're a practitioner and would like to discuss a denial of an authorization request with one of our plan medical directors, request a phone appointment by following the process outlined in the document titled **How to request a peer-to-peer review with a BCN medical director**. To discuss an urgent case after normal business hours, call 1-800-851-3904. This number is for non-behavioral health cases only.

How to obtain a copy of utilization management criteria

Upon request, Blue Care Network will provide the criteria used in the decision-making process for a specific authorization request. For a copy, call Utilization Management at 1-800-392-2512 from 8:30 a.m. to 5 p.m. Monday through Friday.

You can also fax your request to us. First, complete the BCN **Criteria Request Form** (found on **ereferrals.bcbsm.com**) and fax it to 1-866-373-9468. (This applies to non-behavioral health authorizations requests only.)

The process for requesting utilization management criteria is also available in the Care management chapter of the *BCN Provider Manual*.

Due to licensing restrictions, we can't distribute complete copies of the InterQual® criteria to all practitioners and providers. However, all contracted hospitals have the electronic version of the criteria as part of BCN's licensing agreement.

Clinical review decisions are based solely on appropriateness of care

Utilization decisions regarding care and service are based solely on the appropriateness of care prescribed in relation to each member's medical or behavioral health condition.

Blue Care Network's clinical review staff doesn't have financial arrangements that encourage denial of coverage or service that would result in underutilization.

BCN-employed clinical staff and physicians don't receive bonuses or incentives based on their review decisions.

Review decisions are based strictly on medical necessity within the limits of a member's plan coverage.

How to request a member transfer

In some circumstances, a primary care physician can request that a member be removed from his or her practice and assigned to another primary care physician. This applies to both BCN HMO℠ (commercial) and BCN Advantage℠ members.

Submit a Member Transfer Request Form

The member's current primary care physician must complete and submit the *Member Transfer Request Form* to BCN.

The form is on the last page of a frequently asked questions document and is available on BCN's Forms page:

1. Visit **bcbsm.com/providers**.
2. Log in to Provider Secured Services.
3. Scroll down and click *BCN Provider Publications and Resources*, on the right.
4. Click *Forms*.

Click *Member Transfer FAQ and Request Form*, under the "Member transfer" heading.

You'll also find a link to the Member Transfer FAQ and Request Form on the Health e-Blue℠ home page.

Criteria for requesting a member transfer

Review the FAQ to make sure your request meets the member transfer criteria. The criteria involve a member's:

- Financial obligations
- Behavior
- Geographic distance from the physician office
- Seeing a primary care physician in a different office
- Lack of response to outreach by your office

The FAQ also outlines details for submitting the request and your responsibilities once the request has been submitted.

Remember, BCN must approve the request before the member can be transferred.

Network Operations

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

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

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

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

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

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

Have a question about authorizations and referrals?

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

Have a medical policy question?

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

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

Other resources

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

BCN staff available to our members for utilization management issues

Did you know that we're available for our members (your patients) to discuss utilization management issues at least eight hours a day during normal business hours?

We accept inbound collect or toll-free calls; we return calls the same day or the next business day.

Our staff members identify themselves by name, title and organization when receiving or returning calls. We also provide language assistance free of charge to discuss utilization management issues with our members. We offer TTY assistance for the hearing impaired.

Tell your patients to call the number on the back of their member ID card for information about our communication services.

See related article, "Behavioral health providers may discuss decisions with BCN physician reviewers," **Page 22**.

Virtual provider symposiums to focus on patient experience and HEDIS

We've scheduled this year's provider symposiums virtually throughout May and June for physicians, office staff and coders. The dates are listed below. You may register by clicking on the registration links, and you may register for more than one topic.

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

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

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

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

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

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

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

For more information, see the **COVID-19 patient testing recommendations for physicians** document on our public website at **bcbsm.com/coronavirus** or within Provider Secured Services by clicking on Coronavirus (COVID-19).

Changes coming to preferred products for infliximab for Medicare Advantage members

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

Preferred products:

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

Nonpreferred products:

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

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

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

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

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

BCN Advantage

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

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

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

Submitting requests for prior authorization

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

- **Preferred products:** Preferred products don't require prior authorization. Don't submit a request.
- **Nonpreferred products, for members who must take them:** Submit the prior authorization request through the NovoLogix® online tool. NovoLogix offers real-time status checks and immediate approvals for certain medications. If you have access to Provider Secured Services, you already have access to enter authorization requests through NovoLogix. If you need to request access to Provider Secured Services, complete the **Provider Secured Access Application** form and fax it to the number on the form.

List of requirements

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

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

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

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

Additional drugs that require prior authorization

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

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

NovoLogix offers real-time status checks and immediate approvals for certain medications. If you have access to Provider Secured Services, you already have access to NovoLogix. If you need to request access to Provider Secured Services, complete the **Provider Secured Access Application** form and fax it to the number on the form.

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

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

Drug that no longer require prior authorization

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

List of requirements

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

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

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

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

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

When prior authorization is required

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

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

Submitting prior authorization requests

Submit prior authorization requests for these drugs through NovoLogix. It offers real-time status checks and immediate approvals for certain medications. If you have access to Provider Secured Services, you already have access to NovoLogix.

If you need to request access to Provider Secured Services, complete **the Provider Secured Access Application form** and fax it to the number on the form.

List of requirements

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

BCN Advantage

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

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

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

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

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

As a reminder, naviHealth:

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

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

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

Medicare sequestration suspension extended through March 31, 2022

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

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

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

BCN Advantage

Gain insights from CAHPS research on improving the patient experience

The Centers for Medicare & Medicaid Services can help health care providers better understand their Medicare patients' needs and expectations by understanding research from the Consumer Assessment of Healthcare Providers and Systems, or CAHPS, survey. CMS annually compiles findings about improving the patient experience and understanding health outcomes.

You can access reports, articles and case studies through the **Agency for Healthcare Research and Quality: Research on Improving the Patient Experience**.

Read the CAHPS survey tip sheet to learn more about why this annual survey is important, how it's conducted, what questions are asked and ways you can successfully address care opportunities for patients.

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

CAHPS survey tip sheet

Advanced illness and frailty exclusions allowed for HEDIS star measures

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

You can submit claims with advanced illness and frailty codes to exclude patients from select measures. Using these codes also reduces medical record requests for HEDIS data collection purposes.

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

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

Advanced Illness and Frailty Exclusions for HEDIS Star Measures guide

BCN Advantage

Encourage eligible Medicare Advantage patients to get screened for colorectal cancer

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

The Colorectal Cancer Screening (COL) HEDIS® star measure assesses patients ages 50 to 75 who had appropriate screenings for colorectal cancer.

Colonoscopy is the gold standard for colorectal cancer screening. There are alternative options for patients who are hesitant to have one.

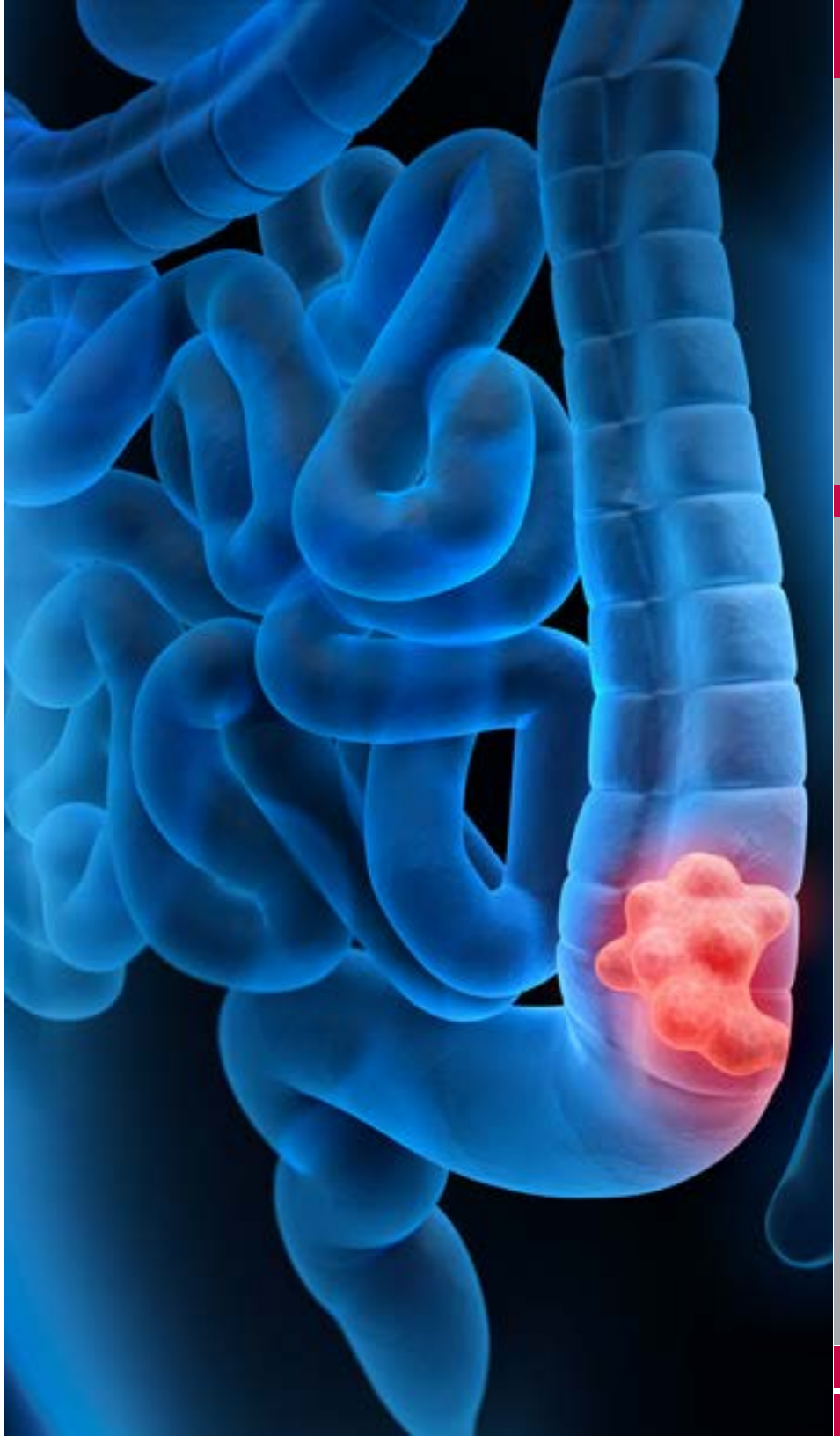
Read the *Colorectal Cancer Screening tip sheet* to learn about this measure including what information to include in medical records, codes for patient claims and tips for talking with patients.

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

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

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

Colorectal Cancer Screening tip sheet



2022 HEDIS quality measure changes

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

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

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

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

BCN Advantage

What you need to know about Medicare fraud, waste and abuse

BCN Advantage uses Medicare funds to pay doctors, hospitals, pharmacies, clinics and other health care providers to provide care to patients eligible for Medicare benefits. Sometimes, providers and patients misuse Medicare resources, leaving less money to help people who need care. This misuse falls in the following categories: fraud, waste or abuse.

Definition of fraud

Fraud is intentional deceit or misrepresentation of the truth that results in some extra cost to the health care system. Fraud schemes range from those committed by individuals acting alone to broad-based activities by institutions or groups of individuals. Seldom do these schemes target only one insurer or the public or private sector exclusively. Most are simultaneously defrauding several private and public-sector victims, including Medicare and Medicaid.

Health care fraud is defined in Title 18, United States Code (U.S.C.) § 1347, as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

This definition applies to health care programs such as Medicare and Medicaid.

Definition of abuse

Abuse occurs when a provider or a patient behaves in a way that is inconsistent with sound business or medical practices, resulting in an unnecessary cost to the Medicare program. Abusive practices can involve payment for services that aren't medically necessary or that fail to meet professionally recognized standards for health care.

Differences between fraud and abuse

Fraud is distinguished from abuse in that there is clear evidence that fraudulent acts were committed knowingly and intentionally. Abusive practices, on the other hand, may not be intentional or it may be impossible to show that intent existed. Although these types of practices may initially be classified as abusive, they may develop into fraud if there is evidence that the provider or patient was intentionally conducting an abusive practice.

Definition of waste

Waste describes the outcome from practices that result in unnecessary costs to the health care system, but generally don't involve intentional or criminally negligent actions.

Waste can result from poor or inefficient billing or treatment methods, for example.

Minimizing fraud, waste and abuse means the federal government, through contracted insurers such as BCN Advantage, can provide more care to more people and make the Medicare program stronger. Together, all of us can work to find, report and investigate fraud, waste and abuse.

Fraud, waste and abuse prevention

See our policy and applicable laws on web-DENIS under *BCN Provider Publications and Resources*. Click on *Policies and Information* and then *Detection and Prevention of Fraud, Waste and Abuse Policy*. Information on fraud, waste and abuse can also be found in the *BCN Provider Manual*.

BCN Advantage HMO-POS℠ and BCN Advantage HMO℠ providers and members can report fraud and abuse to the anti-fraud hotline for Blue Cross Blue Shield of Michigan at 1-888-650-8136.

You may also contact the Office of Health Services Inspector General one of the following ways:

Phone: **1-800-HHS-TIPS** (1-800-447-8477)
Online: **Medicare.gov/fraud**.
Mail: Office of Inspector General
Attention: OIG Hotline Operations
P.O. Box 23489
Washington, D.C. 20026

What you need to know

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

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

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

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

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

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

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

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

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

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

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

We're providing more information on aligning local rules for acute inpatient medical admissions

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

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

What you need to know

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

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

Effective date for this change

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

This applies to members with the following conditions:

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

How determinations will be made

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

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

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

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

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

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

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

Reason for change

We expect that this change will:

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

Additional information

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

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

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

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

Medical policy updates

Blue Care Network's medical policy updates are posted on Provider Secured Services. Go to *BCN Provider Publications and Resources* and click *Medical Policy Manual*. Recent updates to the medical policies include:

Covered services

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

Noncovered services

- Miscellaneous genetic and molecular diagnostic tests
- Subchondroplasty

Medical Policy Updates

Know member rights and responsibilities

Blue Care Network members have certain rights and responsibilities. Providers should be aware of these rights.

Members have a right to:

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

Members have a responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need to provide care
- Follow plans and instructions for care that they have agreed to with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

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

Patient Care/ Quality

Quality improvement program information available upon request

We provide you with ongoing information about our quality improvement programs and clinical practice guidelines through this newsletter. Approved clinical practice guidelines are available to all Blue Care Network primary care physicians, primary care groups and specialists.

Copies of the complete guidelines are available on our secure provider portal. To access the guidelines:

- Log in to Provider Secured Services.
- Click on *BCN Provider Publications and Resources*.
- Click on *Clinical Practice Guidelines*.

The Michigan Quality Improvement Consortium guidelines are also available on the **MQIC website**. BCN promotes the development, approval, distribution, monitoring and revision of uniform, evidence-based clinical practice guidelines and preventive care guidelines for practitioners. We use MQIC guidelines to support these efforts. These guidelines facilitate the delivery of quality care and the reduction in variability in physician practice and medical care delivery.

Our Quality Improvement Program encourages adherence to MQIC guidelines and offers interventions focusing on improving health outcomes for BCN members. Some examples include member and provider incentives, reminder mailings, telephone reminders, newsletter articles and educational materials. We use medical record reviews and quality studies to monitor compliance with the guidelines.

Behavioral Health

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

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

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

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

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

Behavioral health providers may discuss decisions with BCN physician reviewers

Blue Care Network is committed to a fair and thorough process of determining utilization by working collaboratively with its participating behavioral health practitioners.

BCN's behavioral health physician reviewers may contact practitioners for additional information about their patients during their review of all levels of care, patient admissions, additional hospital days and requests for services that require medical policy and benefit interpretations.

When BCN doesn't approve a service request, we send written notification to the requesting practitioner. The notification includes the reason the service wasn't approved and a phone number for BCN's behavioral health physician.

Practitioners may discuss any decision with a BCN behavioral health physician reviewer. Call Behavioral Health at 1-877-293-2788, from 8 a.m. to 5 p.m., Monday through Friday, to schedule a peer-to-peer review. To discuss a behavioral health case after normal business hours with one of our clinicians, call 1-800-482-5982.

How to obtain a copy of behavioral health criteria

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

Depression toolkit available for providers

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

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

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

The kit includes:

Tip Sheet: Major Depressive Disorder

Depression Office Flyer for Members

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

Antidepressant Medication Management (AMM) HEDIS tip sheet

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

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

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

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

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

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

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

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

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

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

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

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

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

Pharmacy News

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

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

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

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

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

What you need to know

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

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

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

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

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

Changes coming to preferred products, continued from Page 25

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

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

- For commercial members: Members must transition to a preferred product by April 1, 2022.
- For Medicare Advantage members (Medicare Plus Blue PPO or BCN Advantage):
  - For members who start courses of treatment on or after April 1: Prescribe preferred products when possible. See "Submitting requests for prior authorization" below on how to submit requests for preferred products and — for members who can't receive preferred products — how to submit requests for nonpreferred products.
  - For members who receive nonpreferred products for courses of treatment that start before April 1: These members can continue their courses of treatment using the nonpreferred product until their authorizations expire.

Submitting requests for prior authorization

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

- **Preferred products:** These products require prior authorization through AIM Specialty Health®. Submit the request through the **AIM provider portal** or call the AIM Contact Center at 1-844-377-1278.
- **Nonpreferred products — for members who must take them:** Submit the prior authorization request through the NovoLogix® online tool. NovoLogix offers real-time status checks and immediate approvals for certain medications. If you need to request access to Provider Secured Services, complete the **Provider Secured Access Application** form and fax it to the number on the form.

Additional information for Blue Cross commercial members

The requirements outlined in this article apply as follows:

- These requirements apply only to Blue Cross commercial groups that participate in the standard commercial Medical Drug Prior Authorization program for drugs covered under the medical benefit.
- These requirements don't apply to UAW Retiree Medical Benefits Trust members with Blue Cross non-Medicare plans.
- For Blue Cross commercial self-funded groups other than UAW Retiree Medical Benefits Trust:
  - **For preferred products:** These groups don't participate in the AIM oncology management program. Because of this, you don't need to request prior authorization for members who have coverage through these groups.
  - **For nonpreferred products:** You'll need to request prior authorization through NovoLogix for members who have coverage through these groups.

List of requirements

See the following lists to view requirements for these products.

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

Changes coming to preferred products for infliximab for Medicare Advantage members

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

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

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

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

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

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

What you should do

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

Benefits of new authorization screen

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

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

Additional information

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

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

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

Reminder: Our transition to OptumRx

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

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

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

We've also made some enhancements to our provider-facing tools to assist with prescribing and submitting prior authorizations electronically.

These enhancements will primarily take place behind the scenes and won't have a major effect on how providers prescribe and submit prior authorizations or check on patients' benefits.

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

Need more information?

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

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

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

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

What you need to know

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

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

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

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

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

Billing Bulletin

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

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

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

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

Federal No Surprises Act prohibits 'surprise billing'

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

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

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

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

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

What you need to know

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

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

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

Billing Bulletin

BCN Provider *News*

Feedback

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

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

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

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

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

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

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

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

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

Virtual provider symposiums to focus on documentation and coding

We've scheduled this year's provider symposiums virtually throughout May and June for physicians, office staff and coders. The dates are listed below. You may register by clicking on the registration links, and you may register for more than one topic.

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

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

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

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

Clinical editing billing tips

In most issues, we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and the performed procedure is correctly reported to us.

This issue's tips:

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

Clinical editing billing tips

AIM Specialty Health to update clinical guidelines for prostate cancer imaging

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

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

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

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

This applies to the following members:

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

Where to find AIM's clinical guidelines

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

Submitting prior authorization requests

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

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

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

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

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

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

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

Submitting prior authorization requests

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

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

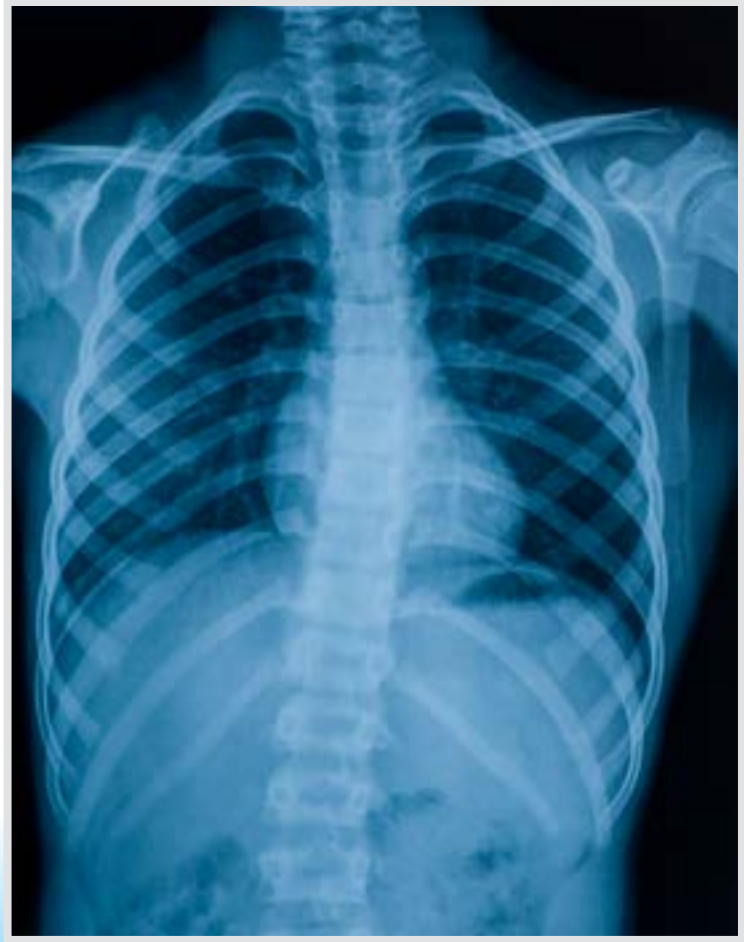
We've updated the list of **Procedures that require prior authorization by AIM Specialty Health** to reflect this requirement.

Additional information

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

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

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



Updated questionnaires open in the e-referral system

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

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

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

Preview questionnaires

You can access preview questionnaires at **ereferrals.bcbsm.com** to help prepare your answers ahead of time.

To find the preview questionnaires:

- **For BCN:** Click BCN and then click ***Authorization Requirements & Criteria***. Scroll down and look under the "Authorization criteria and preview questionnaires" heading.
- **For Medicare Plus Blue:** Click Blue Cross and then click ***Authorization Requirements & Criteria***. In the "Medicare Plus Blue members" section, look under the "Authorization criteria and preview questionnaires - Medicare Plus Blue" heading.

Authorization criteria and medical policies

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

Changes to the musculoskeletal procedure codes that require authorization through TurningPoint

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

Procedure codes that no longer require authorization

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

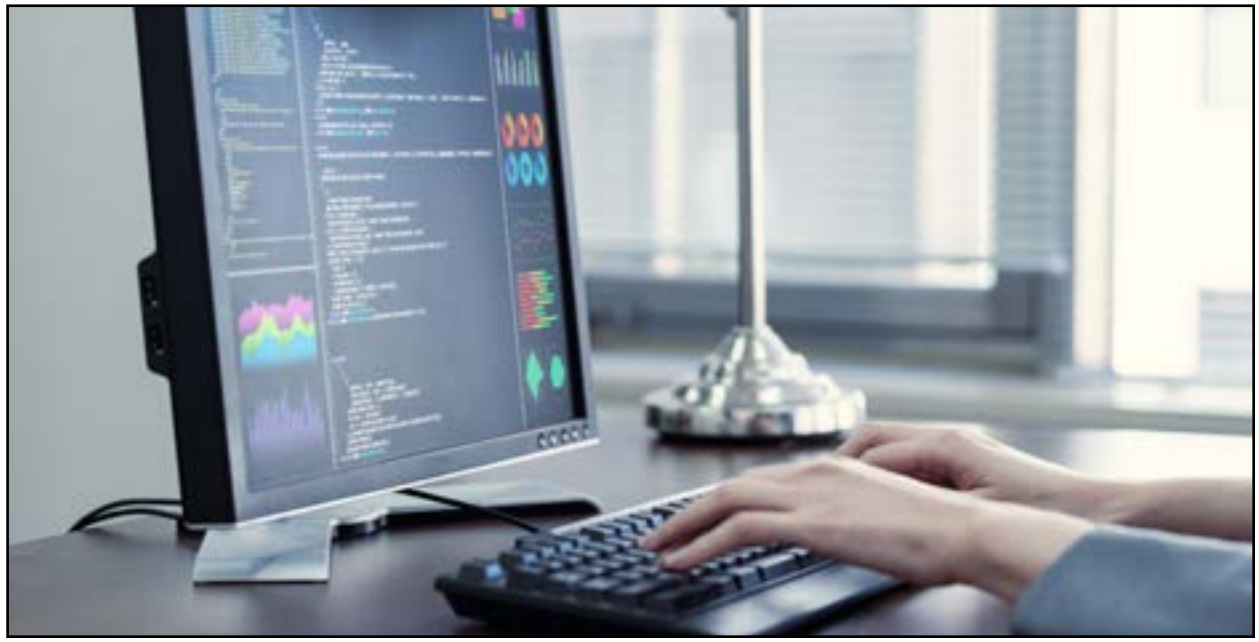
Additional procedures codes that will require prior authorization

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

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

Additional information

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



Referral Roundup

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

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

TurningPoint made the following changes:

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

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

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

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

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

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

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

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

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

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

Submitting a request

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

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

Checking the status of a request

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

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

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

Additional information

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

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

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BCN Provider News User Guide

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

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

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

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

Need help?

Here's where you can find it:

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

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

Inside this issue…

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BCN Provider *News*
Feedback

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

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

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

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

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

What you need to know

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

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

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

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

Please see Providers score Blue Cross high continued on Page 3

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Network Operations

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

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

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

Physicians want a partnership

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

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

Provider Inquiry can be improved

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

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

In addition:

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

Prior authorizations

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

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

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

Our move to Availity

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

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

Please see Providers score Blue Cross high continued on Page 4

Network Operations

Providers score Blue Cross high,

continued from Page 3

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

Survey methodology

Here's how we conducted the survey

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

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

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

Check out our new secure Provider Resources site

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

To reach the website:

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

Make it a favorite

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

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

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

Filter by plan

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

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

You can now search

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

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

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

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

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

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

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

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

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

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

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

The following videos also show the setup steps:

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

Network Operations

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

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

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

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

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

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

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

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

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

Providers must comply with access and availability guidelines

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

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

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

To find the manual:

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

Network Operations

Action item

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

New on-demand training available

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

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

We recently added the following new learning opportunities:

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

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

HEDIS® measures overview and scenarios — This eLearning lesson gives an overview of 10 HEDIS® measures. Each scenario covers the steps you should take to help close gaps in the measure.

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

To request access, complete the following steps:

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

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

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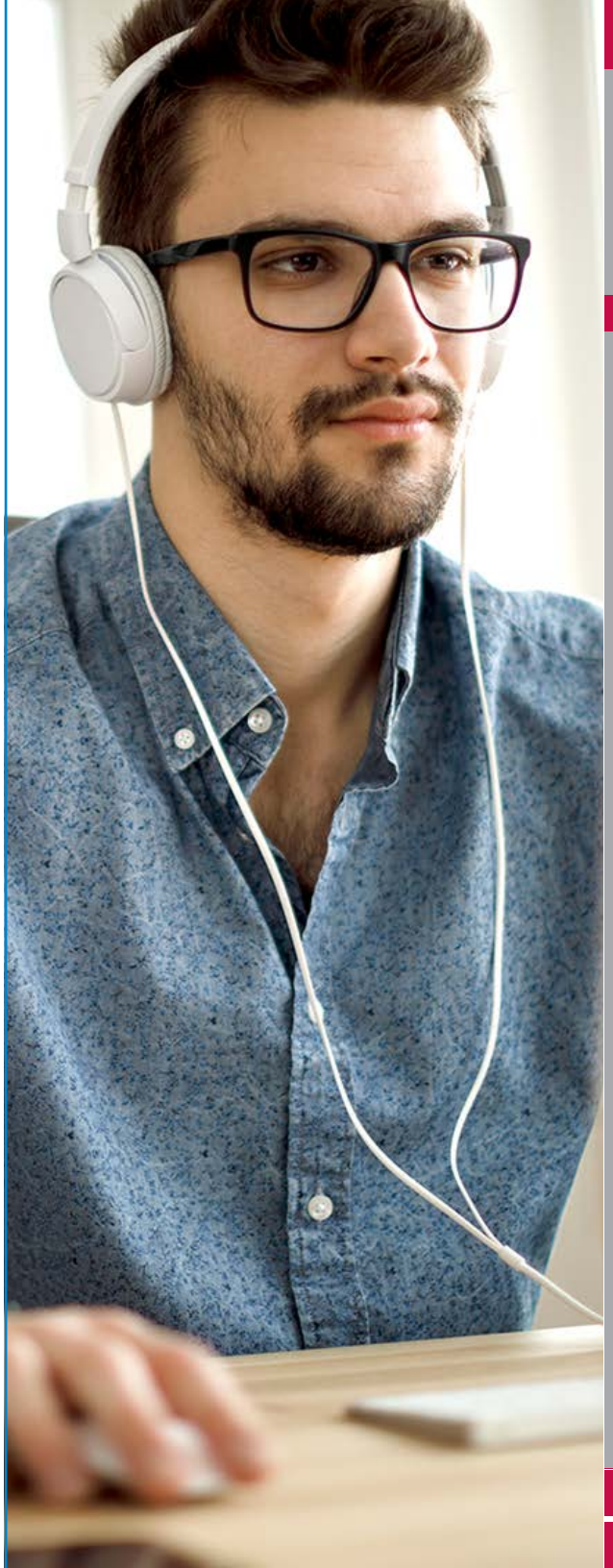

Network Operations

Virtual provider symposiums to focus on patient experience and HEDIS

We've scheduled this year's provider symposiums virtually throughout May and June for physicians, office staff and coders. The dates are listed below. You may register by clicking on the registration links, and you may register for more than one topic.

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

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

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

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

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

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

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

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

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

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

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

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

Please see Five questions with Vanita Pindolia continued on Page 10

Five questions with Vanita Pindolia,
continued from Page 9

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

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

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

4. How can taking such steps benefit older patients?

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

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

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

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

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

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

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

BCN Advantage

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

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

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

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

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

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

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

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

Submit prior authorization requests through the NovoLogix® online tool.

When prior authorization is required

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

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

Submitting prior authorization requests

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

List of requirements

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

BCN Advantage

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

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

Here are the important things to know:

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

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

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

Additional information

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

Star tip sheets updated for 2022

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

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

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

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

Custom measure: A new tip sheet for 2022

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

Accessing the tip sheets

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

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

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BCN Advantage

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

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

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

Carvykti requires prior authorization for Medicare Advantage members

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

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

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

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

The Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions is a new HEDIS® measure for star ratings. It focuses on the percentage of members ages 18 and older who have multiple high-risk chronic conditions and who had a follow-up visit within seven days of an emergency department visit.

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

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

Follow-up After Emergency Dept. Visit

Revised HEDIS measure focuses on helping prevent unnecessary hospital readmissions

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

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

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

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

Plan All-Cause Readmissions

Importance of statin therapy for patients with cardiovascular disease and diabetes

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

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

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

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

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

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

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Statin Use in Persons with Diabetes (SUPD)

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

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

The Transitions of Care HEDIS® measure for star ratings focuses on the percentage of members who had an acute or non-acute inpatient discharge during the measurement year and who had each of the following:

- Notification of inpatient admission
- Receipt of discharge information
- Patient engagement after inpatient discharge
- Medication reconciliation post-discharge

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

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

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

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

Transitions of Care tip sheet

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

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

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

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

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

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

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

New solutions

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

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

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

Blue Cross advances efforts to transform care delivery,

continued from Page 15

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

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

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

Market demands

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Behavioral health resources to discuss with your patients

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

The document includes information about the following behavioral health resources:

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

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

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

Blue Distinction Centers for Substance Use Treatment and Recovery program expands

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

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

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

A growing issue

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

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

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

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

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

For more information

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

Patient Care/ Quality

Criteria corner

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

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

Question:

What would be considered a complex wound?

Answer:

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

Question:

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

Answer:

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

Medical policy updates

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

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

Recent updates to the medical policies include:

Covered services

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

Noncovered services

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

Medical Policy Updates

It's now easier to find medical policies

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

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

Try our new search feature

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

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

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

Blue Care Network promotes continuity of care in some situations

Continuity of care services are available for the following members:

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

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

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

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

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

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

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

An active course of treatment is defined as:

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

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

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

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

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

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

Blue Care Network promotes coordination of care between practitioners

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

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

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

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

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

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

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

Medical record guidelines policies require providers to maintain member records

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

Content of the medical record should include:

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

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

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

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

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

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

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

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

What you need to know

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

Important

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

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

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

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

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

Quality corner: Michigan Quality Improvement Consortium Clinical Practice Guidelines

The Michigan Quality Improvement Consortium publishes clinical practice guidelines for various medical and behavioral health disorders; they're updated every two years. The MQIC committee is comprised of medical directors from a wide variety of insurers and professional organizations across Michigan and is devoted to publishing evidence-based guidelines to improve service delivery and outcomes.

MQIC guidelines include information on the diagnosis and treatment of attention deficit hyperactivity disorder, depression and other medical conditions, such as diabetes, that may be comorbid with behavioral health disorders. There's also a recent guideline on opioid prescribing (excluding palliative and end-of-life care). The MQIC guidelines are intended for behavioral health practitioners and primary care professionals to help deliver the most effective, evidence-based care for behavioral health and related disorders.

Below is a list of some of the guidelines available for the specific issues noted above:

ADHD

Diagnosis guidelines

Treatment guidelines

Depression

Primary care diagnosis guidelines

Treatment guidance update alert

Diabetes

Diabetes mellitus management guidelines

Opioid prescribing

Prescribing guideline update alert

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

Substance use

Screening, diagnosis, and referral for substance use disorders guideline

To join the MQIC mailing list to be notified of any updates, click on the **Join Now** link on **mqic.org**.

Purchasing and billing for Spravato

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

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

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

Behavioral health resources to discuss with your patients

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

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

Pharmacy News

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

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

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

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

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

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

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

Avsola and Inflectra are the preferred infliximab products for commercial members

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

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

The following products are designated as nonpreferred infliximab products:

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

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

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

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

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

List of requirements

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

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

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

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

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

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

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

How to submit authorization requests

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

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

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

More about the authorization requirements

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

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

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

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

Requirements changed for some commercial medical benefit drugs

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

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

*Will become a unique code

For additional details, see the **Blue Cross and BCN utilization management medical drug list**. This list is available on the following pages of the **ereferrals.bcbsm.com** website:

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

As a reminder, an authorization approval isn't a guarantee of payment. Health care providers need to verify eligibility and benefits for members.

Additional information

For Blue Cross commercial groups, this authorization requirement applies only to groups that currently participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit. To determine whether a group participates in the prior authorization program, see the **Specialty Pharmacy Prior Authorization Master Opt-in/out Group list**. A link to this list is also available on the ***Blue Cross Medical Benefit Drugs* page** of the **ereferrals.bcbsm.com** website.

Note: Blue Cross and Blue Shield Federal Employee Program® members and UAW Retiree Medical Benefits Trust (non-Medicare) members don't participate in the standard prior authorization program.

Pharmacy News

Carvykti requires prior authorization for Medicare Advantage members

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

Submit prior authorization requests using the NovoLogix® online tool.

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

Submitting prior authorization requests

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

List of requirements

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

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

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

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

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

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

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

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

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

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

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

Pharmacy News

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

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

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

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

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

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

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

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

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

Save time when submitting prior authorization requests for prescription drugs

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

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

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

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

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

Billing Bulletin

Purchasing and billing for Spravato

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

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

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

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

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

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

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

Clinical editing billing tips

In most issues, we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and the performed procedure is correctly reported to us.

This issue's tips:

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

Clinical editing billing tips

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

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

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

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

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

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

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

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

See full article on **Page 29**.

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

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

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

Virtual provider symposiums to focus on documentation and coding

We've scheduled this year's provider symposiums virtually throughout May and June for physicians, office staff and coders. The dates are listed below. You may register by clicking on the registration links, and you may register for more than one topic.

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

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

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

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

Referral Roundup

Update: We'll stop accepting faxed requests for commercial SNF admissions starting June 1

Starting June 1, 2022, we'll stop accepting prior authorization requests for commercial skilled nursing facility admissions that are submitted by fax. These requests must be submitted through the e-referral system.

This applies to SNF requests for initial admissions and additional days for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

We previously communicated that we'd stop accepting faxed requests on Jan. 1, 2022, but we're allowing additional time for SNFs to sign up for access to the e-referral system and learn how to use it.

Starting June 1, we'll accept faxes **only** for urgent requests when the e-referral system isn't available. In those instances, fax the form using the instructions on the document titled **e-referral system planned downtimes and what to do**.

Sign up now to use the e-referral system

Refer to our **ereferrals.bcbsm.com** website:

- To sign up for the e-referral system: Follow the instructions on the **Sign Up or Change a User page**.
- To learn how to use the e-referral system: Refer to the **Training Tools** page, where you'll find the **e-referral User Guide and Online self-paced learning modules**.

How to submit through the e-referral system

For tips on how to use the e-referral system when submitting commercial SNF prior authorization requests, refer to the **article** in the May-June 2021 issue of *BCN Provider News*, Page 38.

Submit Medicare Advantage requests to naviHealth

naviHealth manages prior authorization requests for SNF admissions for our Medicare Plus Blue℠ and BCN Advantage℠ members.

Reminder: Starting March 1, we aligned our Local Rules for acute inpatient medical admissions

As a reminder, for acute inpatient medical admissions of members with certain conditions, authorization requests should be submitted only after the member has spent two days in the hospital.

This update to our Local Rules went into effect for all members admitted to Michigan hospitals on or after March 1, 2022. This includes Blue Cross Blue Shield of Michigan and Blue Care Network commercial members, as well as Medicare Plus Blue℠ and BCN Advantage℠ members.

For non-Michigan hospitals, this update to our Local Rules applies only to Medicare Plus Blue members.

About observation orders

Some hospitals have asked whether an observation order is required when billing Blue Cross or BCN for observation.

Blue Cross and BCN don't require an observation order when reimbursing an observation claim. This applies to all lines of business: Blue Cross Blue Shield of Michigan commercial, Medicare Plus Blue, BCN commercial and BCN Advantage.

Additional information

For other important details about this change, refer to these documents:

- **Blue Cross and BCN Local Rules for 2022 (non-behavioral health)**
- **Blue Cross and BCN Local Rules: Frequently asked questions**

We communicated about this change earlier, in our provider newsletters. Refer to these articles:

- **February 2022 issue** of *The Record*
- **March-April 2022 issue** of *BCN Provider News*, Pages 18 and 19

Use the *Criteria request form* to obtain the criteria used in making a specific determination

When you submit an authorization request, we use medical necessity criteria to make a determination. Those criteria are available to you on request.

To obtain the criteria we used in making a determination on a specific authorization request, complete and submit the ***Criteria request form***.

Here are some things to keep in mind:

- Use this form for non-behavioral health authorization requests for which the Blue Cross Blue Shield of Michigan and Blue Care Network Utilization Management departments made the determination.
- Don't use this form for determinations on authorization requests you submitted to our contracted vendors.

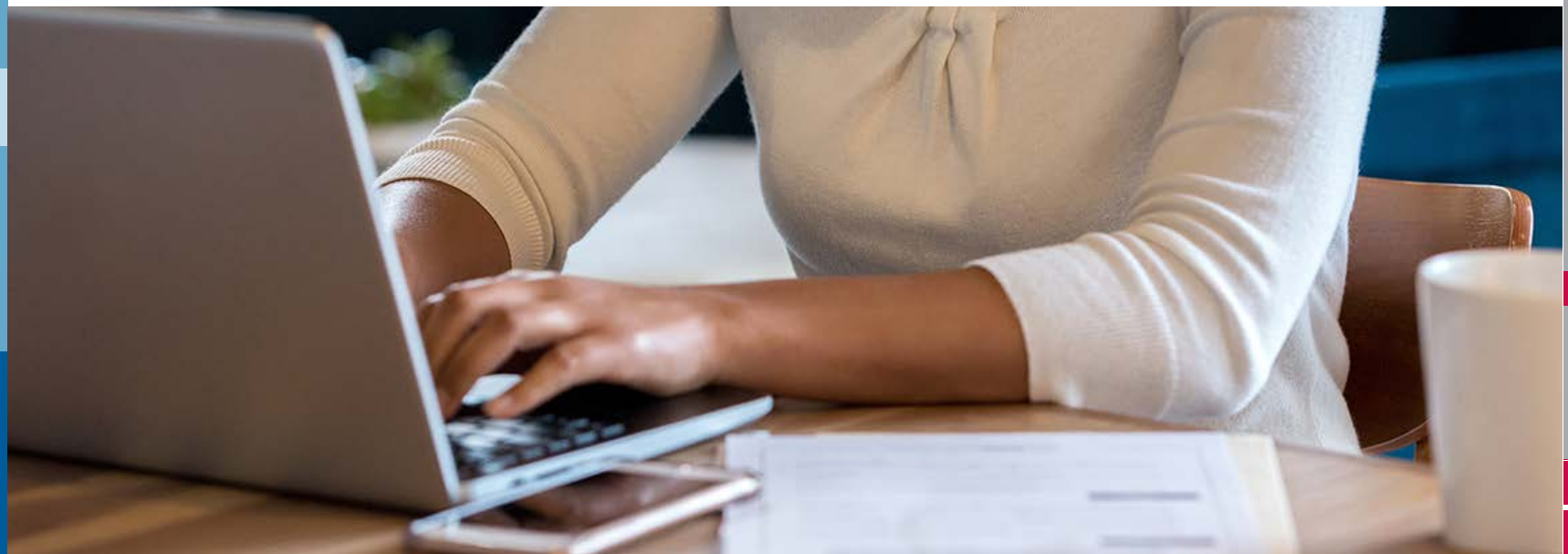
This form is available for Blue Cross commercial, Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ requests. Previously, it was used only for BCN requests.

Here's what to do:

1. Complete every field on the form.
2. Fax the completed form to us at the number on the form.

You can access this form on these pages on our **ereferrals.bcbsm.com** website:

- **Blue Cross Authorization Requirements & Criteria.** Look under the "Forms – Blue Cross commercial" or the "Forms – Medicare Plus Blue" heading.
- **BCN Authorization Requirements & Criteria.** Look under the "Referral and authorization information" heading.
- We're updating our provider manuals to include information about this form.



Referral Roundup

We ended the temporary suspension of clinical review requirements for admission to skilled nursing facilities

The temporary suspension of clinical review requirements for admission to skilled nursing facilities for all Michigan hospitals and for hospitals in certain other states ended on Feb. 28, 2022.

For SNF stays starting on or after March 1, 2022, clinical review is required on the first day of the stay.

The temporary suspension went into effect for Blue Cross Blue Shield of Michigan commercial, Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠ members in September for admission to SNFs in Michigan and certain other states.

These changes are reflected in the following documents, available on our public website at **bcbsm.com/coronavirus** (click the *Health Care Providers* tab).

- *Temporary changes due to the COVID-19 pandemic*
- *Ends Feb. 28, 2022: Clinical review requirements temporarily suspended for admissions to skilled nursing facilities from hospitals in certain states*

In addition, the change for hospitals in certain states is reflected in the following documents for out-of-Michigan providers, which are available from the **Medical Policy & Pre-Cert/Pre-Auth Router** page of our **bcbsm.com** website:

- ***Provider Preauthorization and Precertification Requirements*** for Blue Cross commercial and Medicare Plus Blue members
- ***Non-Michigan providers: Referral and authorization requirements*** for BCN commercial and BCN Advantage members

TurningPoint authorizations for musculoskeletal surgical and related procedures are valid for six months

Prior authorization requests approved by TurningPoint Healthcare Solutions LLC on or after Jan. 1, 2022, are valid for six months from the planned date of service for all outpatient musculoskeletal procedures, including pain management procedures.

For example, if TurningPoint approves an authorization request for a service planned for June 1, the approval will be valid from June 1 through November 30. If the surgery is performed during that time period, the authorization will match the claim without any changes to the authorization.

We updated the following documents to reflect this change:

- **Musculoskeletal procedure authorizations: Frequently asked questions for providers**
- **Musculoskeletal procedure authorizations: Quick reference for providers**

Prior authorization requests that were approved on or before Dec. 31, 2021, are valid for 30 days from the planned date of service.

TurningPoint Healthcare Solutions LLC is an independent company that manages authorizations for musculoskeletal surgical and related procedures for Blue Cross Blue Shield of Michigan and Blue Care Network.

Musculoskeletal procedure authorizations: Reminders for facilities

Here's how to change the place of service from outpatient to inpatient for musculoskeletal surgical and related procedures that require authorization from TurningPoint Healthcare Solutions LLC.

- **Prior to inpatient admission:** If TurningPoint approved an authorization with an outpatient place of service and you need to change it to inpatient before surgery, the ordering provider should contact TurningPoint to make the change. Call TurningPoint toll-free at 1-833-217-9670 or locally at 313-908-6040.
- **After inpatient admission when the setting must be inpatient based on Centers for Medicare & Medicaid Services requirements:** If TurningPoint approved an outpatient setting for a procedure that's on the CMS list of inpatient-only procedures, call TurningPoint toll-free at 1-833-217-9670 or locally at 313-908-6040. TurningPoint will update the setting on the authorization.
- **Due to a change in a member's condition during outpatient stay:** If a change in a member's condition during their outpatient stay requires an extended stay, the facility should submit an inpatient request to Blue Cross Blue Shield of Michigan or Blue Care Network. To do this, submit procedure code *99222 as outlined in the ***e-referral User Guide***; see the "Submitting an emergency or urgent admission (includes Blue Cross member submissions)" subsection within the "Submit an inpatient authorization" section for more information. The request must meet InterQual® criteria.

What you need to know

- Review this article to learn how to change the place of service for a musculoskeletal procedure.
- Musculoskeletal surgeries don't require prior authorization from TurningPoint when they're performed in an emergency during an inpatient admission that originated in the emergency department.
- To update the procedure codes on an authorization after a musculoskeletal surgery has taken place, see the *Postservice change request form* link below.

Additional reminders

- When TurningPoint approves an authorization request from an ordering physician, the authorization covers both the procedure and the site of service. Facilities **don't** need to submit a separate authorization request for an inpatient request if TurningPoint already approved an inpatient place of service.
- Musculoskeletal surgeries don't require prior authorization from TurningPoint when they're performed in an emergency during an inpatient admission that originated in the emergency department. For more information, see "Do musculoskeletal procedures that are performed during an inpatient admission that originated in the emergency department require prior authorization from TurningPoint?" in the document titled ***Musculoskeletal procedure authorization: Frequently asked questions for providers***.
- To update the date of service on a prior authorization, call TurningPoint.
- To update the procedure codes on an authorization after a musculoskeletal surgery has taken place, see the ***Postservice change request form***.
- You can request additional days for an inpatient stay through the e-referral system. In the e-referral system, you'll need to search for the member, not for the TurningPoint authorization number.

TurningPoint Healthcare Solutions LLC is an independent company that manages authorizations for musculoskeletal surgical and related procedures for Blue Cross Blue Shield of Michigan and Blue Care Network. For more information, see the Musculoskeletal Services pages on our **ereferrals.bcbsm.com** website.

Note: See the document titled ***Musculoskeletal procedure codes that require authorization by TurningPoint*** to determine which codes require authorization. Only the codes on this list require prior authorization. Incidental codes don't require prior authorization.

TurningPoint fax form and site-of-care guideline have been updated

In January, the following documents were updated for the TurningPoint Healthcare Solutions LLC musculoskeletal surgical quality and safety management program:

- **Pain management: Epidural steroid injections authorization request fax form** — The form reflects updated criteria from the Centers for Medicare & Medicaid Services. When faxing authorization requests, be sure to use the form that's dated January 2022.

  You can access this form through the **Blue Cross Musculoskeletal Services** and **BCN Musculoskeletal Services** pages of our **ereferrals.bcbsm.com** website.

  Note: TurningPoint made the same updates to the questionnaire in their provider portal.

- **TurningPoint Site-of-Care Guideline (GN-1004)** — The updated guideline reflects the site-of-care changes that went into effect on Jan. 3, 2022, for total hip and total knee surgeries for Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ members. (For more information about the requirement, see this **news item** on our **ereferrals.bcbsm.com** website.)

  You can access the updated guideline by logging in to the TurningPoint provider portal and clicking *Help* in the menu at the top of the screen.

TurningPoint Healthcare Solutions LLC is an independent company that manages authorizations for musculoskeletal surgical and related procedures for Blue Cross Blue Shield of Michigan and Blue Care Network.

AIM authorization IDs now include alpha characters

Starting mid-April 2022, authorization IDs from AIM Specialty Health® include randomly placed alpha characters. The authorization IDs with the alpha characters will be visible in any communication involving AIM Specialty Health, including those within the AIM ProviderPortal® and the Blue Cross and BCN e-referral system.

This change will affect all authorizations managed by AIM Specialty Health. This includes the following services: cardiology; high-tech radiology; in-lab sleep management; radiation oncology; and medical oncology and supportive care drugs.

More details about the change

Here's more information about this change:

Before the change: The authorization IDs in the AIM ProviderPortal contained eight characters, all of which were numeric. Example: 23456789

After the change: The authorization IDs in the AIM portal still contain eight characters but those characters are a mix of alphabetic and numeric. Example: 2J6Y789M

What's not affected by this change

This change will not affect how determinations are made on authorization requests that AIM manages for Blue Cross and Blue Shield of Michigan commercial, Medicare Plus Blue, Blue Care Network commercial and BCN Advantage or the claims related to them. In addition, this change does not affect authorization IDs issued before the change; those remain the same.

AIM Specialty Health is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage authorizations for select services. For more information, go to our **ereferrals.bcbsm.com** website.

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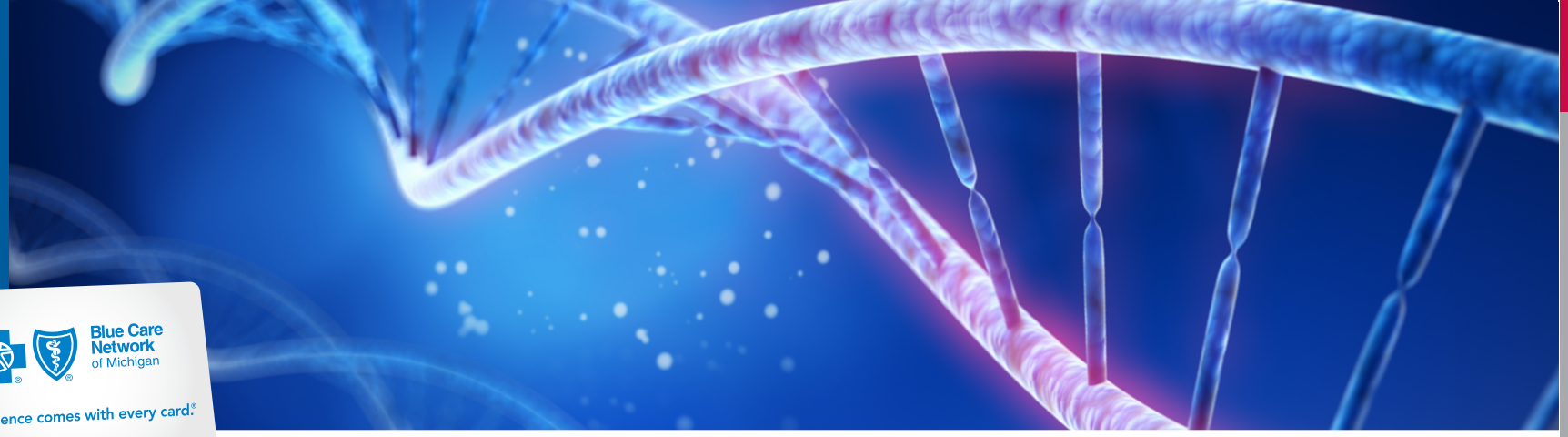

BCN Provider News User Guide

A message from Dr. Scott Betzelos, vice president of HMO strategy and affordability at Blue Care Network

We're introducing a new program that uses genetic testing to personalize medication treatments

Blue Care Network is pleased to announce a new precision medicine program, Blue Cross Personalized Medicine℠, that will help physicians tailor the medication regimen of patients to their specific needs.

The program uses pharmacogenomics, or genetic testing, to personalize medication treatments. As you may have read, pharmacogenomics, also known as PGx, is a subgroup of precision medicine that uses an individual's genetic makeup to guide medication treatment options, rather than taking a "one-drug-fits-all" approach for an entire population.

BCN has contracted with OneOme, an independent precision medicine company, to facilitate the new program. OneOme will provide testing through its evidence-based RightMed® Test, which analyzes 27 genes that may affect how a patient would respond to certain medications to reduce treatment trial and error.

Health care providers can use test results to help evaluate medications across multiple specialties, including behavioral health, oncology, pain management and cardiology, among others. Of course, any recommendations for medication or regimen changes are entirely optional and changes to the treatment regimen are determined by the prescribing physician, with the support of a PGx pharmacist and in agreement with the member.

A pilot program is underway for select members through the end of this year, with a comprehensive program launch scheduled for January 2023 for eligible BCN members. Blue Cross Personalized Medicine will be provided at no additional cost to members or employer group customers.

Please see New precision medicine program continued on Page 2

Inside this issue…

Network Operations

New precision medicine program, *continued from Page 1*

Our first priority with this program is to ensure that a physician is able to provide the right medication, at the right dose, as early in the treatment process as possible. This is a real opportunity to address health care on a person-by-person basis that's tailored to each member's individual needs. Working closely with our members and their physicians, we're now able to cut out the guesswork and make informed decisions that lead to sustainable treatment options and better patient outcomes.

Using the advanced analytics of OneOme's stratification process, OneOme will determine if one or more of your patients is eligible for pharmacogenomic testing. If you have an eligible member in your practice, both you and the member will receive a letter explaining the program. Letters sent to members give them the option to contact OneOme to initiate the testing supported with your order. Once testing is completed, you, as the provider, will receive a consultation report from the clinical pharmacist with recommendations that you can consider when making prescribing decisions for the patient.

We anticipate that using pharmacogenomic testing to guide prescribing decisions will also help to increase medication adherence and decrease the risk of adverse drug reactions. Adverse drug reactions are the fourth leading cause of death and are estimated to cost $136 billion annually. They account for up to 7% of all hospital admissions and up to 20% of readmissions, according to the Center for Education and Research on Therapeutics at Georgetown University and the Center for Drug Evaluation and Search at the Food and Drug Administration

To learn more about Blue Cross Personalized Medicine, testing or pharmacogenomics, I invite you to visit **oneome.com/bluecarenetwork-pgx** or call OneOme at 1-844-663-6635 (TTY: 711), Monday through Friday, from 8 a.m. to 6 p.m. Eastern time.

CQI incentive program now available for ambulatory surgery facilities

Our Collaborative Quality Initiatives are statewide, clinician-led quality improvement initiatives that address many of the most common areas of surgical and medical care in Michigan. Historically, the CQI program has involved the engagement and participation of hospitals and physician practices in CQI activities.

We recently expanded the program to include procedures performed at independent, free-standing ambulatory surgery facilities.** As a result, we've developed a CQI incentive program for ambulatory surgery facilities to support their participation and engagement in specific CQIs.

Please see CQI incentive program continued on Page 3

**Independent free-standing ambulatory surgery facilities are entities that operate exclusively for the purpose of providing outpatient surgical services to patients and aren't associated with one or more of Blue Cross Blue Shield of Michigan's participating hospital agreements related to hospital outpatient services.

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CQI incentive program, *continued from Page 2*

This CQI incentive will reward ambulatory surgery facilities that meet all of these requirements:

- They participate in our CQI program.
- They contribute data to the statewide registry.
- They learn and share best practices.
- They participate in continuous quality improvement activities.

Ambulatory surgery facilities that participate in this CQI incentive program will be eligible for a facility fee increase of 1%, or 101% of the standard fee schedule amount for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

This increase will apply to all services reimbursed at the facility level. The following CQIs are participating in the CQI incentive program for ambulatory surgery facilities:

- **The Michigan Arthroplasty Registry Collaborative Quality Initiative**
- **The Michigan Spine Surgery Improvement Collaborative**

Ambulatory surgery facilities must meet specific eligibility requirements, including procedure volumes and participation expectations, to be involved with this program.

To learn more about the eligibility requirements and participation expectations for the ambulatory surgery facilities CQI incentive, refer to the *2022 Blue Cross Blue Shield of Michigan and Blue Care Network Collaborative Quality Initiative ASF CQI Incentive Program for Independent Free-Standing Ambulatory Surgery Facilities*.

Ambulatory Surgery Facilities CQI Program Guide

Background information on our CQI program

With the Collaborative Quality Initiatives model, participants submit clinical condition-specific or procedure-specific data to a center responsible for analyzing the data to identify best practices and opportunities for improvement.

Quality improvement interventions are implemented, and collaborative participants meet regularly to share and learn best practices based on relevant, timely clinical data. For more information, visit our **Collaborative Quality Initiatives** site.

Clarification: At-home COVID-19 testing policy revised for Blue Cross and BCN commercial plans

We ran an article in our March-April issue about our revised at-home COVID-19 testing policy. On May 19, we posted a provider alert clarifying the frequency that members can obtain at-home rapid diagnostic COVID-19 tests from monthly to every 30 days. The federal government's website has also been updated and the quantity and timing on shipping has been removed as this continues to change.

See the May 19 **provider alert** and the prior article in the March-April **issue** for details.

Resources for learning about the new provider portal

If you're looking for training or have questions about the new Blue Cross Blue Shield of Michigan and Blue Care Network provider portal, Availity Essentials, take advantage of the following resources.

View recorded trainings

You can view recorded trainings on how to use Availity Essentials for your Blue Cross and BCN business. You must have an Availity® account to access these recordings. See the section on registration, below, if you're not yet registered.

There are two ways to find recorded trainings:

- Go to the **Availity Get Up to Speed with Training webpage**. (Note that this website will be available through October 2022.)
- Within the provider portal, you can find them by following these steps:
  1. Log in to our provider portal (**availity.com**).
  2. Choose *Help & Training* and then click on *Get Trained*.
  3. In the search field at the top of the screen, enter BCBSM.

Find answers to your questions

Here's where you can find answers to your questions:

- Call Availity Client Services at 1-800-AVAILITY (282-4548) Monday through Friday, 8 a.m. to 8 p.m. Eastern time (excluding holidays).
- Within Availity, click on *Help & Training* and then click on *Availity Support*.
- ***Welcome to Availity* special edition newsletter**
- ***Welcome to Availity* webpage**
- ***Transitioning to the Availity provider portal frequently asked questions for providers***

Still need to register?

If you haven't yet registered for an Availity Essentials account, you no longer have access to some Blue Cross Blue Shield of Michigan and Blue Care Network online tools. For information about registering with Availity, go to the **Blue Cross and BCN Welcome to Availity** webpage, scroll down the page and click *Register for Availity Essentials*.

After registering, your Availity administrator will need to take additional steps for users to access e-referral and Health e-Blue℠. For more information, go to our **Register for web tools page** and scroll down to *Getting access to Blue Cross and BCN tools through our provider portal*.

Availity is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal services.

Provider Secured Services and web-DENIS end date extended for some functions

Blue Cross Blue Shield of Michigan and Blue Care Network are extending the original June 21, 2022, retirement date for some functions within Provider Secured Services, including web-DENIS.

We encourage you to continue to make the move to the new portal. Some functions will remain up for a limited time, but many links and resource information will only be accessible through Availity.

See the **Provider Alert** for more details.

Commercial DRG clinical validation audits will begin in August 2022

EquiClaim, an independent company that provides auditing support for Blue Care Network, will perform clinical validation and coding claim audits on inpatient hospital diagnosis related groups, or DRGs.

This audit will ensure that a patient's diagnosis is consistent with the clinical documentation in the medical record. Audits will confirm that the ICD-10 diagnosis identified by the facility is generating the DRG assignment accurately, in accordance with the accepted standards of medical practice and diagnostic criteria.

Be ready to share medical charts for review at the time of an audit. After an audit, EquiClaim will send you a letter with the findings and information on how to request an appeal, if necessary.

The DRG clinical audit process:

- Ensures that diagnosis identified by the facility is validated based on DRG reimbursement methodology and national coding guidelines
- Performs clinical review of the physician documentation to determine if the patient diagnosis is consistent with the clinical documentation in the medical record
- Uses widely accepted standards of medical practice and peer-reviewed guidelines, citing references on every revision
- Includes ongoing research and literature reviews to ensure criteria and guidelines are always current
- Uses sepsis 3 criteria on related sepsis claims
- Includes review of the medical record by an EquiClaim registered nurse (If the diagnosis billed and the medical documentation don't match, a EquiClaim physician will review for validation before sending a finding letter to the facility.)

Questions?

Contact the EquiClaim Customer Service Line at 1-866-481-1479 if you have any questions.

New collections vendor for most Blue Cross and BCN commercial claims

Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with a new collections vendor, GB Collects, for most Blue Cross commercial and BCN commercial claims.

See article on **Page 35** for more information.

Network Operations

Action Item

Visit our provider training site to find important updates to existing training and new resources on topics that are important to your role.

Important updates to training courses and new on-demand training available

In support of the transition to our new provider portal, Provider Experience has updated many of our existing training courses with new screen examples and steps to align with the change. To access these courses, follow the steps at the end of this article. For training related to our new provider portal, visit the Availity Learning Center located on the portal by clicking *Help and Training* in the top navigation, then *Get Trained*.

We also continue 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 review recorded webinar: This lunch and learn webinar shares new information on documentation and coding of common and challenging diagnoses. Topics include a review of risk adjustment and hierarchical condition categories.

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***.

Here's how to confirm the networks you participate in

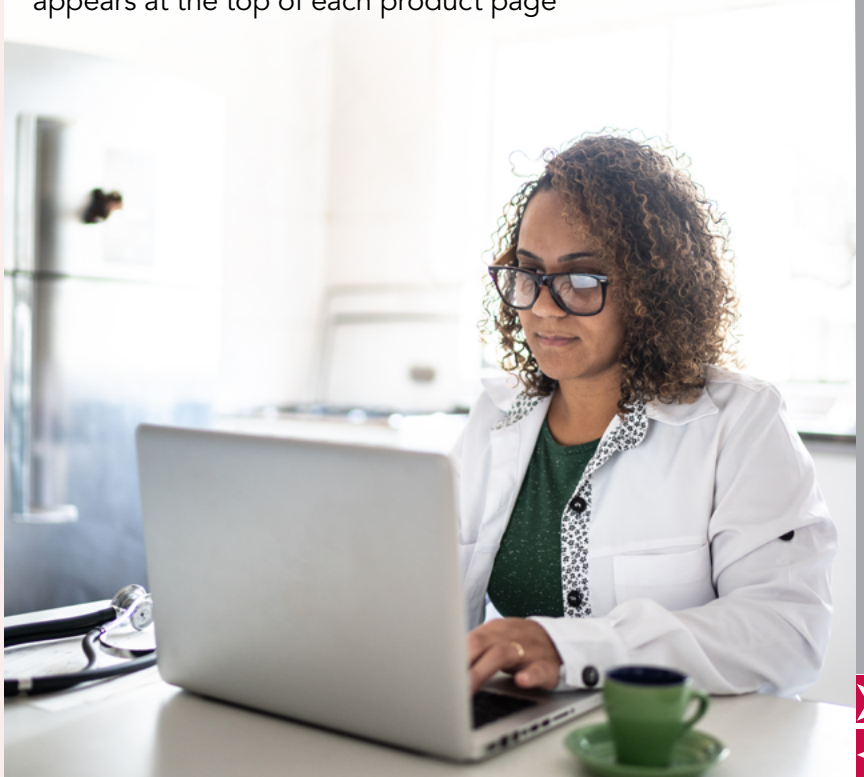
Blue Care Network has a document that helps providers find the Blue Cross Blue Shield of Michigan and Blue Care Network products they participate in. It's called *Finding your Blues plans* and is posted on our provider portal.

This guide shows you how to use the online provider search to confirm which Blue Cross and BCN products you accept. When new patients present themselves or current patients change health plans, you'll know if you accept the plan they have.

Here's how to find the document:

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.

Choose a product from the *Products* tab. The document appears at the top of each product page



BCN Advantage

Important news about submitting medical benefit drug prior authorization requests for Medicare Advantage members

Blue Cross Blue Shield of Michigan and Blue Care Network have transitioned to a new provider portal, Availity® Essentials. You should continue to submit prior authorization requests for most medical benefit drugs, including CAR-T cell therapy drugs, for Medicare Plus Blue℠ and BCN Advantage℠ members in one of the following ways:

- **Preferred method:** Through the NovoLogix® online tool. See the next section for the steps you need to take to access NovoLogix through Availity.
- **For providers who aren't able to submit requests through NovoLogix:** You have two options:
  - Use the new global **Medication Authorization Request Form** (for any medication), which we created to reduce the number of forms you have to manage. Fax the completed form to 1-866-392-6465.
  - Call our Pharmacy Clinical Help Desk at 1 800-437-3803.

Accessing NovoLogix through Availity

Important: Be sure to **register for Availity**, so you can continue to submit requests through NovoLogix.

If you have an Availity account, you have access to NovoLogix.

To submit requests through Availity:

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. In the Applications tab, click the appropriate tile:
   - NovoLogix MAPPO
   - NovoLogix BCN/BCN Advantage

Additional information

You can access the *Medication Authorization Request Form (for any medication)* on the **For Providers: How do I Submit Medicare a Drug Prior Authorization Request for Medicare Plus Blue PPO and BCN Advantage?** page of the **bcbsm.com** website. Later this year, we'll remove the medical drug prior authorization request forms for specific medications.

For more information about submitting requests and to view the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**, see the following pages of ereferrals. bcbsm.com website:

- **Blue Cross Medical Benefit Drugs**
- **BCN Medical Benefit Drugs**

We're designating preferred and nonpreferred IV iron therapy replacement drugs for Medicare Advantage members

Starting Aug. 8, 2022, we're designating certain intravenous iron replacement therapy drugs as preferred or nonpreferred for our Medicare Advantage (Medicare Plus Blue℠ and BCN Advantage℠) members. These drugs are covered under members' medical benefits.

If you're currently treating one of our Medicare Advantage members with a drug that will be designated as nonpreferred, we encourage you to transition to a preferred drug as soon as possible.

See the article on **Page 31** for full details.

Starting Aug. 1, reimbursement is changing for compounded Avastin eye injections, for Medicare Advantage

For claims received on or after Aug. 1, 2022, reimbursement will change to $160 per eye injected with compounded Avastin® (bevacizumab) eye injections. This is for medical drug claims for our Medicare Advantage (Medicare Plus Blue℠ and BCN Advantage℠) members. See full article on **Page 30**.

Reminder: 2% Medicare sequestration reduction slated to resume July 1

We're reminding providers that Medicare sequestration reduction is scheduled to resume July 1, 2022, at 2%. Blue Cross Blue Shield of Michigan and Blue Care Network are aligned with the Centers for Medicare & Medicaid Services' guidance regarding Medicare sequestration reductions.

You may recall that Congress and the Biden administration suspended the mandatory Medicare 2% sequestration reduction through March 31, 2022, and reduced the sequestration cuts to 1% from April through June 2022, to offset the decrease in provider payments because of the COVID-19 public health emergency. If the suspension is extended after June 30, we'll update you with a provider alert

Note: The 2% reimbursement adjustment is applied after determining any applicable member deductible, copayment or other required member out-of-pocket costs. The change won't affect reimbursement to providers who haven't been affected by sequestration previously.

Medicare Advantage post-acute care: New seven-day limit on documents in naviHealth's nH Access portal

Documents for Medicare Plus Blue℠ and BCN Advantage℠ members are available within nH Access™ for only seven days from the day they were posted. This was effective June 3, 2022.

If you need to access a document after it's been removed from nH Access, contact your naviHealth care coordinator.

If you have questions about this change, contact your local naviHealth provider relations manager. If you aren't sure who your naviHealth provider relations manager is, send an email to ***umproviderconcerns@bcbsm.com***.

naviHealth is committed to improving the post-acute care experience for our Medicare Advantage members. As part of this commitment, naviHealth provides access to patient information and documentation during the prior authorization process by making documents available through nH Access.

As a reminder, naviHealth:

- Authorizes patient-driven payment model levels during the patient's skilled nursing facility stay (from preservice through discharge).
- Authorizes PDPM levels based on medical necessity review and their proprietary naviHealth Predict functional assessment.
- Works with SNFs to ensure billers submit proper PDPM levels for reimbursement.

For more information, see **Post-acute care services: Frequently asked questions for providers**.

naviHealth Inc. is an independent company that manages authorizations for post-acute care services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.

BCN Advantage

Manage osteoporosis to limit disability

Musculoskeletal conditions are the second largest contributor to disability, according to the World Health Organization.

The Osteoporosis Management in Women who had a Fracture (OMW) HEDIS® star measure assesses women 67 to 85 years of age who suffered a fracture and had either a bone mineral density test or received a prescription to treat osteoporosis within six months of the fracture.

Read the tip sheet to learn more about this measure and information to include in medical records.

Tip sheet Osteoporosis Management in Women

New HEDIS measures for diabetic patient health

For measure year 2022, the HEDIS® Comprehensive Diabetes Care measure has been retired. In its place are four new standalone HEDIS measures:

- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Eye Exam for Patients with Diabetes (EED)
- Blood Pressure Control for Patients with Diabetes (BPD)
- Kidney Health Evaluation for Patients with Diabetes (KED)

All four measures are used for HEDIS reporting, however only HBD and EED measures are used by the Centers for Medicare & Medicaid Services as star rating measures to drive improvements in patient health. Splitting the CDC measure out into standalone measures allows the National Committee for Quality Assurance to individually adjust and maintain the measures over time as specification changes may be appropriate for one measure and not the others.

View the tip sheets to learn more about the measure specifications and ways you can close gaps in care for patients with diabetes. The tip sheets also cover required medical record documentation and claims coding to reduce the need for medical record reviews.

Note: Tip sheets are only available for the HBD, EED, and KED measures.

Eye Exam Tip Sheet

Hemoglobin A1c Tip Sheet

Kidney Health Tip Sheet

Remember to discuss fall risk, urinary incontinence and physical activity with Medicare patients

According to the National Committee for Quality Assurance:

- Falls are the leading cause of death by injury in people 65 and older; every year, one in four older adults fall.
- Urinary incontinence is significantly underreported and underdiagnosed.
- Any amount of physical activity reduces the risk of developing certain chronic conditions and increases quality of life.

Due to these serious health concerns, the Medicare Health Outcomes Survey measures patient-reported outcomes for three HEDIS® Effectiveness of Care measures:

- Fall Risk Management
- Management of Urinary Incontinence in Older Adults
- Physical Activity in Older Adults

The survey, which runs from August to November, asks randomly selected Medicare Advantage members questions about how providers talk about these important topics with them.

Read the HOS tip sheet to learn more, including what questions are asked and how you can address care opportunities with patients.

Health Outcomes Survey Tip sheet

BCN Advantage

Fyarro to require prior authorization for most members starting Aug. 16

For dates of service on or after Aug. 16, 2022, Fyarro™ (sirolimus protein-bound particles), HCPCS code J9331, will require prior authorization through AIM Specialty Health®. This drug is part of members' medical benefits, not their pharmacy benefits.

See the full article on **Page 27** for important details.

Landmark Health high-intensity in-home care program expands Oct. 1

On July 1, 2022, Blue Cross Blue Shield of Michigan and Blue Care Network will expand the high-intensity in-home care program by Landmark Health to include all Medicare Advantage members with multiple chronic conditions who live in Southeast Michigan counties, as well as in the Lansing and Flint areas.

For more information, see the full article on **Page 11**.

COVID-19 Test to Treat program coverage

The federal government's new Test to Treat program provides a one-stop location for an individual to get a COVID-19 test and, if the test is positive and the individual is eligible for treatment with an oral antiviral drug such as Paxlovid™ or Molnupiravir, the prescription can be written by a health care provider and filled, all in the same visit.

Test to Treat locations can include:

- Federally qualified health centers
- Long-term care facilities
- Pharmacies with an on-site health clinic

Here's what you need to know about Blue Cross Blue Shield of Michigan and Blue Care Network coverage for Test to Treat providers:

- There is no member cost share associated with covered COVID-19 testing. COVID-19 testing for employment, school or public health surveillance isn't covered. However, if an assessment occurs to determine whether the member should be treated with an oral antiviral drug, there may be a member cost share.
- The federal government is supplying the antiviral drugs at no cost to providers. Don't bill for the cost of drugs supplied by the government.
- Health care providers should bill for the test administration and treatment assessment using the member's medical benefit.
- Pharmacies can bill for dispensing the drug using the member's pharmacy benefit.

Here are resources for learning more:

- **COVID-19 Test to Treat at hhs.gov**
- **Antiviral medication information for health care providers**

Landmark Health high-intensity in-home care program expands Oct. 1

On July 1, 2022, Blue Cross Blue Shield of Michigan and Blue Care Network expanded the high-intensity in-home care program by Landmark Health to include all Medicare Advantage members with multiple chronic conditions who live in Southeast Michigan counties, as well as in the Lansing and Flint areas.

Starting Oct. 1, 2022, the program will be available to members in the following additional counties:

- Arenac
- Bay
- Calhoun
- Gladwin
- Gratiot
- Huron
- Jackson
- Kalamazoo
- Lenawee
- Midland
- Sanilac
- Tuscola

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.

The *Non-Opioid Directive form* is available on our website

Michigan law requires insurers to supply enrollees with a *Non-Opioid Directive form*. The form can be found on **bcbsm.com** on the Health and Well-Being page of the member section. The form will also be included in new member enrollment welcome kits starting July 1.

The *Non-Opioid Directive form* allows a patient to refuse opioid medications by signing and submitting the form to their provider for inclusion in their medical files. The form on our website is the same as the one available to the public on the Michigan Department of Health and Human Services website.

For more information on the non-opioid directive, see:

- Michigan's Opioid Addiction Resources website at **Michigan.gov/opioids**. The link can be found under Additional Resources at the bottom of the Find Help page.
- The Blue Cross Blue Shield of Michigan **Using Opioids Safely** page
- MCL § 333.9145 document on the **Michigan Legislature website**.

We'll implement 2022 InterQual criteria on Aug. 1

Blue Cross Blue Shield of Michigan and Blue Care Network will start using 2022 InterQual® criteria on Aug. 1, 2022, to make utilization management determinations.

Keep in mind that there are InterQual criteria for behavioral health services, as well as non-behavioral health services. However, for Blue Cross commercial members, New Directions, an independent company that manages behavioral health services for most Blue Cross members, uses its own criteria for making determinations on behavioral health authorization requests.

Additional information about behavioral health services is at the end of this article.

Non-behavioral health services

We'll use updated criteria for all levels of care to make utilization management determinations for requests to authorize non-behavioral health services, subject to review, for the following members:

- Blue Cross commercial
- Medicare Plus Blue℠
- BCN commercial
- BCN Advantage℠

When clinical information is requested for a medical or surgical admission or for other services, we require submission of the specific components of the medical record that validate that the request meets the criteria.

Please see InterQual criteria continued on Page 13

InterQual criteria, *continued from Page 12*

Blue Cross and BCN also use local rules — modifications of InterQual criteria — in making utilization management determinations. The 2022 local rules for acute care inpatient medical admissions were implemented on March 1, 2022. The 2022 local rules for post-acute care will be announced at a later date.

You can access the modifications (local rules), as applicable, for:

- **Blue Cross** — on the **Authorization Requirements & Criteria** page in the Blue Cross section of our **ereferrals.bcbsm.com** website. You'll see links to the criteria in both Blue Cross commercial and the Medicare Plus Blue sections of that page.
- **BCN** — on the **Authorization Requirements & Criteria** page in the BCN section of our **ereferrals.bcbsm.com** website. Look under the *Referral and authorization information* heading.

Refer to the table below for more specific information about which criteria are used in making determinations for various types of non-behavioral health authorization requests.

Criteria	Application
InterQual acute — Adult and pediatrics	• Inpatient admissions • Continued stay discharge readiness
InterQual level of care — Subacute and skilled nursing facility	• Subacute and skilled nursing facility admissions • Continued stay discharge readiness
InterQual rehabilitation — Adult and pediatrics	• Inpatient admissions • Continued stay and discharge readiness
InterQual level of care — Long-term acute care	• Long-term acute care facility admissions • Continued stay discharge readiness
InterQual imaging	• Imaging studies and X-rays
InterQual procedures — Adult and pediatrics	• Surgery and invasive procedures
Medicare coverage guidelines (as applicable)	• Services that require clinical review for medical necessity and benefit determinations
Blue Cross and BCN medical policies	• Services that require clinical review for medical necessity
Modifications of InterQual for acute medical admissions of adults (condition-specific local rules)	• Exceptions to the application of InterQual criteria that reflect the accepted practice standards for Blue Cross and BCN
Local rules for post-acute care (applies to inpatient rehabilitation, skilled nursing facility and long-term acute care admissions for Blue Cross commercial and BCN commercial)	• Exceptions to the application of InterQual criteria that reflect the accepted practice standards for Blue Cross and BCN

Note: The information in the table above applies to lines of business and members whose authorizations are managed by Blue Cross or BCN directly and not by an independent company that provides services to Blue Cross Blue Shield of Michigan.

Please see InterQual criteria continued on Page 14

InterQual criteria, *continued from Page 14*

Behavioral health services

On Aug. 1, 2022, we'll begin using the 2022 InterQual® criteria to make utilization management determinations for behavioral health services for these members:

- Medicare Plus Blue
- BCN commercial
- BCN Advantage

In addition, certain types of determinations will be based on modifications to InterQual criteria or on local rules or medical policies, as shown in the table below.

Products	Modified InterQual criteria for:	Local rules or medical policies for:
BCN commercial and BCN Advantage	• Substance use disorders: partial hospital program and intensive outpatient program • Mental health disorders: partial hospital program and intensive outpatient program • Residential mental health treatment (adult, geriatric, child and adolescent members) **Note:** Neither BCN commercial members with BCN1, BCN5 and BCN10 plans nor BCN Advantage members have residential mental health treatment benefits.	• Applied behavior analysis for autism spectrum disorder — for BCN commercial members only • Neurofeedback for attention deficit disorder and attention deficit hyperactivity disorder • Transcranial magnetic stimulation, or TMS • Telemedicine (telepsychiatry and teletherapy)
Medicare Plus Blue	• Substance use disorders: partial hospital program and intensive outpatient program • Mental health disorders: partial hospital program and intensive outpatient program **Note:** Only State of Michigan Medicare Plus Blue members have intensive outpatient program benefits.	• Telemedicine (telepsychiatry and teletherapy) **Note:** Medicare Plus Blue members don't have neurofeedback or TMS benefits.

For more information on telemedicine, refer to the **Blue Cross and BCN: Telehealth for behavioral health providers** document.

In early July, we'll have links to the updated versions of the modified behavioral health and autism local rules and to the medical policies. Those links will be located on these pages on our **ereferrals.bcbsm.com** website:

- ***Blue Cross Behavioral Health* page**
- ***BCN Behavioral Health* page**
- ***Blue Cross Autism* page**
- ***BCN Autism* page**

As noted earlier in the article, determinations on Blue Cross commercial behavioral health authorization requests are handled by New Directions. New Directions uses its own **Medical Necessity Criteria**.

New Directions® Behavioral Health is an independent company that manages authorizations for behavioral health and autism services for Blue Cross Blue Shield of Michigan members who have commercial plans.

In Brief: Roundup of important news from Hospital & Physician Update

We're providing links to some articles than ran in Hospital & Physician Update, our provider newsletter that covers high-level policy changes and patient care and quality initiatives.

Blue Cross launches new CQI to improve suicide prevention efforts

Suicide is the 10th leading cause of death in the United States. About 48,000 people die by suicide each year, with nearly 1.4 million people attempting suicide annually. That's why Blue Cross Blue Shield of Michigan is joining forces with Henry Ford Health to launch a new Collaborative Quality Initiative called the Michigan Mental health Innovation Network for clinical Design, or MiMIND. **Read more**.

Blue Cross focuses on maternal health, announces core measures

Blue Cross Blue Shield of Michigan — along with Blue plans across the country — is aligning with the Blue Cross and Blue Shield Association to help reduce racial disparities in maternal health by 50% in five years. Blue Cross Blue Shield of Michigan's Office of Health and Health Disparities created a Maternal Health Workgroup last year with the charge of developing a plan to support reducing maternal health disparities across Michigan. **Read more**.

New Pediatric Weight Management Initiative designed to decrease childhood obesity in Michigan

During the pandemic, the national rate of obesity among children ages 2 to 19 increased from 19.3% in 2019 to 22.4% in 2020. This surge, combined with an already high rate of childhood obesity, was a significant impetus for launching Blue Cross Blue Shield of Michigan's Pediatric Weight Management Incentive for pediatricians who participate in our Provider-Delivered Care Management program. **Read more**.

Michigan Opioid Collaborative: Making a difference in patients' lives

Blue Cross Blue Shield of Michigan has been at the forefront of battling the opioid epidemic in Michigan for several years and we've seen some significant transformation in the delivery of services to Michiganders with opioid use disorder.

Blue Cross has been working closely with the Michigan Opioid Collaborative to increase the number of primary care physicians with medication-assisted treatment, or MAT, waiver training. MOC is a Michigan Medicine initiative that was formed in partnership with the Michigan Department of Health and Human Services. **Read more**.

Patient Care/ Quality

Criteria corner

Blue Care Network uses Change Healthcare's InterQual Level of Care when conducting admission and concurrent review activities for acute care hospitals. To ensure that providers and health plans understand the application of the criteria and local rules, BCN provides clarification from Change Healthcare on various topics.

Question:

Can a blood product transfusion administered in the emergency department count toward admission orders? (GI Bleeding subset)

Answer:

If a patient receives a unit of blood prior to the decision to admit and then meets criteria for any of the listed findings under Hematochezia or melena, they must satisfy both the rule next to Hct or Hb monitoring, meaning colonoscopy within 24 hours and additional blood transfusion. An additional blood product needs to be given in addition to the preadmission blood product.

Question:

To meet criteria in the Pancreatitis subset, Acute LOC, Intervention: Unresponsive to ≥2 doses of analgesic in ED and prior to decision to admit and Analgesic ≥ 4x/24 hr, the doses given in the ED cannot be used as part of the four doses, correct?

Answer:

Correct. In the pancreatitis subset, the patient must continue to experience acute pain despite receiving at least two doses of analgesics in the emergency department and require continued analgesia (doses dependent on level of care) after they have been moved to the higher level of care.

Our Virtual Well-Being site offers health topics for patients

Blue Cross Blue Shield of Michigan and Blue Care Network want to partner with you to help your patients improve their health and well-being.

Blue Cross Virtual Well-Being℠ includes a weekly live, 30-minute, interactive webinar focused on engaging and inspiring people to enhance their overall well-being. Each week the hosts discuss science-based, relevant well-being topics such as eliminating the need for external validation, maternal health and physical activity for healthy aging. The webinar is on Thursdays at noon, Eastern time, and can be seen on demand the next day.

The Drop 5 Virtual Weight-Loss Community is part of the weekly webinar. The community is comprised of people who are trying to lose weight in five-pound increments. Each week participants receive a weight loss tip, interact live and are asked to send in their scale and non-scale victories. Here is what some of our Drop 5 participants have said:

- *I've lost 30 pounds since the beginning of the year with portion control, food journaling, and daily walks or jogs.*
- *My A1c is down!*
- *I combated incontinence so I could exercise. Thank you for the push as I removed this barrier. Now I ski and run!*
- *A victory for this week is I finally went to see my doctor! For me that is a victory, since I struggle with procrastination.*
- *I wish I would've known and started the Drop 5, webinars and meditations sooner. It's helping me with stress, and I like the motivation and tips.*

In addition to the webinars, a guided meditation is presented live each Wednesday at noon, Eastern time.

The webinars and meditations are free and available to the public so all your patients can register and participate.

Visit **bluecrossvirtualwellbeing.com** to register for upcoming webinars and meditations or to view past sessions on demand.

Medical policy updates

Blue Care Network's medical policy updates are posted on **bcbsm.com/providers**. To find them:

1. Go to **bcbsm.com/providers**.
2. Click *Resources*
3. Scroll to "Looking for medical policies?" and click *Search medical policies*.

Recent updates to the medical policies include:

Covered services

- Infertility related to cancer treatment
- Prostate cancer early detection: biomarkers prior to biopsy (previous title: Genetic and protein biomarkers for the diagnosis and cancer risk assessment of prostate cancer)
- Genetic testing for Lynch syndrome and other inherited colon cancer syndromes
- Obstructive sleep apnea and snoring — surgical treatment
- Positive pressure airway devices
- Sleep disorders — diagnosis and medical management

Noncovered services

- Subchondroplasty

Medical Policy Updates

From the medical director
By Dr. William Beecroft
Dr. Beecroft is medical director of behavioral health for Blue Cross Blue Shield of Michigan and Blue Care Network

We need to address alarming rates of suicide among young people

It was alarming to learn last year that suicide attempts among adolescent girls surged by more than 50% during the COVID-19 pandemic, according to data from the **Centers for Disease Control and Prevention**. Suicide is currently the second leading cause of death for youths and young adults in Michigan.

It's clear that the isolation caused by the pandemic exacerbated existing mental health problems. Emergency department visits at hospitals among adolescents were already increasing in early May 2020 as the pandemic began spreading across the U.S. Consider these statistics:

- From late July to late August 2020, the average weekly number of emergency department visits for suspected suicide attempts among 12- to 17-year-old girls increased by **26%** from the same period the previous year.
- The following year, from February to March 2021, average weekly visits to the emergency department for suspected suicide attempts among young girls was **50.6%** higher than the same period the previous year.

In addition to the social distancing and lockdowns that accompanied the pandemic, several other factors have influenced the behavioral health crisis that's leading too many young people to consider suicide. From the ever-present social media to the family disruptions caused by increased substance use during the pandemic, today's young people are coping with more than ever before. Some may not realize the consequences of their actions or lack a clear understanding of the finality of death. As I wrote in a **column** in *Physician & Hospital Update* last year, they need tools for coping with anxiety, depression and low self-esteem.

New initiatives

I'm heartened by the fact that Blue Cross Blue Shield of Michigan has been at the forefront of establishing resources to cope with behavioral health conditions that may lead to suicide. Here are three of the most recent:

- **Adolescent Suicide Prevention for Schools and Communities** — Blue Cross, the Michigan Elementary & Middle School Principals Association and **Michigan Virtual** joined forces last year to provide guidance, resources and support that can be quickly deployed to schools and communities. The initiative offers a series of five online courses on adolescent suicide prevention for educators, student leaders, health professionals, parent-teacher organizations and community members. To read more, see **this blog** on MI Blues Perspectives.

Please see From the medical director continued on Page 19

From the medical director, *continued from Page 18*

- **Our mobile crisis and crisis stabilization services** — Blue Cross offers mobile crisis assessment and crisis stabilization services to help ensure that members in crisis get prompt, appropriate behavioral health treatment. It uses the services of two facilities in Southeast Michigan — Common Ground Resources and Crisis Center and Hegira Health's COPE. Mental health professionals from those facilities can travel to meet members in crisis at their home, doctor's office or other location in select counties in Southeast Michigan. Effective June 1, 2022, we've expanded the program to include our Medicare Plus Blue℠ members.
- **MiMIND Collaborative Quality Initiative** — We're currently in the process of launching the Michigan Medical Health Clinical Quality Improvement Network for Implementation and Dissemination, called MiMIND. This statewide collaborative's aim is to prevent suicide and increase access to behavioral health services across the state. As a first step, we're collaborating with approximately five Physician Group Incentive Group physician organizations and their psychiatrists, psychologists and primary care physicians to implement evidence-based suicide prevention initiatives across their practices, and plan to reach out to additional physician organizations in 2023.

What doctors can do

One of the most important steps a primary care doctor can take to help prevent suicide is to regularly use a standardized assessment tool, such as the PHQ-9, with their patients. Question 9 is especially important as it asks whether the patient has questioned whether they would be better off dead or have had thoughts of hurting themselves. If they have, it's important to get them emergency help immediately. This may involve putting them in touch with a behavioral health specialist or connecting them with a therapist at one of the mobile crisis centers described above. Often, a therapist can talk to the patient by phone right from a physician's office.

In closing

Now, more than ever, there's an increasing need for the health care community to work together more closely to address the behavioral health needs of the populations we serve. We' deeply appreciate efforts of the physicians and hospitals we collaborate with as we continue to look for new solutions to address today's urgent challenges.

For more information, email me at ***WBeecroft@bcbsm.com****.*

We're removing age limits for autism spectrum disorder services for Blue Cross and BCN commercial members

We're removing age limits for autism spectrum disorder services, including applied behavior analysis, or ABA. This change is retroactive to Jan. 1, 2022, to ensure continued access to treatment for members whose plan benefits include ABA treatment, other autism services or both. It applies to Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

For dates of service on or after Jan. 1, 2022, we'll reprocess claims for ASD services that were rejected due to age limits. You don't need to resubmit the claims.

Members who aged out of eligibility for ASD services in 2022 will remain eligible to continue receiving ASD services that are medically necessary.

Background

Previously, following State of Michigan legal guidelines, children aged out of eligibility for certain ASD services when they turned 19. We're updating our benefits to allow members 19 and older to receive these ASD services when medically necessary.

We're making this change because recent medical evidence indicates that age limits are no longer an appropriate method for determining whether ABA treatment is medically necessary.

This change is consistent with recent guidance from the Michigan Department of Insurance and Financial Services, or DIFS, and the federal government.

Additional information

We're updating our *Autism Spectrum Disorder Services* medical policy and provider communications — including provider manuals — to reflect this change.

We'll update our certificate and benefit documents to reflect this change by Jan. 1, 2023.

All behavioral health practitioner specialty changes require new enrollment

You must complete a new mental health practitioner enrollment application when you're making changes to your specialty or licensure. Additional credentialing will be required for managed care networks.

The credentialing process verifies the licenses and qualifications of a provider and ensures that they meet the state requirements for health care. Your status as a network provider won't be active until the credentialing process is completed with your new information. That applies to any new or previous networks you joined.

For example, if you're a limited licensed psychologist who has recently become a fully licensed psychologist, you'll need to complete a new enrollment application. After your new enrollment application is processed, you must submit a request to terminate the LLP profile.

Similarly, if you're a clinical licensed master's social worker who has recently become a licensed professional counselor, a new mental health enrollment application is required. After your new enrollment application is processed, you must submit a request to terminate the LMSW profile.

Any groups you currently practice with will need to complete an administrative update with Blue Cross to reflect your change.

Go to **bcbsm.com/providers** for an **enrollment application**.

Be sure to review and submit all required documents for your newly enrolled specialty or license. Required documents are listed on the **Provider Enrollment and Change Process Required Document Checklist**.

If you have any questions or need additional information, contact Provider Enrollment Data Management at 1-800-822-2761.

Quality corner: Managing comorbid medical and behavioral health issues

With so many patients and members receiving behavioral health medications through their primary care providers, physicians are increasing taking care of medical, emotional and behavioral issues.[1] What's the best way to address all of these complex issues in the short time allotted for a patient visit?

According to the American Academy of Family Physicians [2], making sure to address a patient's co-occurring medical and behavioral health issues in small chunks can be an effective plan of action. Encouraging your patient to make small changes to improve their health, reach out to family and social supports or seek professional help and engage in routine exercise can have positive benefits for their overall health.

For complex issues, such as bipolar disorder and schizophrenia, providers should pay special attention to a member's medication regimen and the possibility of elevated A1c and LDL levels with antipsychotic medications. Routine annual screening (or more often, if indicated) as well as focusing on common medical comorbidities, such as smoking, poor diet and increased risk of cardiovascular disease, can help patients achieve a longer, healthier life.

But it shouldn't fall solely on primary care providers to help manage the health of a member with psychiatric and medical comorbidities. The Collaborative Care Model allows the primary care provider to oversee behavioral health concerns, such as anxiety and depression. In the Collaborative Care Model, the PCP has a behavioral health care manager who frequently checks in on patients receiving treatment for anxiety and depression. A consulting psychiatrist is also part of the care team. The behavioral health care manager meets with the consulting psychiatrist weekly to discuss the Collaborative Care patient caseload. The consulting psychiatrist makes recommendations during that review and the behavioral health care manager reviews the recommendations with the primary care provider. All patient care decisions, including whether to implement the psychiatrist's recommendations, are made by the PCP.

In addition, teaming with a patient's insurer as well as their behavioral health specialists not only lessens the burden for an individual practitioner, but it can also lead to improved outcomes in terms of physical and emotional health.[3]

Blue Care Network is committed to helping our members improve their health across physical, emotional and behavioral areas, as well as helping our providers make this as seamless a process as possible. With collaboration and communication between members, primary care, behavioral health and other specialists, we can help our patients and members lead longer and healthier lives.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2925161/#:~:text=This%20suggests%20that%20each%20year,treated%20for%20a%20psychiatric%20condition.
[2] https://www.aafp.org/fpm/2017/0300/p30.html
[3] https://www.ama-assn.org/delivering-care/public-health/how-payers-can-help-practices-integrate-behavioral-health-care

We'll implement 2022 InterQual criteria on Aug. 1

Blue Cross Blue Shield of Michigan and Blue Care Network will start using 2022 InterQual® criteria on Aug. 1, 2022, to make utilization management determinations.

Keep in mind that there are InterQual criteria for behavioral health services, as well as non-behavioral health services. However, for Blue Cross commercial members, New Directions, an independent company that manages behavioral health services for most Blue Cross members, uses its own criteria for making determinations on behavioral health authorization requests.

See article on **Page 12** for details.

Program provides mobile crisis assessment and stabilization for mental health and substance use

Blue Cross Blue Shield of Michigan and Blue Care Network began offering a new method of obtaining crisis assessment and stabilization services for mental health and substance use, effective Oct. 1, 2021.

Our mobile crisis and crisis stabilization services help ensure that our Blue Cross and Blue Care Network commercial members who are in crisis get prompt and appropriate behavioral health treatment. It can also help members avoid emergency room visits for mental health issues and substance use disorder, as well as unnecessary hospitalizations.

Central to the success of the program has been the establishment of facilities that provide high-quality mobile crisis and crisis stabilization services. Currently two facilities in Southeast Michigan meet the criteria to provide these services as part of our program: Common Ground Resources and Crisis Center and Hegira Health's COPE, which stands for Community Outreach for Psychiatric Emergencies.

Here's additional information about these centers:

Common Ground Resources and Crisis Center
Phone: 1-800-231-1127
Primary geographic areas covered: Oakland County, Macomb County, west of Macomb County

Hegira Health's COPE
Phone: 1-734-721-0200
Primary geographic areas covered: Livonia, Wayne County

Currently, Blue Cross is in discussion with other facilities that are interested in providing such services. We also hope to expand these services to our Medicare Advantage members in the future.

"The beauty of these services is they can meet the member where they are and be accessed any way you need to access them," said Dr. William Beecroft, medical director of behavioral health for Blue Cross.

They can be accessed by a health care provider, the member or other individuals. For example:

- A physician with a patient in crisis can contact one of these centers directly to have the patient evaluated by a member of the mobile crisis team, either in person or by phone.
- An emergency department at a hospital can contact one of the centers to request assistance in evaluating the patient and determining the best course of treatment, placement and referrals.
- A member can call the number on the back of their ID card to connect with a Blue Cross case manager who can direct them to a crisis counselor at one of the participating facilities.
- Members can call one of the participating centers directly or simply walk in to one of the crisis stabilization units.
- A law enforcement officer can call one of the centers for a behavioral health evaluation for a citizen in crisis.

"These services help ensure our members get treated at the right place at the right time and that they're linked to the appropriate level of care and available community resources," Beecroft said. "However, as part of the evaluation and treatment process, some members may still require psychiatric hospitalization as part of their treatment plan."

Mobile crisis services

The mobile crisis mental health team may stay involved for two to four weeks after the initial encounter to ensure patients are connected to the right level of care for mental health or substance use issues.

Following the initial encounter, crisis stabilization services (formerly called psychiatric observation) may take place and include:

- Behavioral health evaluation to initiate appropriate treatment (similar to medical observation services)

Please see Mobile crisis assessment and stabilization continued on Page 23

Mobile crisis assessment and stabilization,
continued from Page 22

- Physical site-based services that are necessary to support the mobile crisis team
  - Services include intake assessment, psychiatric evaluation, crisis intervention, psychotherapy, medication administration, therapeutic injection, laboratory and imaging diagnostics, observation and peer support
- Linkages and "warm handoffs" to the appropriate level of care and community resources

Additional benefits

Here are some additional benefits of mobile crisis and crisis stabilization services:

- A speedy, specialty-focused and confidential assessment of their immediate behavioral health (mental health and substance use disorder) needs
- A multidisciplinary evaluation, including the services of a psychiatrist, which leads to a plan of care and placement in the appropriate level of care
- A positive, less stigmatizing experience than with some other systems of care
- Rapid access to behavioral interventions, including medication, nursing care, psychotherapy and psychoeducation
- Alleviation of a sense of crisis, encouraging feelings of hope

Facilities that offer mobile crisis and crisis stabilization services must meet certain criteria. For example, they must be open 24/7 and incorporate the services of a multidisciplinary staff, including physicians, registered nurses, licensed master social workers, psychologists, clinical supervisors and additional support staff.

For more information

To learn more — or if you're interested in joining the program as a facility offering these services — contact one of the following:

- Dr. William Beecroft at ***WBeecroft@bcbsm.com***
- William Pompos at ***WPompos@bcbsm.com***

Blue Cross and BCN add new virtual option for behavioral health

Blue Cross Blue Shield of Michigan and Blue Care Network are expanding much needed access to behavioral health providers by offering a new national solution.

If you have a patient who is struggling to find assistance and unable to get an appointment with a behavioral health specialist or may benefit from a short-term virtual therapy program, you'll be able to refer that patient to a new virtual option, effective July 15. We've contracted with AbleTo, a network of more than 2,000 therapists serving adults 18 and older. The company offers virtual mental health services in all 50 states.

This option is available for members with Blue Cross PPO, Medicare Plus Blue℠ PPO, BCN HMO commercial and BCN Advantage℠ coverage.

AbleTo provides adult members a structured and evidence-based eight-week cognitive behavioral treatment program, which is the recommended treatment for anxiety and depression, the most prevalent behavioral health conditions. The program includes member access to weekly sessions with a licensed master's level clinician and access to digital tools, resources and relaxation activities for practice between sessions

Members can find an AbleTo provider on our Find a Doctor tool on **bcbsm.com**, the AbleTo website or by calling the number of the back of the member ID card.

AbleTo therapists complete an assessment and provide cognitive behavioral therapy. AbleTo *doesn't* provide medication management. AbleTo will coordinate with existing providers in our network and will refer members requiring additional care or psychiatric evaluation for medication to an alternative in-network provider.

We're changing how we cover some prescription drugs, starting July 1

Starting July 1, 2022, we'll change how we cover some medications on the drug lists associated with our prescription drug plans. We'll send letters to affected members and their groups and providers.

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. If members fill a prescription for one of these drugs on or after July 1, 2022, 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	Common use or drug class	Preferred alternatives
Glucagon emergency kit (brand only) GlucaGen® HypoKit®	Hypoglycemia	Generic glucagon emergency kit, Baqsimi®, Gvoke®, Zegalogue®
Praluent® *	Hypercholesterolemia	Repatha®
Ilevro® ** Nevanac® *	Ophthalmic NSAIDs	generic bromfenac sodium (once daily), generic diclofenac sodium, generic flurbiprofen sodium, generic ketorolac tromethamine, Prolensa®

* Drug is already not covered for Preferred Drug List

**Drug is already not covered for Custom Select Drug List

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.

Nonpreferred drugs that will have a higher copayment (or won't be covered for members with a closed benefit)	Common use or drug class	Preferred alternatives
Nyvepria®	Neutropenia	Neulasta®, Ziextenzo® (Step-therapy through Neulasta® and Ziextenzo® will also be required for coverage of Nyvepria®.)

Blue Cross and BCN are covering additional vaccines

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 vaccines to our list of vaccines covered under the pharmacy benefit:

Vaccine	Common name and abbreviation	Age requirement
Dengvaxia™	Dengue vaccine	None
Prevnar 20®	Pneumococcal (PCV20)	None
Vaxneuvance™	Pneumococcal (PCV15)	None

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 cost.

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

Please see Additional vaccines continued on Page 26

Additional vaccines, *continued from Page 25*

Vaccine	Common name and abbreviation	Age requirement
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)	Under 9: Two vaccines per 180 days 9 and older: One vaccine per 180 days
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
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.

Fyarro to require prior authorization for most members, starting Aug. 16

For dates of service on or after Aug. 16, 2022, Fyarro™ (sirolimus protein-bound particles), HCPCS code J9331, will require prior authorization through AIM Specialty Health®. This drug is part of members' medical benefits, not their pharmacy benefits.

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 and members with individual coverage

  Note: This requirement doesn't apply to members who have coverage through Blue Cross commercial self-funded groups, including the Blue Cross and Blue Shield Federal Employee Program® and UAW Retiree Medical Benefits Trust members with Blue Cross non-Medicare plans.
- Medicare Plus Blue℠ members
- Blue Care Network commercial members
- BCN Advantage℠ members

How to submit authorization requests

Submit authorization requests to AIM using one of the following methods:

- Use the **AIM ProviderPortal**
- 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 practitioners need to verify eligibility and benefits for members.

For additional information on requirements related to drugs covered under the medical benefit, see:

- **Blue Cross commercial and BCN commercial:**
  - **Medical oncology prior authorization list for Blue Cross commercial fully insured and BCN commercial members**
  - **Blue Cross and BCN utilization management medical drug list**
- **Medicare Advantage: Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**

We'll update the pertinent drug lists to reflect the information in this message before the effective date.

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.*

Pharmacy News

Fusilev no longer requires prior authorization

Because Spectrum Pharmaceuticals has stopped manufacturing Fusilev® (levoleucovorin), HCPCS code J0641, we no longer require prior authorization through AIM Specialty Health® for dates of service on or after May 31, 2022. The drug was part of members' medical benefits, not their pharmacy benefits.

This change applies to:

- Blue Cross and 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

For additional information on requirements related to drugs covered under the medical benefit, refer to the following drug lists:

- Blue Cross and BCN commercial members:
  - **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**

Note: Accredo manages prior authorization requests for additional medical benefit drugs for these members.

- Medicare Plus Blue and BCN Advantage members: **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**

Important news about submitting medical benefit drug prior authorization requests for Medicare Advantage members

Blue Cross Blue Shield of Michigan and Blue Care Network have transitioned to a new provider portal, Availity® Essentials. You have two ways to submit prior authorization requests for most medical benefit drugs, including CAR-T cell therapy drugs, for Medicare Plus Blue℠ and BCN Advantage℠ members.

See the article on **Page 7** for how to access the NovoLogix® online tool through Availity or through our new global *Medication Authorization Request Form*.

Additional medical benefit drugs to have site-of-care requirements for BCN commercial members, starting Sept. 1

Starting Sept. 1, 2022, the following drugs will have site-of-care requirements for Blue Care Network group and individual commercial members:

- Bavencio® (avelumab), HCPCS code J9023
- Imfinzi® (durvalumab), HCPCS code J9173
- Keytruda® (pembrolizumab), HCPCS code J9271
- Libtayo® (cemiplimab-rwic), HCPCS code J9119
- Opdivo® (nivolumab), HCPCS code J9299
- Tecentriq® (atezolizumab), HCPCS code J9022
- Yervoy® (ipilimumab), HCPCS code J9228

When the site-of-care requirements go into effect, these drugs may be covered only when administered at the following sites of care:

- Doctor's or other health care provider's office
- Home infusion therapy provider
- Ambulatory infusion center

These drugs already require prior authorization through AIM Specialty Health®. The new site-of-care requirements are in addition to the current prior authorization requirements.

This change doesn't apply to Blue Cross Blue Shield of Michigan commercial members or to our Medicare Advantage (BCN Advantage℠ and Medicare Plus Blue℠) members.

How the site-of-care requirements will be phased in

The site-of-care requirements will apply as follows for infusions involving any of the drugs listed above:

- **For courses of therapy starting on or after Sept. 1, 2022:** These infusions may not be covered at outpatient hospital facilities starting Sept. 1, 2022.
- **For courses of therapy in progress as of Sept. 1, 2022:**
  - These infusions may not be covered at outpatient hospital facilities starting Dec. 1, 2022.
  - If you choose to continue the member's treatment in an outpatient hospital facility, you'll need to obtain prior authorization from AIM by Nov. 30.

What to do for members currently receiving these drugs

- For BCN commercial members who currently receive these drugs at an outpatient hospital facility, you should do the following:
  - Check the list of **In-network home infusion therapy providers and ambulatory infusion centers** at which the member may be able to continue their infusion therapy.
  - Discuss with the member how to facilitate moving their infusions to one of the allowed sites of care.
- For BCN commercial members who currently receive these drugs at a doctor's office, at home or in an ambulatory infusion center:
  - Make sure you or the center bills infusions as a doctor's office, home infusion therapy provider or an ambulatory infusion center. Some offices and clinics are considered part of an outpatient hospital and bill as a hospital.
  - If you or the center bills as a hospital, you must obtain prior authorization for the member to continue receiving infusions there or the services won't be covered. If the prior authorization request isn't approved, the member will need to switch to a different infusion therapy provider for the services to be covered.

Please see Site-of-care requirements continued on Page 30

Pharmacy News

AllianceRx Walgreens Prime is now AllianceRx Walgreens Pharmacy

Effective June 24, 2022, AllianceRx Walgreens Prime, a provider of specialty pharmacy services, will change its name to AllianceRx Walgreens Pharmacy.

AllianceRx Walgreens Pharmacy will continue to provide Blue Cross members with specialty medications used to treat chronic, complex or rare conditions.

Starting Aug. 1, reimbursement is changing for compounded Avastin eye injections, for Medicare Advantage

For claims received on or after Aug. 1, 2022, reimbursement will change to $160 per eye injected with compounded Avastin® (bevacizumab) eye injections. This is for medical drug claims for our Medicare Advantage (Medicare Plus Blue℠ and BCN Advantage℠) members.

The change is based on clinical trials that show the product's safety and effectiveness.

Here's the information to include on the claim:

- HCPCS code number
  - For Medicare Plus Blue: J3590
  - For BCN Advantage: J9035
- National Drug Code
- NDC units (example: 0.05 ml)
- Exact dose in milligrams (example: 1.25 mg)
- Specific ICD codes pertinent to eye disease

This change for Avastin eye injections aligns reimbursement for Medicare Plus Blue and BCN Advantage claims with reimbursement in the marketplace.

Important: Avastin eye injections don't require authorization.

Site-of-care requirements,

continued from Page 29

How we'll help

For members who need to transition to a new infusion location, we'll work with you and the member to facilitate the transition. We'll notify members and do the following:

- Encourage them to talk to you before changing their infusion location.
- Let them know that this location change does not affect the treatment you're providing.

List of requirements

For a list of requirements related to drugs covered under the medical benefit that require authorization, refer to the **Blue Cross and BCN utilization management medical drug list** for Blue Cross and BCN commercial members. We'll update this list before Sept. 1.

You can access this list and other information about requesting prior authorization from AIM on BCN's **Medical Benefit Drugs** page on our **ereferrals.bcbsm.com** website.

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.

CareCentrix is an independent company that manages the in-state, independent home infusion services and ambulatory infusion center provider network for Blue Cross Blue Shield of Michigan and Blue Care Network members who have commercial plans.

We're designating preferred and nonpreferred IV iron therapy replacement drugs for Medicare Advantage members

Starting Aug. 8, 2022, we're designating certain intravenous iron replacement therapy drugs as preferred or nonpreferred for our Medicare Advantage (Medicare Plus Blue℠ and BCN Advantage℠) members. These drugs are covered under members' medical benefits.

If you're currently treating one of our Medicare Advantage members with a drug that will be designated as nonpreferred, we encourage you to transition to a preferred drug as soon as possible.

Preferred medications won't require prior authorization

The preferred IV iron therapy replacement medications are:

- Ferrlecit® (sodium ferric gluconate), HCPCS code J2916
- Feraheme® (ferumoxytol), HCPCS code Q0138
- Venofer® (iron sucrose), HCPCS code J1756
- INFeD® (iron dextran), HCPCS code J1750

These preferred medications won't require prior authorization.

Nonpreferred medications will require prior authorization

The nonpreferred IV iron therapy replacement medications are:

- Injectafer® (ferric carboxymaltose), HCPCS code J1439
- Monoferric® (ferric derisomaltose), HCPCS code J1437

For dates of service on or after Aug. 8, 2022, we'll require prior authorization for these nonpreferred IV iron therapy medications.

Submit prior authorization requests using the NovoLogix® online tool.

Exception: Injectafer and Monoferric will not require prior authorization when members receive them through a dialysis facility, in line with Original Medicare guidelines.

Refer to the **ESRD PPS Drug Designation Process** guidelines published by the Centers for Medicare & Medicaid Services.

When prior authorization is required

We require prior authorization for the nonpreferred drugs when they are administered in any site of care other than inpatient hospital (place of service code 21) and are 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 requests for the nonpreferred drugs 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, 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'll update the list to reflect these changes before the effective date.

Inflectra and Avsola will be the preferred infliximab products for pediatric commercial members

The following drugs will be the preferred infliximab products for pediatric Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members, effective July 1, 2022.

- Inflectra® (infliximab-dyyb), HCPCS code Q5103
- Avsola® (infliximab-axxq), HCPCS code Q5121

The nonpreferred infliximab products will be:

- Remicade® (infliximab), HCPCS code J1745
- Renflexis® (infliximab-abda), HCPCS code Q5104

These drugs already require prior authorization for both adult and pediatric members.

How this will affect pediatric members

- Pediatric members who have an active authorization for a preferred infliximab product as of July 1, 2022, won't be affected by this change.
- For pediatric members who have an active authorization for a nonpreferred product, their authorization will remain in effect through Aug. 31, 2022. In addition, we have approved authorizations for Inflectra and Avsola from July 1, 2022, through Aug. 31, 2023, so these members can continue their infliximab therapy without interruption. Health care providers don't need to submit prior authorization requests for dates of service within this time frame.
- For pediatric members who will be initiating therapy for an infliximab product, submit a prior authorization request.

How to submit prior authorization requests

Submit prior authorization requests through the NovoLogix® online tool. To learn how to do this, visit **ereferrals.bcbsm.com** and do the following:

- **For Blue Cross commercial members:** Click *Blue Cross* and then click **Medical Benefit Drugs**. In the Blue Cross commercial column, see the "How to submit requests electronically using NovoLogix" section.
- **For BCN commercial members:** Click *BCN* and then click **Medical Benefit Drugs**. In the BCN commercial column, see the "How to submit requests electronically using NovoLogix" section.

Definition of pediatric members

Pediatric members fit into one of these categories:

- 15 years old or younger, regardless of weight
- 16 through 18 years old who weigh 50 kilograms or less

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**.

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**.

Authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.

Leqvio to have site-of-care requirement for commercial members, starting Aug. 1

Leqvio® (inclisiran), HCPCS code J3590, will have a site-of-care requirement in addition to its current prior authorization requirement for Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members, starting Aug. 1, 2022.

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

Members who start treatment in a location other than those outlined above before Aug. 1, 2022, will be able to continue receiving the drug in that location until their current authorization expires. Providers should then transition members to one of the above sites of care.

Important information

- Starting July 1, 2022, the HCPCS code for this drug will be J1306.
- This drug is part of members' medical benefits, not their pharmacy benefits.
- As a reminder, prior authorization requests are submitted using the NovoLogix® online tool.

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 before Aug. 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.

We're expanding our Coding Advisor program to educate providers about appropriate use of procedure codes

It can be challenging for health care providers and their office staff to select the Current Procedural Terminology, or CPT®, code that best reflects the complexity of a patient visit. That's why Blue Cross Blue Shield of Michigan contracted with Change Healthcare, an independent company, to implement our Coding Advisor program in 2019.

Earlier this year, the Coding Advisor program was expanded to include Blue Care Network and BCN Advantage℠. While Change Healthcare won't review E/M services for BCN and BCN Advantage because they use a repricing program that's already in place, the company will review other modules that include services provided by BCN and BCN Advantage.

Change Healthcare reviews evaluation and management codes billed and other scenarios such as modifier 25, observation care and nursing facility care, on claims submitted to Blue Cross. The program provides useful data insights to the provider community and works to maximize coding efficiency and accuracy through up-front education, rather than a traditional post claim review process.

Effective July 1, 2022, the Coding Advisor program will expand to include the review of the Global Surgical Package. The GSP review is meant to help ensure the surgeon is using global service modifiers appropriately, based on modifier definitions. Global surgery applies in any setting, including an inpatient hospital, outpatient hospital, outpatient surgical center and physician's office.

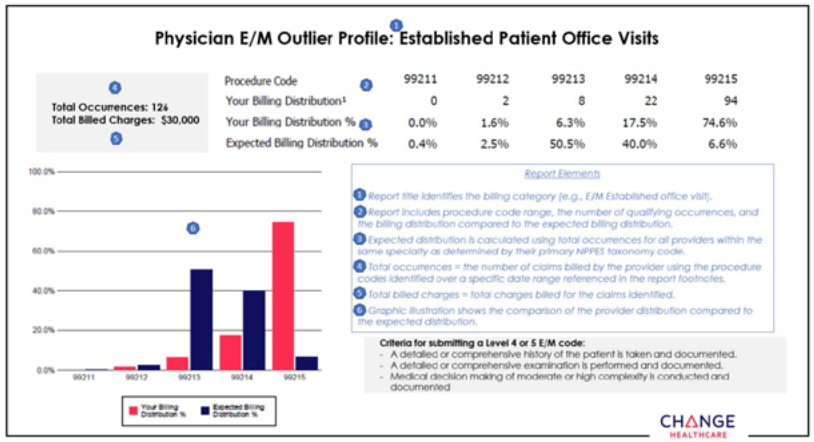
In July, Change Healthcare will reach out by phone or letter to providers who submit claims to Blue Cross and BCN. Coding Advisor will compare the billing of CPT codes to the codes used by a provider's peers through a physician profile.

Throughout the course of this program, Coding Advisor will continue to monitor billing practices and send updated reports periodically. It may contact your practice to discuss coding variances and to offer one-on-one coding education. You'll receive all correspondence from Change Healthcare.

If you have any questions, call the Coding Advisor customer support line at 1-844-592-7009 and select option 3.

For reference, we've included an example of a physician profile below.

Example of a physician profile:



New collections vendor for most Blue Cross and BCN commercial claims

Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with a new collections vendor, GB Collects, for most Blue Cross commercial and BCN commercial claims.

GB Collects will handle collections cases that are created on or after April 1.

This change affects all commercial claims except those for the Blue Cross and Blue Shield Federal Employee Program®.

What you should know:

- Collections cases that are affected by this change and are created on or before March 31 will be handled by Windham Professionals.
- Windham Professionals will continue to handle all claims for FEP.

GB Collects and Windham Professionals are independent companies that provide collections services for Blue Cross commercial and BCN commercial claims.

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 multi-leaf collimator device with intensity-modulated radiation therapy plan
- ICD-10 coding reminder

Clinical editing billing tips

Starting Aug. 1, reimbursement is changing for compounded Avastin eye injections, for Medicare Advantage

For claims received on or after Aug. 1, 2022, reimbursement will change to $160 per eye injected with compounded Avastin® (bevacizumab) eye injections. This is for medical drug claims for our Medicare Advantage (Medicare Plus Blue℠ and BCN Advantage℠) members.

See full article on **Page 30**.

Reminder: BCN Advantage members are eligible for one physical exam per calendar year

We want to remind providers that BCN Advantage℠ members are eligible for a physical exam once per calendar year.

This policy is applicable for CPT codes *99381-*99387 and *99391-*99397.

A clinical edit will occur if a member receives more than one physical exam per calendar year. Even though the provider is allowed to appeal, the appeal won't be overturned for payment.

Action Item

Register now for webinars that can improve your coding and documentation processes.

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.

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
July 19	Coding and Documentation for Vascular Disease	**Register here**
Aug. 17	Coding and Documentation for History and Rheumatoid Arthritis	**Register here**
Sept. 22	Coding and Documentation for 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**

How to access recorded webinars

To locate the recorded webinars from login to our Provider Training website, use the keyword "Lunch" to search for the courses. You will also find them listed in the Quality management section of the course catalog.

If you are already registered for the site, **log in**.

To request access for 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 for provider-related needs. This will become your login ID.

Previously recorded webinars	Topic
April 19	Coding and Documentation for HCC Capture and Risk Adjustment
May 5	Coding and Documentation for Cancer and Neoplasms
June 16	Coding and Documentation for Heart Disease and Heart Arrythmias

If you have any questions about the sessions, contact April Boyce at ***aboyce@bcbsm.com***. If you have questions about registration, email Patricia Scarlett at ***pscarlett@bcbsm.com***.

Prior authorization requirements change for radiology code *71271

Radiology code *71271 no longer requires prior authorization through AIM Specialty Health® for these members:

- Medicare Plus Blue℠ PPO
- Blue Care Network commercial
- BCN Advantage℠

This information is intended to clarify earlier communications about prior authorization requirements for this procedure code.

We've updated the document **Procedures that require prior authorization by AIM Specialty Health: Cardiology, radiology (high technology) and sleep studies (in lab)** to reflect this.

As a reminder, AIM Specialty Health makes authorization determinations for select high-tech imaging services and other services performed in freestanding facilities, outpatient hospital settings, ambulatory surgery centers and physician offices.

For additional information about submitting prior authorization requests to AIM, visit these webpages at **ereferrals.bcbsm.com**:

- **Blue Cross AIM-Managed Procedures**
- **BCN AIM-Managed Procedures**

Updated questionnaires in the e-referral system

We updated the following questionnaires in the e-referral system for BCN commercial and BCN Advantage℠:

- *Endoscopy, upper gastrointestinal, for Gastroesophageal Reflux Disease (GERD)* — For adult members
- *Oral surgery* — For adult pediatric and adult members
- *Otoplasty (outpatient)* — For pediatric and adult members

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.

Preview questionnaires

You can access preview questionnaires at **ereferrals.bcbsm.com**. They show the questions you'll need to answer so you can prepare your answers ahead of time.

To find the preview questionnaires, click *BCN* and then click ***Authorization Requirements & Criteria***. Scroll down and look under the "Authorization criteria and preview questionnaires" heading.

Authorization criteria and medical policies

The pertinent authorization criteria and medical policies are also available on the **Authorization Requirements & Criteria** page.

Time frames for determinations on authorization requests for acute inpatient medical admissions

The time frame within which Blue Cross and BCN must make a determination on a request to authorize an acute inpatient medical admission depends on the type of request.

We've updated the document **Submitting acute inpatient authorization requests: Frequently asked question for providers** to include information on the time frames for determinations. You can access that document on these webpages:

- **Blue Cross Authorization Requirements & Criteria**
- **BCN Authorization Requirements & Criteria**

For easy reference, we also included the details in the table below. This information applies only to acute inpatient medical admissions, not to behavioral health inpatient admissions.

Request for…	Time frame for determination	Line of business				Standard set by …
		Blue Cross commercial	Medicare Plus Blue	BCN commercial	BCN Advantage	
Preservice expedited organization determination	Within 72 hours of receipt of request	✓	✓	✓	✓	CMS NCQA
Concurrent expedited organization determination	Within 72 hours of receipt of request	✓		✓	✓	NCQA
Preservice standard organization determination	Within 14 calendar days of receipt of request	✓	✓	✓	✓	CMS NCQA
Concurrent standard organization determination	Within 14 calendar days of receipt of request		✓			CMS
Postservice standard organization determination	Within 30 calendar days of receipt of request	✓	✓	✓	✓	CMS NCQA

Please see Acute inpatient authorization requests continued on Page 39

TurningPoint coding requirements for musculoskeletal procedures and related services

TurningPoint Healthcare Solutions LLC has developed a new document titled **TurningPoint Coding Requirements**. It outlines the coding requirements that each prior authorization request must meet, along with examples.

To access this document and other resources, see the following pages of our **ereferrals.bcbsm.com** website:

- **Blue Cross Musculoskeletal Services**
- **BCN Musculoskeletal Services**

TurningPoint Healthcare Solutions LLC is an independent company that manages authorizations for musculoskeletal surgical and related procedures for Blue Cross Blue Shield of Michigan and Blue Care Network.

Acute inpatient authorization requests,
continued from Page 38

Here's more information about the types of requests:

- Standard: Request to reimburse for services.
- Expedited: Request when standard time frame could seriously jeopardize the life or health of a member or the member's ability to regain maximum function. Requires that a physician attest to the need for an expedited request.
- Preservice: Request is received prior to receipt of care.
- Concurrent: Request is received while member is receiving care.
- Postservice: Request is received after member has been discharged.

Reminders:

- We don't use the CMS two-midnight rule; we require authorization for all hospital admissions, both Medicare Advantage and commercial.
- Our authorization program is oriented toward providers, not members. We don't deny care, services or treatment. Our program determines the appropriate level of care for reimbursement (observation versus inpatient).

We're removing age limits for autism spectrum disorder services for Blue Cross and BCN commercial members

We're removing age limits for autism spectrum disorder services, including applied behavior analysis, or ABA. This change is retroactive to Jan. 1, 2022, to ensure continued access to treatment for members whose plan benefits include ABA treatment, other autism services or both. It applies to Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

See full article on **Page 20** for details.

Medicare Advantage post-acute care: New seven-day limit on documents in naviHealth's nH Access portal

Documents for Medicare Plus Blue℠ and BCN Advantage℠ members are available within nH Access™ for only seven days from the day they were posted. This was effective June 3, 2022.

For more information, see the full article on **Page 8**.

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BCN Provider News

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

Inside this issue…

Provider Secured Services and web-DENIS,

continued from Page 1

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.

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.

Controlling High Blood Pressure_CPB

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.

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

BCN Advantage

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.

BCN Advantage

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**.

BCN Advantage

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**.

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.

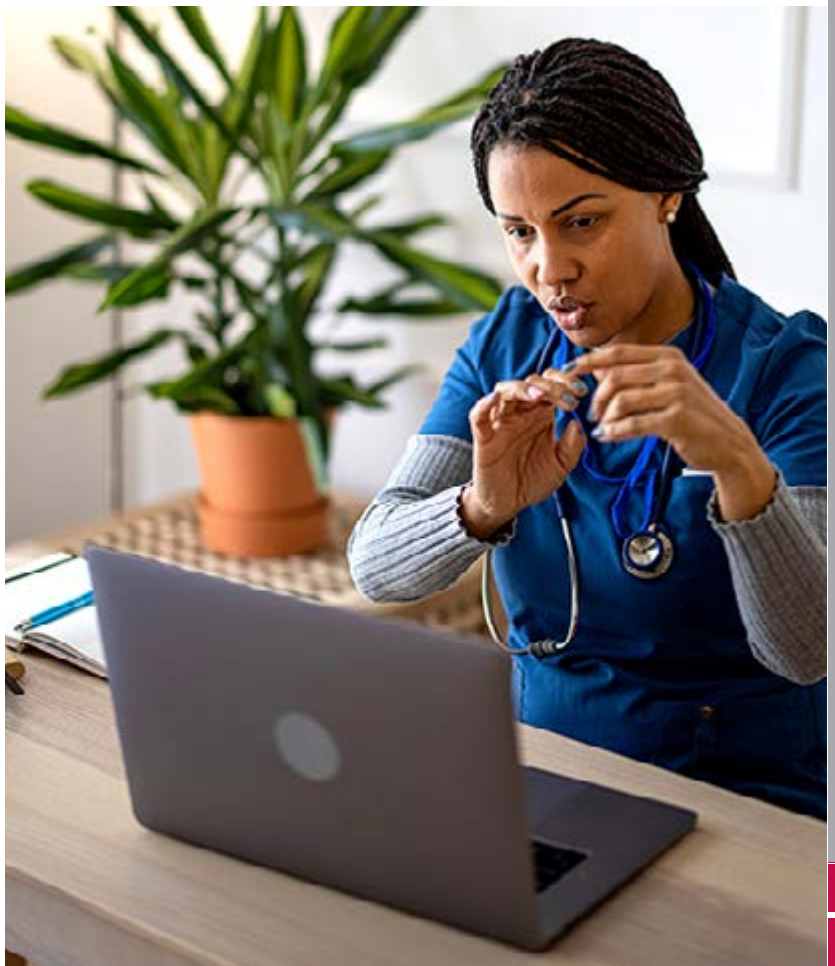
Keeping members involved in treatment for optimal outcomes

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.



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.

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.

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.

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® (faricimab-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.

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.

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.

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

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
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.

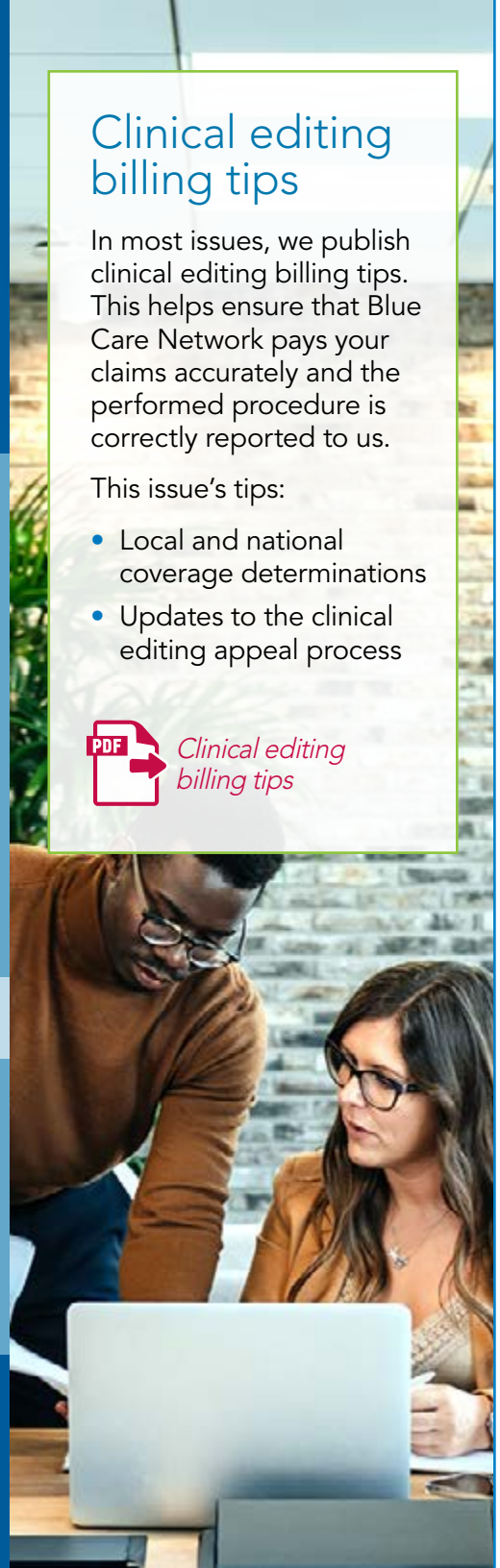
Vaccines must be administered by certified, trained and qualified registered pharmacists.

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.

Billing Bulletin



Clinical editing billing tips

In most issues, we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and the performed procedure is correctly reported to us.

This issue's tips:

- 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

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.

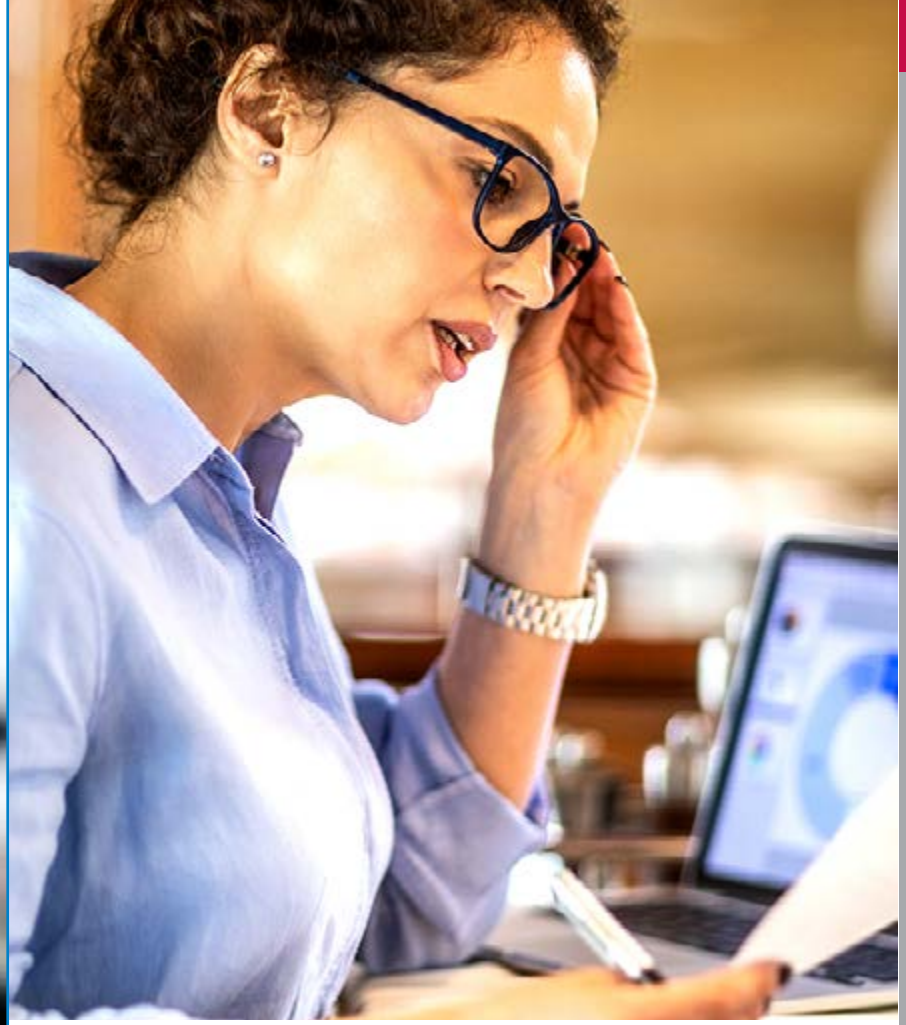
Billing Bulletin

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

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For details, see the full article on **Page 18**.

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.

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**

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.

Referral Roundup

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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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.

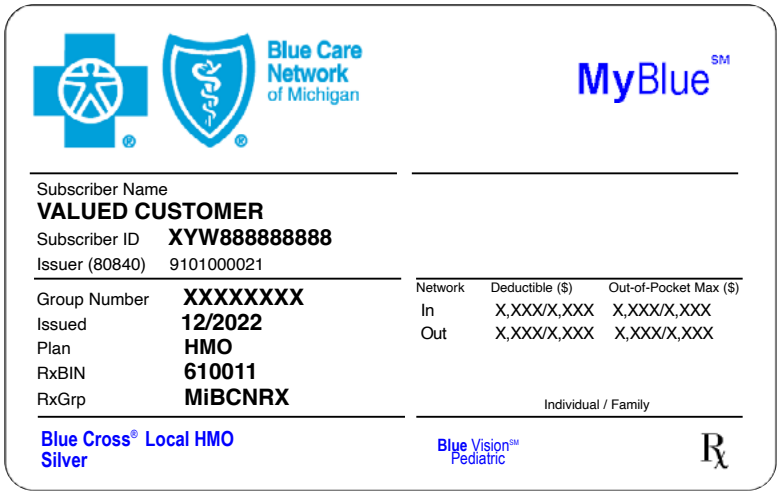
Members must receive services within this local network. The primary care physician coordinates care with the network specialists and hospitals. If a member needs services found outside the network, a referral is required from the primary care physician. BCN will only authorize the service if it is something 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

Network Operations

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. PCPs may refer to specialists and facilities from the full BCN Advantage network for all other services.

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

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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